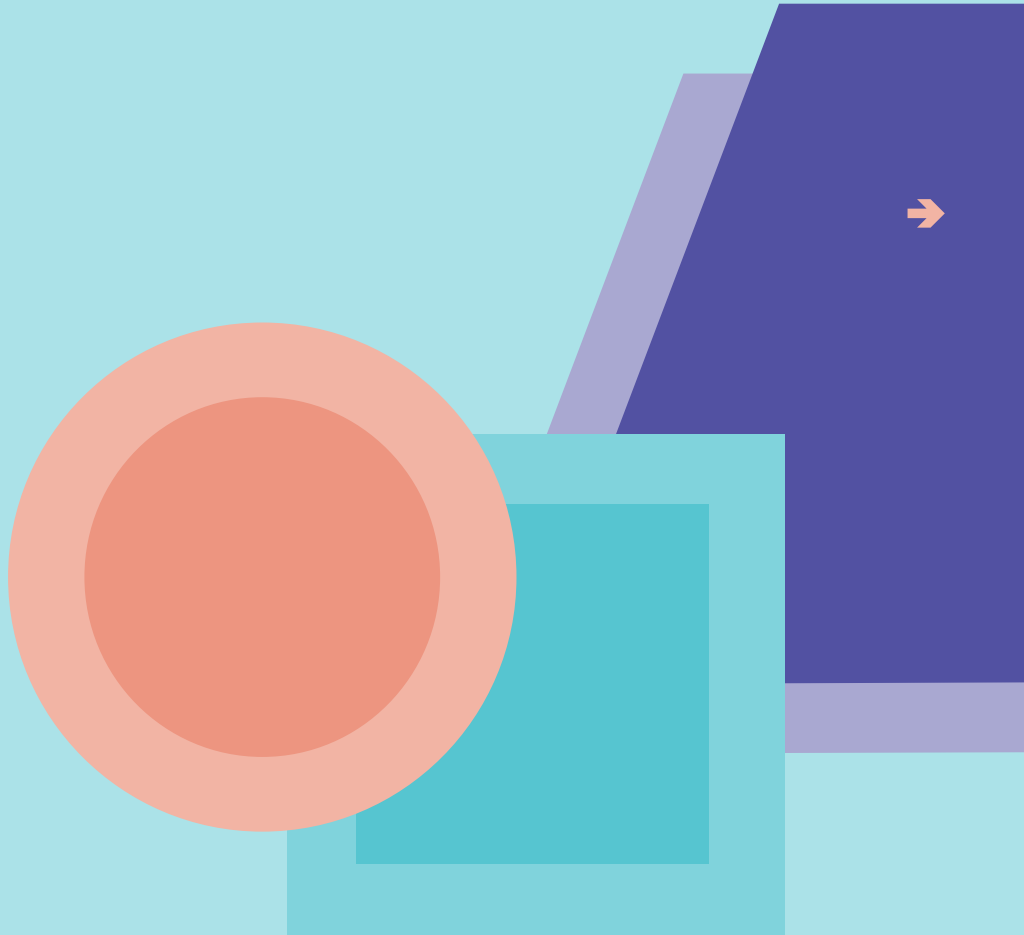
Guide to Good Governance

Fourth Edition

START READING

Introduction



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Acknowledgements

The content relied on in the Guide to Good Governance (Fourth Edition) was comprehensively updated and revised by **Heather Pessione** and **Nick Pasquino** of Borden Ladner Gervais LLP (BLG).

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The Ontario Hospital Association (OHA) thanks Nick and Heather for their diligent review of this edition of the Guide.

Working in close collaboration with BLG on the development of this edition of the Guide, the OHA acknowledges the following for their significant contributions as authors and editors:

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Disclaimer

As with previous editions of the Guide to Good Governance (the Guide), the Guide provides a broad overview of applicable legal topics and governance best practices at the time of publication. The Guide is not intended to be, nor should it be construed as, legal advice. As always, hospitals are advised to seek and obtain legal and/or professional advice based on their individual situations, as the laws and practice may change over time. In addition, the resources and templates accompanying the Guide should be reviewed and considered in the unique context of each hospital's existing policies, practices and served communities. Accordingly, hospitals are encouraged to customize these resources and template materials to meet their distinctive circumstances.

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About the Guide

Ontario hospitals are uniquely situated under both the *Not-for-Profit Corporations Act* as well as the *Public Hospitals Act*. These two pieces of legislation guide the way hospital boards operate and are structured. That said, efficient and effective board operation requires much more than simply strict legislative compliance. Good governance must leverage policy, processes and practice to build capacity to adapt to emerging issues.

Governance is a muscle that can atrophy over time and must be built and maintained. This fourth edition of the Guide to Good Governance (the Guide) provides information and resources supportive of a hospital board's ability to carry out its hindsight, oversight and foresight roles.

The Guide was first published in 2005 and updated twice as new legislation and accountabilities emerged. This Guide re-emphasizes the importance of foundational governance structures and processes and sees the requirements of the *Not-for-Profit Corporations Ac*t incorporated throughout the resource; rather than being a stand-alone chapter. In addition, this fourth edition of the Guide includes an overview of hospitals as civil society organizations, contains additional resourcing templates, and creates clear distinction between legal requirements and broader governance principles.

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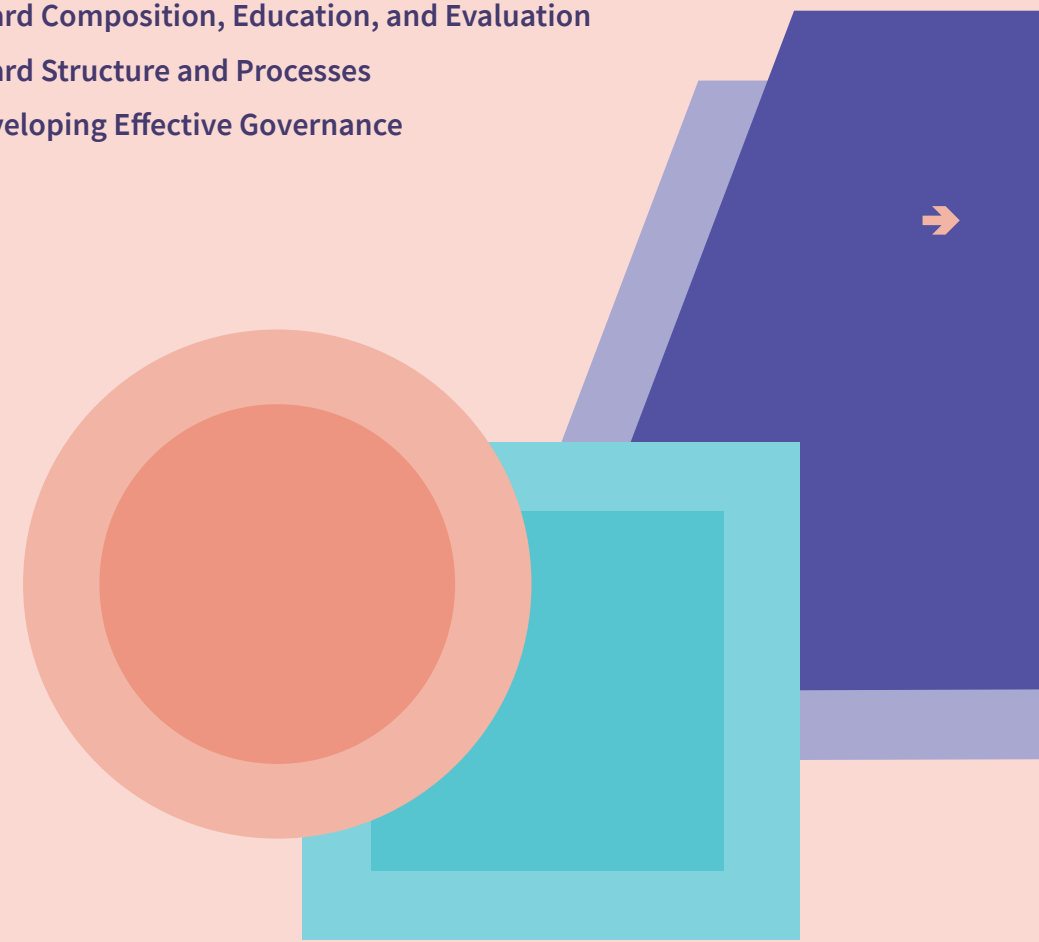

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Chapter 1: Understanding Good Governance

The Guide to Good Governance (Guide) is designed to assist boards of public hospital corporations with implementing effective governance by reviewing leading governance practices adapted to the context and landscape applicable to hospital corporations in Ontario.

In This Chapter:

The *Not-for-Profit Corporations Act*

In October 2021, the Ontario government proclaimed into force the *Not-for-Profit Corporations Act*, which replaces the *Corporations Act* where it applies to hospitals. Minor amendments were made to the *Not-for-Profit Corporations Act* in October 2023. The *Not-for-Profit Corporations Act* makes several changes to the *Corporations Act* as it impacts corporate governance of not-for-profit corporations in Ontario. This Guide refers to some of the more significant changes that impact corporate governance.

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Defining Good Governance

While the entirety of this Guide ultimately defines good governance, the next section of this chapter focuses on reviewing the core components. These core components include a review of corporate structure, fiduciary duty, and board culture.

Corporate Structure

Generally speaking, the affairs of a hospital corporation are governed by its board of directors. The regulations under the *Public Hospitals Act* confirm the role of the board by providing that "every hospital shall be governed and managed by a board".

Hospital corporations are non-share capital corporations generally incorporated by articles of incorporation under the *Not-for-Profit Corporations Act* (formerly letters patent under the *Corporations Act*) or, in some cases, incorporated by special legislation. A hospital's corporate structure is also subject to, and affected by, the provisions of the *Public Hospitals Act*. In addition to these two pieces of legislation, a board should be more acutely aware of the requirements contained in the *Connecting Care Act*, the *Commitment to the Future of Medicare Act*, the *Excellent Care for All Act*, the *Freedom of Information and Protection of Privacy Act,* the *Personal Health Information Protection Act*, the *Broader Public Sector Accountability Act*, and the *Broader Public Sector Executive Compensation Act*.

The hospital's objects or purposes are set out in its constating documents: generally, its articles of incorporation under the *Not-for-Profit Corporations Act* (formerly letters patent under the *Corporations Act)*, or under special legislation. While these purposes may vary among hospital corporations, they typically include the establishment, maintenance and operation of a hospital. These purposes are considered charitable.

Hospital corporations have members and not shareholders. Distinct from a business or share capital company in which shareholders are entitled to a share of the company's profits by receiving dividends, a hospital, as a non-share corporation, has members who are prohibited by the *Not-for-Profit Corporations Act* from receiving financial gain. Members elect

directors, appoint auditors, receive financial statements and approve certain fundamental changes, including amendments to by-laws. While many, if not most, public hospitals in Ontario have established closed membership models where the directors are also the members, it remains fundamental to understand the unique roles and obligations of both members and directors. There are actions that must be taken or confirmed by members, and actions that must be taken or confirmed by directors. These actions and confirmations are important and extend beyond mere formalities. A board member should be aware when they wear a director hat and when they wear a member hat.

Fiduciary Duty

Directors stand in a fiduciary relationship with the hospital corporation. The fiduciary duties owed by a hospital director to the hospital corporation are among the highest standards of conduct imposed at law. Among other things, directors are required to:

- Act honestly, in good faith and in the best interests of the hospital;
- Comply with the *Not-for-Profit Corporations Act*;
- Comply with the hospital's articles and by-laws;
- Discharge accountability obligations; and
- Exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances.

> **→ Find Out More**
>
> Hospital accountability and stakeholder relations are discussed in Chapter 4. Directors' duties are discussed in Chapter 6.

Exercising care, diligence and skill of a reasonably prudent person in comparable circumstances is an objective standard of care but it is also context specific. The fiduciary duties owed by directors to the hospital also include the duties of loyalty, maintenance of confidentiality, avoidance of conflicts of interest, as well as the duty of corporate obedience.

Directors are not accountable for errors in judgment provided they have followed a reasoned and informed process and discharged their fiduciary duties, pursuant to what is called the "business judgment rule". The business judgement rule and directors' duties are more fully discussed in Chapter 6.

Board Culture

Exploring what constitutes good 'board culture' is best outlined by focusing on the practice of good governance itself. A board actively seeking to understand, implement and achieve good governance is more likely to demonstrate good board culture. Good board culture is more likely to exist when best practices are followed, corporate and internal structures are observed, and good governance is consistently a board's focus. That said, adherence to good governance practices will not, by itself, achieve good board culture. Board member cohesion, board chair leadership, continuous improvement efforts, the earned trust of management, and director candour also contribute heavily to good board culture.

> **→ Find Out More**
>
> Board culture is more fully discussed in Chapter 9.

Framework for Good Governance

Effective board performance requires a board to understand the three framework conditions conducive to, and supportive of, good governance. These framework conditions are outlined below and shown in Figure 1.1: Framework for Good Governance

1. **Board Quality** – The quality and diversity of the individuals at the table and the collective impact of their knowledge (i.e., **who** is on the board)
2. **Board's Role** – The areas in which the board exercises a governance role and the approach the board takes when exercising its role (i.e., **what** a board does).
3. **Board Structure and Processes** – The structures and processes implemented and observed by the board to perform its governance role (i.e., **how** the board does its work).

Figure 1.1: Framework for Good Governance

Condition #1 – Board Quality

The quality of a board inevitably impacts the effectiveness of the two subsequent framework conditions (board role and board structures and processes). Due to this impact, it is paramount for boards to be attentive to their quality. Board quality includes the following dimensions:

- Board size;
- Board composition (including the knowledge, experience, and attributes of the board);
- Recruitment (including the processes that the board uses to recruit and train its directors);
- Terms and renewal of directors;
- Onboarding and education;
- Feedback and evaluation of governance; and
- Individual director development.

→ **Find Out More**

These elements are more fully discussed in Chapter 7.

Condition #2 – The Board's Role

All corporate boards, regardless of industry, size, scope or composition, fundamentally have the same role. Effective performance of the board's role includes the following dimensions:

- Being explicit about the board's role as the governing body;
- Ensuring all directors understand the board's role and their individual duties as directors;
- Strategic planning;
- Ensuring individual directors discharge their own duties accordingly;
- Differentiating the board's role from the role of the chief executive officer, chief of staff, and management as clearly as possible; and
- Overseeing management, quality, risk management, and stakeholder engagement.

→ **Find Out More**

These elements are discussed in Chapter 2, Chapter 3, and Chapter 6.

Condition #3 – Board Structure and Processes

The structure and processes implemented and observed by a board are key to effective board performance. Relevant considerations when establishing and reviewing board structures and processes include the following:

- **Leadership** – The board chair, and other appointed officers, take on board leadership roles.
  - Consider the processes respecting the appointment of officers. This may include defining the roles and qualifications of officers, setting term lengths, and establishing the process for selecting officers.
- **Committees** – Board committees assist the board in performing work the board may not otherwise have been able to complete itself.
  - Consider the processes respecting committee formation, operation, and sunsetting. This may include distinguishing between standing and ad hoc committees, ensuring committees are not doing the work of management, determining and reviewing committee terms of reference, reviewing committee composition and selection processes, and ensuring efficient practices for board reporting and oversight.

- **Meeting Processes** – Meeting processes are an essential component of effective board performance. Meetings without clear direction or targeted outcomes countervail effective performance.
  - Consider how agendas are set, how directors have input into agenda setting, open board meeting and *in camera* meeting processes, how virtual meetings are managed, verification of minutes, and distinction between matters before the board (information, discussion, decision etc.).
- **Relationships and Culture** – Although less tangible, relationships among board members, and with management, are an important element in creating effective governance.
  - Consider how to build effective bonds between board members, how members interact on topical issues, assessing whether board members are comfortable sharing their opinions.

→ Find Out More

Matters of board structure and processes are discussed in Chapter 8 and board culture is more fully discussed in Chapter 9.

Board Responsibility for Governance

It is important that a board take ownership over the quality of its own performance. While external assessments exist through organizations such as Accreditation Canada and the Ontario Hospital Association, the board remains accountable to itself for ensuring the quality of its own performance. That said, while this accountability ultimately remains internal, its origins are externally tied through the fiduciary obligation of stakeholder accountability.

The entirety of this Guide is designed to empower boards to take ownership over the quality of their own performance. The chapters that follow will provide the insight, tools, and information necessary to action this element of good governance.

→ Find Out More

Hospital accountability and stakeholder relations are discussed in Chapter 4.

Directors' duties are discussed in Chapter 6.

Developing good governance is reviewed in Chapters 9.

Chapter 2: Models of Governance

This chapter will equip boards with a foundational understanding of the nature of governance models. In doing so, it will enable a board to assess where on the spectrum it currently exists and inform decision-making and accountability in this context.

In This Chapter:

Board Authority

Hospital boards are legislatively tasked with "manag[ing] or supervis[ing] the management of the activities and affairs of the corporation".[1] While this authority is broad, there are a few specific legal roles, namely:

- Electing or appointing its officers;
- Approving the financial statements of the corporation;
- Reporting to members by calling and holding the annual meeting of members; and
- Passing by-laws subject to approval by the members.

Hospital corporations have the capacity, rights, powers and privileges of a natural person.[2] This authority applies, by extension, to the board as the hospital's directing mind. As with a natural person however, this authority is not limitless. A board's authority is subject to legislative constraints, its constating documents, internal structures, policies and procedures, contracts and agreements, and its broader accountabilities. More descriptively, a board's authority is subject to the following:

- **Legislative and Regulatory Constraints** – Public hospitals in Ontario operate in increasingly complex regulated environments. The principle statutory instruments applicable to corporate hospital governance are the *Public Hospitals Act* and the *Not-for-Profit Corporations Act*. In addition to these two pieces of legislation, and as was outlined in Chapter 1, a board should also be acutely aware of the requirements contained in the *Connecting Care Act*, the *Commitment to the Future of Medicare Act*, the *Excellent Care for All Act*, the *Freedom of Information and Protection of Privacy Act*, the *Personal Health Information Protection Act*, the *Broader Public Sector Accountability Act*, and the *Broader Public Sector Executive Compensation Act*.

> **→ Find Out More**
>
> See the OHA's *A Guide to Hospital Statutory Compliance* for additional information on legislative and regulatory compliance.

- **Articles of Incorporation and By-laws** – A hospital corporation cannot carry out activities or exercise powers that are restricted by, or contrary to, its articles of incorporation.[3] Although a by-law is not formally required to "confer any particular power on a corporation or its directors", such a by-law may either restrict an exercise of corporate power, or potentially deviate from minimum legislative standards.[4] In addition to these foundational corporate elements, attention should be paid to the elevated requirements of the *Public Hospitals Act* and its according regulations.[5]

- **Special Members Declarations or Agreements** – By-laws or related agreements may provide special rights to certain members; for example, a sponsor of a denominational hospital.
- **Partnership or Alliance Agreements** – Hospitals may have established agreements that merge aspects of their administration and services, which can affect how a board's authority is constrained.
- **Accountability and Related Service Agreements** – Agreements between a hospital and Ontario Health, the Ministry of Health (Ministry), or Ministry of Long-Term Care may also limit or impact a board's broad authority.

Governance Models

While boards have ultimate authority over the corporations they govern, each board can choose how to exert their authority. This is broadly referred to as choosing a governance model; and it is a primary function of the board. As Figure 2.1: Board Continuum indicates, three overarching governance models exist: working, management, and policy. Choosing a governance model requires a board to be intentional about what responsibilities it assumes, what it delegates to committee, and what is the responsibility of management. In addition, a chosen model is commonly impacted by the age, stage, and categorization of the hospital being governed.

Age and Stage: The length of time a corporation has existed, the growth of the organization relative to its overall potential, and the maturity of its administrative and operating policies and procedures.

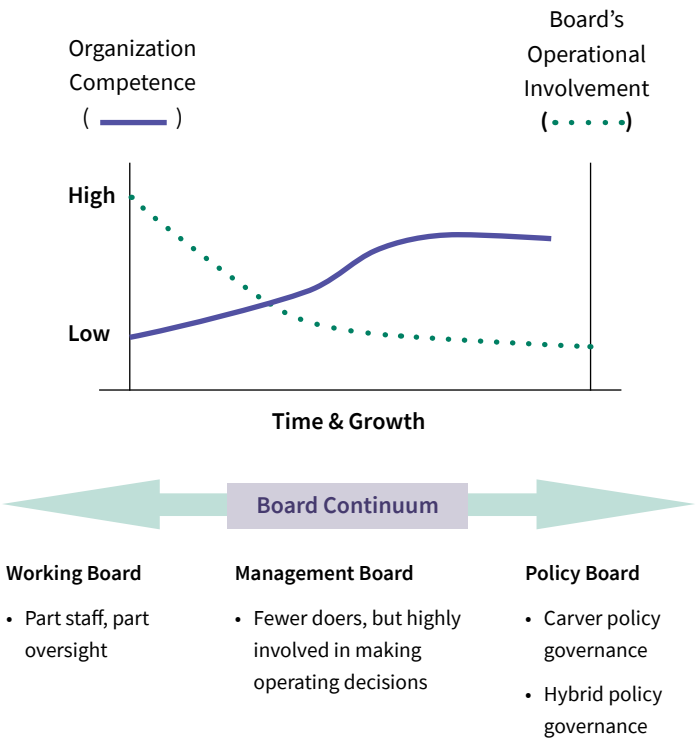
Hospital Categorization: Includes the size and complexity of the hospital together with the nature of its services (teaching, specialized, community, rural, etc.).

Evolution of a Chosen Governance Model

A board's chosen governance model may evolve over time and is largely dependent upon the degree to which a board is consistently involved in operational decisions. Factors impacting the evolution of a board's chosen governance model may include:

- A regression or growth in the corporation's age, stage or categorization;
- Comprehensive reduction in service offerings;
- Complexities of alliance, affiliate, or subsidiary relationships;
- A public health emergency;
- Changes in executive leadership;

Figure 2.1 Evolution of a Board's Role



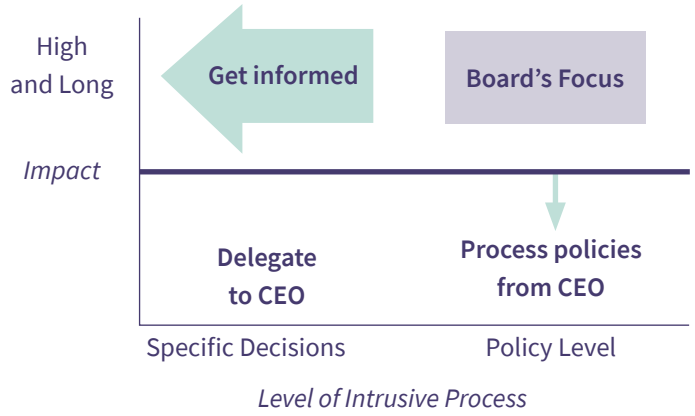
- Significant capital project delays;
- Erosion of the board-management relationship; or
- External accountability requirements.

A working board governance model is frequently implemented when corporate organizations are initially formed, or when they have limited staffing resources. In this model, a board routinely deals with both strategy and operations. In other words, it sees both the forest and the trees.

A management board is often chosen by smaller or more novice organizations. A management board may retain some degree of operational involvement in support of its executive director, chief executive officer and/or management. That said, a management board is less involved in corporate operations than a working board and focuses more heavily on strategic matters.

A policy board commonly takes form as a natural result of the maturation of corporate entities. Policy boards have highly developed policies, performance reporting structures, and sophisticated and specialized management knowledge. The boards of these organizations are more infrequently required to be involved in operational matters and focus more heavily on strategic, policy, performance, and longer-term planning. (See Figure 2.2: Board Focus)

Figure 2.2: Board Focus



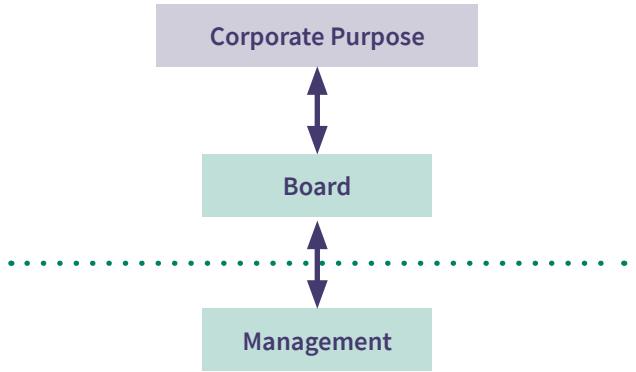
Many Ontario hospitals exist as policy boards but may evolve and adapt between management and policy board roles as required to ensure effective execution of fiduciary responsibilities. Policy boards commonly focus on:

- High impact issues that affect the purposes or mission, vision and values of the organization;
- Provision of high-level strategic direction to guide delegated decision-making; and
- Dealing with fundamental issues in a manner complementary of management's operational role.

The Board-Management Complement

As outlined above, many Ontario hospitals exist as policy boards. As a general principle applicable to this model of governance the board governs, and management manages. This is colloquially described as a board: "having its nose in but fingers out" of managerial operations – or identifying a board's role as: "hindsight, oversight, and foresight." In practice, these understandings mean that boards monitor what effort management is making toward board-approved strategies, mission, vision and values, but do not consistently second-guess or intervene in operational decisions. This is commonly understood as the line between board and management (See Figure 2.3: Board-Management Line below).

Figure 2.3: Board-Management Line



Like many elements of good governance, it is not sufficient to merely understand the board-management complement. These roles should be reduced to writing, internalized, and regularly revisited. For this reason, boards should declare their governance model and develop a written statement outlining its roles and primary function.

Access All Forms

See *Form 2.1: Sample Statement of the Roles and Responsibilities of the Board*

Ontario hospital governance is unique from the broader corporate community. Hospital boards must maintain oversight of not one, but two 'employees' – the chief executive officer (responsible for administrative management) and the chief of staff or chair of the medical advisory committee (responsible for patient care management). While a board typically delegates the day-to-day management of corporate affairs to these two respective 'employees,' it is required to maintain supervision over the management.[6] This is the board-management complement.

As previously outlined, a board may have to adapt its chosen governance model in response to unique circumstances. These circumstances may include, among other things, changes in executive leadership or erosion of the trust underpinning the board-management relationship. The recent global pandemic is a concrete example of circumstances that may thrust a board into a more operational role. The roles and responsibilities of a board-management complement should be adapted when the board determines a shift in its chosen governance model is required. While these roles may shift, it is important for a policy board to reconsider its state following the resolution or removal of the factors causing the initial role shift. Without a reset, a board may have more permanently regressed into a management board, created role confusion, and produced lasting organizational consequences. These consequences may include:

- Management recruitment and retention challenges;
- Poor culture among management;
- Lack of board cohesion; and
- Overall decline in organizational quality.

Role Confusion

A board that excessively, or unnecessarily, exercises its power of oversight on non-material matters runs the risk of role confusion. While effective exercise of fiduciary duty requires a board to ask probing and pertinent questions of management, giving operational advice may represent role confusion. As outlined above, role confusion can have negative consequences for an organization.

The following scenarios represent common examples of role confusion:

- Local community members and/or hospital donors approach a board member to raise individual concerns. In response, the board member agrees to personally investigate the issue, as it relates solely to the individual;
- A board member asks a litany of extremely detailed operational questions of staff when board education sessions are provided;
- A board member, in a live cyber breach situation, attempts to force management to call and utilize a breach coach the board member knows from their personal business because they 'are the best'; or
- A board receives a managerial report and suggests detailed edits, rather than providing recommendations or outlining concerns with the overall direction of the report.

As previously outlined, a board's declaration of its governance model together with a written statement outlining its roles and primary function will assist in combatting role confusion.

That said, putting these elements in writing is merely a first step. The board, led by its chair, together with the chief executive officer and chief of staff, should collectively monitor the implementation and evolution of the board-management complement. Doing so will help avoid role confusion and ensure the board continues to focus valuable resources on its high-impact governance roles.

Generative Governance

The principle of **generative governance** was first introduced in 2004 in *Governance as Leadership: Reframing the Works of Non-Profit Boards*.[7] Generative governance is largely an extension of the core elements of operating as a policy board.

Generative governance suggests that a board functions in three modes: fiduciary, strategic and generative. Each mode requires a board to focus on different content and follow different lines of questioning. Each mode also requires a different board-management relationship. The three generative governance modes are described in additional detail in Figure 2.4: Modes of Governance.

Figure 2.4: Modes of Governance

	Mode 1: Fiduciary	Mode 2: Strategic	Mode 3: Generative
Focus	• Stewardship, risk and compliance to policy and plan • Budgets, audits, policies	• Strategic directions and future plans • Creating and communicating sound, clear plans across stakeholders	• 'What if' questions and scenarios • Ideas and big questions about responding to change, but not firm plans for action
Management Relationship	• Board independence overseeing management	• Partners with management, recognizing management's lead role in understanding the business	• Board as a resource and co-creator with management • Dialogue with management, not usurping management's planning initiative

Generative governance suggests that each mode represents a progressive milestone. A board performing effectively in its fiduciary mode can advance to focusing on strengthening its second mode: strategy. A board performing effectively in its fiduciary and strategy modes can advance to focusing on strengthening its third mode: generative.

Boards should self-assess which mode they currently operate in and strive toward subsequent modes. Successful implementation of generative governance requires board cohesion. It will not be particularly beneficial to an organization if some board members are in fiduciary mindsets and others are in generative. This will manifest in tension and frustration when working through meeting agenda items.

Implementation of generative governance enables a board to utilize the full scope of its expertise to assist management in driving an organization toward success. When generative governance is practiced, boards spend more time actively discussing important matters and less time passively listening to data and presentation content. Boards wishing to incorporate elements of generative governance may consider the following:

- **Board Retreats** – Annual board retreats are common and provide a more flexible atmosphere to support the development of generative ideas. A board retreat can be purposively organized to deal with generative subjects.
- **Education Sessions** – Hosting staff led education sessions on new trends, programs or emerging practices can assist boards in generating ideas in a non-decision-making context.
- **Identifying Agenda Items for Future Generative Dialogues** – When important considerations emerge during a regularly scheduled board meeting that are not urgent or relevant for current purposes, they can be parked for generative discussion at a future meeting. The board chair can also make it a practice to solicit topics for future generative discussions.
- **Deep Dives** – Boards can allocate blocks of time to discuss a single topic in greater detail. The purpose of these sessions is to develop and discuss ideas, rather than make policy decisions. These conversations can be far-ranging and function without restriction. At the end of the session, the board may ask management to consider the discussion and report back with relevant proposals for consideration.

Chapter 3: Role and Function of a Hospital Board

This chapter will outline the eight key roles and functions of a hospital board. In reviewing these roles and functions, this chapter will provide board members with a deeper understanding of the factors that shape and guide their functioning and decision-making.

In This Chapter:

Access All Forms

See *Form 2.1: Sample Statement of the Roles and Responsibilities of the Board*

Function 1: Approving Strategic Goals and Directions

Like most organizations, a hospital needs a clear sense of organizational purpose and direction together with concrete plans for achieving its intended course. This is commonly referred to as **strategic management** and is a key component of board activity.

Strategic Planning

Most hospitals exercise strategic management through the development and updating of a strategic planning document (the strategic plan). The strategic plan is a foundational document providing direction to an organization, and is often comprised of the following:

- A strategic scan summary (analysis of internal and external influences relevant to the organization);
- Consideration of the strategic planning of system and accountability partners;
- The mission, vision and values of the organization; and
- Strategic directions and priorities, together with success measurements and indicators.

While hospital strategic plans are commonly created and/or updated every three to five years, timing and timeframes may be impacted by additional external factors and organizational needs. These factors may include:

- Strategic planning delays caused by uncontrollable external factors (e.g., global pandemic);
- Chief executive officer transition timing; or
- Significant organizational restructuring.

→ Find Out More

Best interests of the hospital are discussed in Chapter 4. Directors' duties are discussed in Chapter 6.

In determining the appropriate strategic planning term, content and whether to delay efforts, a board should carefully balance its broad accountabilities and the best interests of the hospital. Despite strong direction and influence over hospital funding from accountability partners such as the Ministry, Ontario Health and Ontario Health Teams, a hospital should nonetheless develop and maintain its own strategic plan. A strategic plan that considers the unique needs of the individual hospital, its accountability partners and communities it serves represents an essential exercise of local independent voluntary governance.

Strategic Planning Focus: The Big Picture and Broader Systems Thinking

As outlined above, a board should consider the strategic planning of system and accountability partners when doing its own when strategic planning, to ensure appropriate, co-ordinated, effective and efficient services. [8] The complex nature of strategic planning in the health system generates a substantial amount of information, input and analysis. Despite the volume of information, it remains imperative for a board to focus on the high-level strategic messaging that may be pulled from key findings and themes. This high-level strategy should include monitoring any potential impacts on the organization's mission, vision and values. During the strategic planning process, a board should be asking itself questions such as:

- Does this help us define what success is and how to measure it?
- How well are we doing as an organization and how well will we do in the future?
- Should we change our board goals and directions based on what we are seeing?
- Are our clinical programs and services positioned effectively and competitively?
- Are we the best organization to deliver the services we do?
- Can we continue delivering our services sustainably?
- Do partnership opportunities exist which would benefit the health system?
- Are there collaborative efforts underway within local health teams?
- How comparable and consistent is our hospital's performance with peer hospitals?
- Are we aligned with the plans of the broader health system?
- Are we providing input or influencing the plans of other health service providers?
- Are we monitoring developments at the system level to understand impacts on our organization?
- How aligned are we with our local health team's strategic vision and plans?

As these sample questions illustrate, a board should be focusing on the big picture and broader systems thinking. The effective exercise of this function forms the foundation of board decision-making during the term of the strategic plan's application. As such, it is an essential board role and function.

Board Participation in the Strategic Planning Process

Execution of the strategic planning process is largely a function of management. The board's role is to shape strategy and oversee management's completion of the process. The board is responsible for ensuring that strategic planning is carried out within reasonable timeframes, is properly focused, and that the resulting goals and directions are in the hospital's best interests. In practice, this means the chief executive officer, chief of staff and senior staff complement are commonly responsible for managing the overall process and

ensuring adequate staff support is provided. The board commonly participates in the strategic planning process in the following ways:

- The board approves the strategic planning process framework (often including the establishment of a steering committee);
- The board outlines preliminary areas of focus;
- The board participates in workshop-style dialogue (e.g., retreats) at key points during the process;
- The board receives milestone updates during regular board meetings;
- The board receives the final draft strategic plan document, has opportunities to question its contents and suggest modifications; and
- The board approves the final strategic plan and directs and monitors the chief executive officer and chief of staff on plan implementation.

Opportunities for the board to engage with the results of the strategic scan summary, government policy and funding developments, patient trends, programs and technology should be built into the strategic planning process. A board cannot oversee what it does not know or understand. This engagement may be built into regularly scheduled board meetings or take the form of a dedicated or semi-dedicated retreat.

> **→ Find Out More**
>
> Generative governance is discussed in Chapter 2.

Strategic Planning Steering Committee

As outlined above, it is common for organizations to strike a strategic planning committee to assist with the strategic planning process. These steering committees are often comprised of a blend of management and board members. This blended composition permits management to undertake the strategic planning process and the board to effectively oversee it. Such composition also permits a subset of the board, or individual board member, to possess more intimate knowledge of the process and established milestones. This intimate knowledge may subsequently be required if a board determines it should discuss the strategic planning process in a meeting without management. Without board involvement in the steering committee a subsequent meeting without management may not prove as fruitful as necessary.

Steering committees may perform several roles in the strategic planning process, including:

- Organizing the strategic planning process and major events, such as retreats;
- Assigning groups to undertake consultations and analysis;
- Preparing or approving summaries of the scans, workshops and retreats;
- Preparing or proposing optional directions and/or changes to mission, vision and values, based on board input; and
- Overseeing sub-committees that are conducting portions of the strategic assessment work.

Strategic planning steering committee composition often varies, but likely includes:

- Board member(s);
- Chief executive officer;
- Chief of staff;
- Senior staff complement;
- External community leaders; and/or
- Past board members.

Strategic planning steering committees are commonly co-chaired by a board member (potential future candidate for board chair) and the chief executive officer. Larger organizations may also consider the establishment of a strategic planning standing committee. The task of monitoring the implementation of a strategic plan, and its according milestones, may require extensive work and be a priority squarely within the board's focus. In these circumstances, a standing committee may prove particularly useful.

Strategic Planning Retreats

Strategic planning retreats are commonly held to engage a board more deeply and provide opportunities for members to give direction to, and advise on, the strategic planning process outside traditional and institutionalised governance roles. Although often encouraged, board retreats are not a requirement, and there is no best way to hold one. That said, some factors relevant to an effective board retreat are:

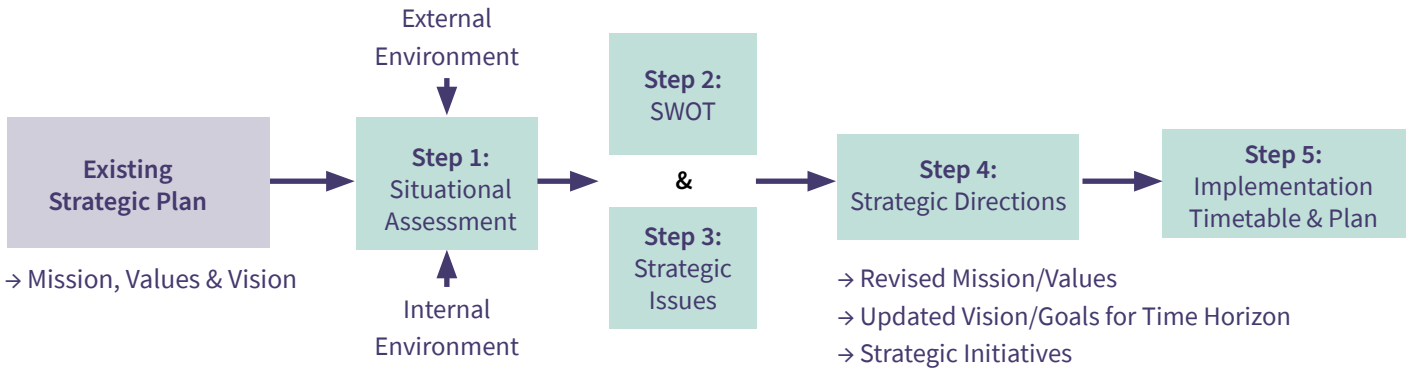
- Cost;
- Extension to additional stakeholders; and
- Specific confidentiality requirements.

The Strategic Planning Process

Strategic planning is a disciplined process and is focused on defining the purpose and direction of an organization. Major strategic planning processes commonly require the following five elements (see Figure 3.1: The Strategic Planning Process below):

1. Situational assessment (environmental scan);
2. Strengths, weaknesses, opportunities and threats analysis (SWOT);
3. Strategic issue identification;
4. Strategic directions; and
5. Implementation timetable and plan.

Figure 3.1: The Strategic Planning Process



Step 1: Situational Assessment (Environmental Scan)

When conducting situational assessments, it is important to review existing internal and external resources. This review likely includes the: organization's existing strategic plan, current mission, vision and values, and other relevant strategic materials and mandates. Other potentially relevant resources include government directions, existing funding agreements, and the strategic materials and mandates of accountability partner organizations. Thorough situational assessments often include reviews of both internal and external resources.

An internal review may include:

- Recent performance on patient safety and quality care;
- Financial condition and performance;
- Asset and infrastructure condition;

- Information technology capability;
- People strengths and capacity, human resources capacity;
- Innovation and new programs;
- Education and research, as appropriate;
- Risk profile;
- Existing funding agreements;
- Current strategic plan and related strategic directions;
- Balanced scorecard results and other metrics; and
- Community and stakeholder relationships.

An external review may include:

- Health sector trends;
- Funding trends;
- Legislative and regulatory developments;
- Population health indicators;
- Patient usage of alternative hospitals and care providers;
- Technology trends;
- Ontario Health strategies and plans;
- Ontario Health Teams' and other health sector providers' plans;
- Government directives; and
- New health system stakeholders.

Step 2: Strengths, Weaknesses, Opportunities and Threats Analysis (SWOT)

Situational assessments are often summarized in the form of a SWOT analysis. These analyses commonly classify the results of an assessment in a four-box format. The strengths and weaknesses are typically informed by the internal environment. The opportunities and threats are commonly informed by the external environment.

Step 3: Strategic Issue Identification

Strategic issue identification is a central component of any strategic planning process. Strategic issue identification may include focusing on:

- **Common themes** – While situational assessments and SWOT analyses identify and focus on more discrete issue identification, it remains imperative that an organization identify common themes across these strategic planning steps and determine which to focus on.
- **Gaps in benchmarking or performance monitoring** – Hospitals with balanced scorecards or an outcome/result performance measurement system may include a review of recent performance gaps to identify strategic issues. In addition, an organization may consider turning their attention to identified gaps in performance of peer hospitals and systems partners.
- **Key success factors** – If common themes and gaps in benchmarking are identified, an organization may more easily distill the content into key success factors. These are the factors requiring greater attention and determining them represents an essential exercise of local independent voluntary governance.

Step 4: Strategic Directions

The organization of strategic directions varies depending on how the identified issues are set out. Hospitals should determine the format best suited to its issues, programs, and mission, vision and values. However, final strategic directions commonly reflect the following features:

- A revised, or entirely new, organizational vision;
- Required time and resource investments;
- Concrete action areas aimed at advancing the strategic direction;
- Clear implementation periods; and
- Tangible and measurable targets.

Step 5: Implementation Timetable and Plan

It is common for strategic planning processes to stop at step 4. However, strategic planning processes should also include the development of implementation timetables and plans, including:

- Clearly defined targets or milestones;
- Board milestone reporting and monitoring mechanisms;
- Assignment of implementation accountability; and
- Risk definitions.

The Strategic Plan

A strategic plan provides a long-term framework for an organization. Foundational elements of a strategic plan include the **mission**, **vision** and **values**. An organization's mission, vision and values change infrequently and are intended to inform both board and management's decision-making, as outlined below:

- **Mission** – A mission statement identifies the enduring role and purpose of an organization. Mission statements commonly define a hospital's role and why it exists.
- **Vision** – A vision statement is an aspirational description of what an organization plans to accomplish or become over a defined period. Vision statements tend to be short and inspiring.
- **Values** – A value statement includes the norms, principles and commitments the organization intends to abide by in performance of the mission and vision. Vision statements commonly shape the 'how'.

Although "mission, vision, and values" are the terms most commonly incorporated into hospital strategic plans, terminology such as "purpose statement, guiding principles, and enablers" are also utilized. A hospital may ultimately adapt whichever fundamental statements best fit their organization's long-term strategy. In addition to an organization's mission, vision and values, each strategic plan should define what the organization will strive to achieve during the plan period. As outlined above, these objectives may include:

- **Mid-term objectives** – Strategic plan objectives should consider, or make reference to, the community served by the hospital and seek to improve services where possible. These objectives should be concrete and measurable where possible. (See Figure 3.2: Making Vision Concrete).
- **Strategic directions** – Themes that build toward the established vision. These may include: the strategic role and positioning of the hospital, what patient groups are served, what clinical programs or services will be offered, and what patient safety, quality of care and/or financial performance improvement initiatives will be focused on.
- **Focus on capacity** – A definition of organizational capacity and the required enhancements necessary to succeed in implementing the strategic plan.
- **Implementation plans** – Tangible milestones and success measurements designed to assist with the ongoing monitoring of strategic plan implementation.

In addition to the above considerations, each organization's strategic plan should be established with a view to the processes best suited to its unique challenges, resources and age and stage. See Chapter 2: Models of Governance to better understand age and stage. That said, additional guidelines for consideration are provided on the next page.

Figure 3.2: Making Vision Concrete

Current	In 5 Years
• Patient satisfaction below average	• Patient satisfaction above average of peer hospitals
• Two of six programs meeting patient result targets	• All six programs are meeting patient result targets
• Staff satisfaction below average	• Staff satisfaction above average
• Four programs with wait times for service 20% or more over target	• Wait for service in all programs within 5% days of target
• Two of three locations are old or poorly designed	• Asset plans for both old buildings
• Non-government revenues eight percent of total	• Non-government revenues 11% of total
• 60 specialist physicians in core programs	• 80 physicians in core programs
	• New specialized program in mental health

- **Choosing an appropriate strategic plan time horizon** – Although strategic plan terms often average three to five years, the time horizon for an organization's strategic plan remains up to each hospital based on its individual circumstances. Some organizations may position themselves to focus on shorter-term environmental uncertainty or hastening rates of change; while others may focus on slow implementation of longer-term strategic visions (10-20 years). Factors relevant to informing these decisions may include: the size of the organization, anticipated timelines for implementation, benchmarking with comparable organizations, the broader environmental context, planning costs and resources, or capital project timelines.
- **Broad consultation as a means of community engagement** – Strategic planning is a major opportunity to engage with, and build support among, stakeholders and the community. Broad consultation improves the diversity of those providing input—and thus thinking and ideas—and enhances the quality of the assessment process. As many channels of participation as possible should be utilized to increase awareness, understanding, and buy-in to the process and its results. For example, surveys, social media outreach, focus groups, community consultations, email updates, newsletters, and presentations may be used to get input and share information.
- **Engage physician leaders in hospital directions** – Physician resources have a critical influence on what services can be offered and how well they can be delivered. The plans of the medical staff for enhancing capacity should be interwoven with strategic and clinical service planning. Involving physician leaders in the hospital's strategic planning and direction-setting is critical as a basis for successful planning and implementation.
- **Engage employees** – Staff within the hospital can be consulted during the situational assessment planning stage to assist with issue identification, provide feedback on emerging priorities, and suggest action ideas. A variety of consultation and communications methods can be used to best capture involvement.
- **Communicate the strategic plan and its progress throughout implementation** – A board should ensure communication of the strategic plan to many audiences, including members of the community, patients/families/

caregivers, staff, and other stakeholders. Reports on progress should also be communicated periodically throughout a plan's execution. The strategic planning process provides the board with an impetus to ensure accountability partners are communicated with.

Reviewing a Strategic Plan

While directors may not be experts in the day-to-day affairs of a hospital, they still play an important role in ensuring the utility of a strategic plan. Directors may wish to consider the following when reviewing a strategic plan for approval:

- **Reasonableness of underlying assumptions** – As outlined above, effective strategic plans often represent a series of reasonable assumptions based on the information collected during a situational assessment. Directors should identify these fundamental assumptions and ensure they are appropriate.
- **Clear, concise, and concrete** – Strategic plans commonly create high-level direction for an organization. Despite this, strategic plans should remain clear, concise and concrete. Strategic plans should include annual action initiatives and directors should inquire into the appropriateness of these initiatives to ensure progress can be assessed.
- **Consider contingencies** – Effective strategic planning processes consider alternative assumptions and contingent situations, and board members may seek to ensure this contingency consideration has taken place by posing "what if" questions during the review and approval process. This may include questions around the secondary effects of the strategic plan on system accountability partners.

Monitoring Implementation of a Strategic Plan

As outlined above, strategic plans are not produced annually. That said, once a strategic plan is implemented, it should be revisited annually. Some organizations may create evergreen—or rolling—strategic plans, where revised operational targets for the following year or years are established. Other organizations may create separate annual operational plans that align with the broader strategic planning resource. These strategies ensure operational and strategic targets are in place and always being worked toward.

A review of the current strategic plan should also occur prior to the annual operational planning and budgeting cycle. A board should review progress made on strategic directions and identify any significant actions still required. In certain circumstances, a board may even consider modifying strategic directions and priorities based on new knowledge, developments and external events. The implications of such a review and revision process should be communicated clearly to the organization to inform annual operational and budget planning. In addition, a board should be regularly briefed on management's progress on the implementation of the strategic plan's initiatives.

Finally, a board should also consider the implications of any major decision, investment or organizational change on the hospital's strategic plan and its mission, vision and values.

Function 2: Establishing a Framework for Performance Oversight

To fulfill its fiduciary responsibilities, a board oversees the operating performance of the corporation. For hospitals, operating performance is largely concerned with the quality of its services to patients, financial performance and effective use of resources.

Performance Management Frameworks

Boards are challenged to execute their fiduciary responsibility of overseeing performance, while not becoming excessively involved in managing the organization and details of its operations. In order to strike this appropriate oversight balance, boards should establish a performance management framework. Performance management

frameworks shape performance objective setting, reporting on performance results, assessing whether results are adequate, and determining whether corrective action is required. Frameworks often include the following umbrella components:

- **Legislative and regulatory compliance** – Assessing whether the hospital is complying with applicable legislative and regulatory standards related to operations (e.g., patient safety and service delivery, infection and critical incident reporting, staff qualifications, resources, facilities, etc.)
- **Meeting service agreements** – Determining whether the hospital is meeting service standards and expectations contained in service accountability agreements with Ontario Health.
- **Meeting internally established targets** – Monitoring whether the hospital is achieving established targets outlined in its strategic plan, operating plan, budget, and other guiding documents. Other guiding documents may include patient satisfaction, services delivered, patient outcomes, costs per case, usage rates or employee engagement.

Performance management frameworks assist board decision-making by providing the information required to exercise the fiduciary responsibility of managerial oversight.

Designing a Performance Management Framework

While the performance objectives and measures monitored by a board may vary from organization to organization, the following are commonly relevant principles and practices:

- **Creation of an overall performance reporting system** – As outlined above, hospital operating performance is largely concerned with the quality of its services to patients, financial performance, and effective use of resources. Tools and board reporting measures should include these, and other, major elements of organizational performance.
- **Monitoring strategic plan objectives** – Performance monitoring should focus on the objectives and associated indicators outlined in an organization's strategic plan. As outlined above, it is common for organizations to develop annual operational plans based on the longer-term strategic plan. Annual operating plan targets should also inform the objectives and measures reported to the board as part of the established performance management framework.
- **Inclusion of mandatory indicators** – An organization's performance management framework should measure and monitor mandatory indicators for which the hospital is responsible. These mandatory indicators may include those outlined in an organization's quality improvement plan under the *Excellent Care for All Act*, Service Accountability Agreements or other significant legislative or contractual obligations.
- **Considering balanced scorecard and/or dashboard concepts** – Many different performance management framework styles and tools exist that balance simplicity with relevance. That said, balanced scorecards and use of dashboards remain among the most common. Many hospitals have developed board reporting tools that combine both balanced scorecards as well as dashboards; where a balanced scorecard outlines the pillars and dimensions for reporting (e.g., patient care or financial stability) and a dashboard report on actual performance on specific indicators (e.g., green, yellow or red).

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See *Form 3.1: Balanced Scorecards and Dashboards*

- **Keeping it simple but relevant** – Measurement systems utilized for board reporting should balance simplicity and relevance. Reporting on fewer measures makes it easier for an organization to communicate important information both internally and externally when required. That said, reporting on too few measures may leave gaps in board knowledge and fail to provide the information

necessary to ask appropriately probing questions of management. Due to the complexity of hospital operations, it is common for organizations to include between 10 and 20 reporting measures. These measures should naturally align downward with increasing levels of detail (e.g., the chief executive officer, vice presidents, directors, and managers).

- **Reporting on comparisons** – Performance management framework measures should be developed with consideration to the following:
  - Actual performance compared to planned results (targets);
  - Actual performance compared to historical performance (quarter over quarter);
  - Actual performance compared to available benchmarks (other similar hospitals);
  - Actual performance compared to acceptable standards or ranges (corridors);
  - Clearly identifying variances in the above; and
  - Commentary from management to explain significant variances identified.

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See *Form 3.2: Balanced Scorecard and Dashboard Approach*

See *Form 3.3: Quality Measures Dashboard*

Implementing a Performance Management Framework

In exercising its fiduciary responsibility of overseeing management's operating performance of the corporation, a board should consider the following roles and functions:

- **Question performance issues** – Boards reasonably rely on the information reported to them. As a result, it is important that boards inquire into, and make assessments about, the meaning of measurements being reported on. This includes ensuring management adequately explains variances, causes, and potential corrective actions for consideration. While a board should rely on management to address operational issues (unless given reason not to), it should ensure it satisfies itself with the nature and results of information being reported to it. Performance management frameworks should reinforce the importance of management accountability.
- **Required board action** – When a board determines urgency and imminent risk to the hospital and/or its reputation, the board may self-direct corrective action. For example, a board may determine it is compelled to intervene or lead organizational performance in matters involving government or external relations when major strategic projects have been identified to be at risk.
- **Carefully interpret performance results** – A board should exercise diligence and caution when making judgments based on reported performance measurements. While quantitative measurement is necessary and useful, a board should review and consider the meaning of measurement indicators and any corresponding variance when necessary. The following are common areas requiring additional board inquiry:
  - **Reported measures may only partially reflect reality.** For example, a board may receive a report indicating high employee turnover rates. There may be a host of underlying factors relevant to the reported measure. If a board simply assumes the reported measure is based solely on general staff quality or organizational culture, it may not reflect reality.
  - **Reported measures may be aggregated to reflect overall results.** An overall positive report score may mask serious performance issues. Boards may need to inquire into specific programs to investigate performance concerns.
  - **Reported measures may be missing data, resulting in under-reporting.** A positive report score may be the result of failed data capture. Similarly, efforts to improve data capture may result in less positive score reports. Boards may need to make additional inquires to understand reporting measures.

- **Reported measures may highlight changes over longer periods of time and quarterly improvement may not be an achievable outcome.** A board should assure itself that the activities designed to promote long-term success are being undertaken with discipline.
- **Some indicators might show changes over a longer period of time, and improvement cannot be expected every quarter.** In these cases, the board needs to assure itself that the activities that will promote success are being undertaken with discipline.
- **Uncontrollable external factors may cause measure reporting variance.** It is important for a board to acknowledge and understand these elements. However, a board may be interested in determining why the external uncertainties were not predicted or provided for in original planning.

When organizational performance is consistently positive, and a board has exercised its diligence in ensuring the accuracy of positive performance, it should find ways to acknowledge and reinforce the efforts that led to the positive performance.

Board's Role in Designing and Implementing Performance Management Frameworks

Hospital corporations are highly complex, and it can be difficult to distill measurement reporting into reasonable portions. Management should simplify and translate its own performance management regimes for use and tracking by the board. That said, and in exercising its fiduciary responsibility, a board should not rely solely on management's opinion of what should be monitored. A board should consider the following roles and functions in establishing and implementing a performance management framework:

- The board should approve the framework;
- The board should direct management to assist in improving the framework when necessary;
- The board should understand the meaning of measurement reporting; and
- Individual directors may focus on obtaining more detailed knowledge of certain measurement reporting information to assist board colleagues in interpreting the meaning.

In addition, a board may be supported by a relevant organizational committee. Many, if not most, performance management frameworks ensure measurement reporting on quality of services to patients, financial performance and effective use of resources. Committee members may be more knowledgeable about specific measurement reporting areas and how best to interpret them. Committees also work closely with management on an ongoing basis to improve measurement reporting and can probe into the reasons for variances without taking time from the full board.

Function 3: Overseeing Quality

Hospital boards provide policy and strategic direction, oversee performance, and make decisions with broad accountabilities in mind. Each of these elements encapsulate the effectiveness and quality of the programs and services delivered by the hospital. In addition, hospital boards must also respect legislatively codified quality oversight requirements. Quality of care is a complex issue, requiring professional and technical knowledge of medicine and hospital operations. As a result, hospital management and related health professionals are commonly the active drivers of quality care and patient safety issue identification and resolution.

Understanding Quality Care

Quality care encompasses a number of foundational elements, including patient outcomes and safety, patient flow and access, and patient experience.

The effects of hospital care on patient outcomes and safety include:

- Mortality and functional health outcomes;
- Adverse events or critical incident rates;
- Re-admission (included here as an indication of outcomes); and
- Degree to which services meet accepted standards, and best practices are used by staff.

Patient flow and access refers to the efficiency, equity and timeliness of the service delivered, including:

- Length of stay relative to benchmarks;
- Wait times for procedures;
- Emergency wait times;
- Turnaround times for diagnostics; and
- Percentage of Alternate Level of Care (ALC) patients.

Although patient experience is sometimes seen as patient satisfaction with services, a broader view involves a patient-centred and client-centred approach, including:

- Patient satisfaction surveys;
- Employee satisfaction surveys and views of care;
- Patient stories and case studies;
- Patient- and client-centred care practices;
- Patient family and caregiver advisory committees;
- Patient advisors; and
- Patient complaints.

Board's Role in Overseeing Quality

Oversight of quality requires a board to ensure there is an organization-wide focus on quality and patient care. A board should focus on creating the conditions and culture necessary to promote quality care and patient-centered approaches. These roles are often achieved when a board measures and monitors patient outcomes, cost-effectiveness of services, receives reports on patient outcome variances, celebrates successes, and consistently focuses on quality processes and issues. Risk management related to client and patient care is receiving much more attention in terms of developing evidence and standards. New practices are emerging, and the board's best practice approach will continue to evolve. This does not, however, mean a board should make or question specific recommendations to improve quality outcomes. That is not how it adds value. In fact, in a board's passion for quality, they should be careful not to become too involved in trying to solve operational and technical issues that should best be left to management and health professionals.

While boards have themselves chosen to spend more time on quality, there are also external legislative reasons for this increase. These legislative reasons include the codification of mandatory reporting and accountability requirements under the *Public Hospitals Act*, as well as the requirements of the *Excellent Care for All Act*. More specifically:

- **Mandatory reporting and accountability requirements** – The Hospital Management Regulation made under the *Public Hospitals Act* mandates oversight and reporting of critical incidents and quality indicators, including (among other things) a requirement that the hospital board ensures the chief executive establishes a system with respect to critical incident reporting.
- **Hospital Service Accountability Agreements (HSAA)** – Include required reporting indicators to demonstrate quality care and service accessibility. The government

has established mandatory reporting requirements in a number of patient safety and quality areas, including C. difficile rates and critical incident reporting. The board needs to ensure these are complied with by the chief executive officer and medical staff.

- ***Excellent Care for All Act*** – The *Excellent Care for All Act* requires the following of hospitals in relation to service quality:
  - A quality committee;
  - Annual quality improvement plan;
  - Patient declaration of values;
  - Patient relations process;
  - Satisfaction surveys of patients and staff; and
  - Performance-based compensation for executives.

Broadly speaking, and in partial overlap with the above, a board is responsible for overseeing quality by:

- Appointing and reappointing qualified medical staff;
- Establishing a quality committee;
- Approving the hospital quality improvement plan;
- Establishing and monitoring performance reporting;
- Monitoring quality risk management;
- Supporting directors in understanding quality improvement efforts; and
- Reviewing programs.

Appointing and Reappointing Qualified Medical Staff

One of the most critical aspects of board oversight of quality care is in respect of the appointment and reappointment of qualified medical staff. Through processes established under the *Public Hospitals Act*, and internalized in organizational by-laws, boards receive reports and recommendations from the medical advisory committee respecting privilege appointments. The board's diligent oversight in this role and function forms a strong basis for assuring patient safety and quality care.

> **→ Find Out More**
>
> See the OHA's *Professional Staff Credentialing Toolkit* for a detailed review of the privileging process.

Establishing a Quality Committee

As outlined above, the *Excellent Care for All Act* requires hospital boards to "establish and maintain quality committee".[9] The *Excellent Care for All Act* and its according regulations also outline required committee responsibilities and composition. The establishment of quality committees, together with the development of improved measurement indicators, has advanced the ability of boards to oversee quality.

Approving the Hospital Quality Improvement Plan

The *Excellent Care for All Act* requires hospitals to develop an annual quality improvement plan and make it available to the public. These plans must contain annual performance improvement targets, justification for the selected targets, and information respecting the manner and extent to which executive compensation is linked to the selected targets (consider also the *Broader Public Sector Executive Compensation Act*, its regulations, and Management Board of Cabinet directives).

These quality improvement plans must be developed with insight from patient and employee surveys, the patient relations process, critical incident data, and a review of provincially identified priority indicators. When prepared with these insights in mind, quality improvement plans help boards set policies and approve future quality improvement initiatives.

Establishing and Monitoring Performance Reporting

Regular reporting of performance measurements is necessary for a board to successfully oversee program effectiveness and quality. (The general approach to performance oversight, including balanced scorecards and/or dashboards, was discussed in greater detail earlier in this chapter under Function 2: Establishing a Framework for Performance Oversight).

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See *Form 3.3: Quality Measures Dashboard*

Monitoring Quality Risk Management

Effective oversight of quality care requires a board to have a risk perspective. Quality risk management initiatives are commonly undertaken by management in conjunction with medical leadership. That said, a board should satisfy itself that management has processes and procedures in place to identify, assess and mitigate quality care and patient safety risks. A board should also oversee the processes to ensure that risks to quality care are properly accounted for. Quality care and patient safety measurement reporting should be incorporated into the performance management framework established under Function 2: Establishing a Framework for Performance Oversight. Along with this, a board should understand the risks involved when dashboard quality indicators become yellow or red.

Supporting Directors in Understanding Quality Improvement Efforts

For a board to effectively oversee quality care, it must understand the business operations of the hospital. While directors are not expected to become experts in clinical affairs, overseeing quality improvement plans and corresponding targets requires an appreciation of the complexities and cause-and-effect relationships of care. The following are examples of practices instituted by boards to enhance their knowledge of hospital operations and quality care:

- **Education sessions on clinical services** – Boards may organize, both at quality committee meetings and/or pre-board meetings, to have staff present aspects of clinical services and operations to enhance board understanding.
- **Hospital tours** – Directors may be encouraged participate in 'walkabouts' with senior leadership team members through clinical programs.
- **Patient stories** – Patient stories may be presented at committee and/or board meetings to breathe life into the otherwise two-dimensional aspects of quality care issues. Patient stories help board members understand the patient experience more concretely.

Reviewing Programs

Some hospitals are creating systematic processes for reviewing clinical programs and departments. Typically, these are performed by the quality committee and results are subsequently reported back to both the full board and chief executive officer. These processes provide more time for board members to understand and comment on quality care and improvement plans.

The purpose of these review processes is not to have the board directly guide clinical operations, which would go beyond its role in governance, but to support the chief executive officer and chief of staff through understanding quality care and enable positive recognition where appropriate. These processes also help a board to understand the complexities of quality in the context of affordability. There are various approaches to implementing program reviews, but the following represent common elements:

- **Assigned reporting cycles** – Each program or department (e.g., women's health, emergency department or diagnostic imaging) is placed on a fixed reporting cycle. The fixed reporting cycle may vary depending on the number of programs or departments as well as available quality committee time.

- **Standard reporting templates** – Each program or department provides a report using a standardized template in advance of the assigned meeting. The template may include topics such as a description of the program or department, recent performance measures, successes, challenges, and opportunities.
- **Highlight presentations** – Highlights are presented by the senior staff of the program, and committee members may ask questions, where appropriate.
- **Concluding summary** – At the end of a program review, a committee chair summarizes the comments and suggestions, including positive feedback on performance, areas for more attention, and items where further planning or coordination is required.
- **Written feedback** – A committee chair or chief executive officer commonly sends a note to the program or department leaders noting the committee's thoughts and suggestions.

The specific program review protocols should be designed to maintain the appropriate distinction between the role of the board and the role of management.

The Quality Committee

Hospital boards have long chosen to establish quality committees to support their quality oversight role; even before it was legislatively mandated by the *Excellent Care for All A*ct. That said, the *Excellent Care for All A*ct requires hospitals to have a quality committee that reports directly into to the board. The committee's membership must include the following:

- A sufficient number of members to ensure that one-third of the members are voting members of the board;
- One member of the medical advisory committee;
- Chief nursing executive;
- Chief executive officer;
- One person who works in the hospital who is not a physician or registered nurse; and
- Others as appointed by the board.[10]

The *Excellent Care for All Act* also requires quality committees to:

- Monitor and report to the board on quality issues and on the overall quality of services provided in the hospital, with reference to appropriate data;
- Consider and make recommendations to the board regarding quality improvement initiatives and policies;
- Ensure the best practice information supported by available evidence is translated to materials that are distributed to employees and persons providing services within the health care organization, and to subsequently monitor the use of these materials by these people;
- Oversee the preparation of annual quality improvement plans; and
- Carry out any other responsibilities provided for in the regulations.[11]

Challenges for the Board

The role of the board in the quality arena often creates challenges. When a board is required to deal with additional specific issues of quality monitoring and process, the board will need to be vigilant about sticking to its governance role to ensure it is not becoming overly involved in operations and clinical processes.

Another challenge involves bringing systems and collaborative thinking to quality issues. This means looking at opportunities for integration, coordination and better hand-offs with other hospitals and health care providers within the province. This brings the strategic agenda and the quality agenda together. Boards should pay greater attention to partnerships and joint ventures with other organizations which may potentially require board-to-board consultation and collaboration.

Function 4: Overseeing Financial Conditions and Resources

The board's overall governance function is to guide the hospital to sustained success in meeting its purposes. Achieving this requires a board to ensure the ongoing viability and sustainability of the hospital, including protecting assets from risk and resourcing strategic initiatives. Oversight of financial conditions and resources involves the following:

- Overseeing financial performance, viability, and sustainability;
- Ensuring resources and assets are available and effectively used; and
- Overseeing risk management processes designed to protect assets and resources.

Overseeing Financial Performance, Viability, and Sustainability

A board needs to ensure the hospital has, or will have, the funds necessary to meet its service and program agreements and/or commitments. This requires being attentive to the following items:

- Ensuring funding is available for ongoing operations;
- Ensuring cash flow is sufficient in order to maintain viability and sustainability; and
- Monitoring operating performance to ensure agreements and commitments are met.

If the board becomes aware that the hospital cannot meet the requirements contained in its service accountability agreement(s), the hospital should promptly follow the processes outlined in its service accountability agreement.

Ensuring Resources and Assets are Available and Effectively Used

Hospitals need assets to carry out their business (e.g., facilities, operating rooms, technology, offices, equipment, and computers). The corporation needs resources to provide, maintain and, at a future time, replace those assets. The board needs to ensure these assets are available to the organization and used effectively. This means:

- Ensuring the availability of capital funds to maintain and replace facilities and other assets that are needed to provide services to patients, including by way of fundraising by, and alignment with, the hospital foundation;
- Ensuring that the assets are used properly and effectively; and
- Avoiding impairment of assets due to poor preventive maintenance or other causes.

Overseeing Risk Management Aimed at Protecting Assets and Resources

It is important for a hospital to consider and oversee its financial position to ensure continued service provision. A broad view of financial risk management may include the following issues:

- Risks to meeting the mission;
- Maintaining corporate goodwill;
- Reputational risks;
- Quality of care concerns;
- Liabilities and losses owing to service delivery or ineffective management;
- Business viability risks related to providing funding for operations or maintaining sources of funding;
- Ensuring hospital performance meets funder service commitments (under accountability agreements);
- Oversight of information technology, human resources, facilities and related assets; and

- Maintaining a greater emphasis on organizational capacity, processes and information integrity.

In exercising its governance responsibilities, a board needs to assure itself that management has put in place the appropriate policies, plans, processes and programs to both protect the hospital from foreseeable and material risks as well as ensure the ability to meet current and future obligations and accountabilities.

Board's Role in Overseeing Financial Conditions and Resources

Boards have a number of more specific roles and functions with respect to overseeing the hospital's financial conditions and resources. These roles and functions include:

- Approving Operating and Capital Budgets;
- Monitoring Financial Performance;
- Ensuring Integrity of Information;
- Insurance Protection;
- Procurement and Contracts;
- Investment Policy;
- Pension Funding; and
- Finance Committee.

Each of these roles and functions are reviewed below in additional detail.

Approving Operating and Capital Budgets

Financial plans, including both operating and capital budgets, provide foundational protection against predictable risks to the viability of the organization. Ensuring internal budget review and approval processes are in place and complied with is an essential component of board financial oversight. These processes may include:

- Budget planning and monitoring;
- Internal productivity comparisons against benchmarks to ensure the organization is not falling behind its peer group;
- Cash flow management to ensure operations are not jeopardized by lack of cash to meet short-term obligations;
- Capital planning to ensure the capital necessary to maintain and replace buildings and facilities is available and utilized cost-effectively;
- Ensuring adequate capital reserves and fundraising capacity to meet forecasted needs;
- Information technology (IT) resources planning. While IT resources planning has historically been considered part of capital planning, it has become a more significant item in the resources planning checklist given the major investments required. That said, IT systems are increasingly changing to subscription-based, which moves these expenses form capital to operating budget; and
- Final board approval of operating and capital budgets.

Monitoring Financial Performance

Once operating and capital budgets are reviewed and approved by the board, the board should continue monitoring financial performance based on accepted performance indicators, targets, regular reporting, and early variance identification. Factors guiding the monitoring of financial performance may include:

- Operating financials;
- Variance to the current budget and/or prior years;
- Margin levels (percent contribution to overheads or fixed costs);
- Efficiency measures (cost per case, per result);
- Capital measures;
- Level of operating reserves;
- Adequacy of reserves for building and equipment replacement;
- Staff pension funding adequacy;

- Solvency;
- Working capital level and change;
- Forecasts and projections: and
- Ongoing revenues relative to ongoing costs (e.g., one-time revenues and costs removed).

Access All Forms

Standard financial performance indicators for hospitals are noted in the graphics found in *Form 4.1: Balanced Scorecards and Dashboards*.

Ensuring Integrity of Information

A hospital's financial information systems are an essential and informative component of an organization's financial condition and resource oversight. Accordingly, one of the board's roles and functions is to oversee the status of financial information systems. A board may carry out this duty by approving the initial implementation of a selected financial information system and overseeing audits designed to ensure systems, policies, and processes are functioning and being actioned. Effective oversight of financial information systems may include:

- Approving expenditures (transaction approvals at various amounts);
- Signing contracts at various levels (a process for monitoring compliance to authorities and controls);
- Ensuring competent and qualified staff;
- Processes to detect fraud and/or incompetent staff; and
- Monitoring whistleblower policies.

More specifically, and with respect to audits, ensuring the integrity of information may require a board to:

- Oversee the external auditors and their reports;
- Ask auditors questions respecting materially identified issues;
- Recommend the acceptance of annual reports; and
- Recommend the appointment and terms of external auditors.

Insurance Protection

A board should review insurance programs to ensure they are adequate, aligned with risk management strategies, funded and maintained at appropriate levels, and regularly reviewed by management.

Procurement and Contracts

A board should be satisfied there is an effective policy framework in place for managing the procurement of goods and services, as well as for the management of corporate contracts. These policy frameworks should include:

- Appropriate approval authority for policies and processes;
- Compliance with both internal policies as well as government-required policies;
- Adequate numbers of competitive bidders for specified levels of contract value;
- Contract review and retention processes;
- Limited appointment of agents;
- Due diligence with respect to key relationships to ensure performance targets can be met; and
- Monitoring performance of service providers.

Investment Policy

Investments are an important element of financial sustainability. A board should establish, approve, and review policies that organize the investment program. Establishing, approving, and reviewing investment policies and programs may require:

- Determining the rate of return required to support and sustain investments over time;
- Defining the nature of acceptable investments;
- Ensuring adequate diversification;
- Reviewing portfolio performance;
- Monitoring investments for compliance with policies; and
- Approving investment revenue contribution toward annual operating budgets.

Pension Funding

A board should ensure that staff pension plans are adequately funded. Almost all hospitals in Ontario participate in the Healthcare of Ontario Pension Plan (HOOPP), a multi-employer, defined benefit pension plan. Those hospitals do not have a legal obligation to HOOPP with respect to any underfunding of the plan and are only obligated to remit monthly contributions. Consequently, they treat their pension contributions in the same manner as organizations with defined contribution plans.

Finance Committee

A board needs to oversee management's actions and efforts to ensure protection of the financial condition and assets of the corporation. Since this is such an important board function, nearly every board will establish a committee responsible for overseeing financial conditions and performance of the organization.

It is a board's fiduciary duty to appoint directors with financial expertise to sit on a finance committee. That said, merely appointing individuals with appropriate financial knowledge will not relieve the board of its fiscal oversight obligations. A finance committee supports a board but does not replace it. Finance committees typically have the following responsibilities:

- Approving process and guidelines for budget development;
- Developing financial authorities and control policies for approval by the board, including those addressing authorizing transaction and signing contracts;
- Establishing performance controls for financial review and variance reporting;
- Reviewing on a regular basis, key cost, productivity and financial indicators, and identifying issues;
- Establishing investment policies and monitoring status and compliance;
- Reviewing risk management, including insurance policies and protection;
- Assessing adequacy of financial information, systems and controls; and
- Liaising with the external auditors on behalf of the board and following up on audit reports.

Naming conventions for an organization's finance committee should be reflective of the scope of its responsibilities. For example, if a finance committee is responsible for broader organizational resourcing (human resources, facilities, information technology etc.), more broadly descriptive names could be considered. In addition to an established finance committee, and due to the detail and oversight required, boards may create additional, task-specific committees or borrow support from additional standing committees.

Access All Forms

See *Form 8.8: Sample Committee Responsibilities*

When liaising with external auditors, a finance committee may assume oversight by:

- Handling matters directly;
- Creation of a further sub-committee responsible for overseeing the work of the external auditor; and
- Formation of a separate audit committee reporting directly to the board.

No legislation mandates an audit committee; however, the *Not-for-Profit Corporations Act* (Ontario) requires that if such a committee is established, it must review the financial statements of the corporation before they are approved by the directors.[12] Further, if an audit committee is established, it must be composed of directors, and a majority of the committee must not be directors who are officers or employees of the corporation or any of its affiliates.[13] Boards may also establish a separate investment committee or further sub-committee in organizations where there is a significant investment portfolio.

→ Find Out More

Audit committee composition is more fully explored in Chapter 8.

Function 5: Overseeing Enterprise Risk Management

Risk was historically considered to be discrete events created by external or internal influences that affected a hospital's ability to achieve its purposes. This understanding has evolved, and the focus is now on Enterprise Risk Management (ERM). ERM considers risk from a broader perspective and seeks to understand the relationships among identified risks to evaluate the potential impacts of the collective risks on the organization's ability to achieve its purposes. To be effective, ERM should be aligned with the following key hospital functions:

- Governance;
- Strategic planning;
- Performance management;
- Process management;
- Risk management;
- Internal control; and
- Compliance.

Governance

A board sets the tone for acceptable risks through its own action (e.g., recruiting of new board members), delegation to management (e.g., signing authority limits), oversight of board-approved processes (e.g., appointment of professional staff), and other activities that inform the risk tolerance and risk appetite of the hospital.

Strategic Planning

A board plays an integral role in developing the vision and objectives for the hospital to enable it to deliver on its mission. This requires analysis of risks and opportunities in all aspects of the hospital's business. An essential part of this process is identifying impediments and consequences of different programs and challenges and developing prevention and mitigation tactics.

Performance Management

As discussed in earlier sections, the board develops tools to assess management, operational, and financial performance using a variety of tools and assisted by management and committees.

Process Management

A board should oversee operational processes having significant impacts on the hospital's ability to serve patients. These include:

- **Stakeholder engagement** – Hospital communication with stakeholders can open it to significant criticism. This criticism may include failure to respond to the needs of its communities and/or dissatisfaction from funders and donors about the quality and capacity of programs.
- **Information systems** – Hospitals rely on mature patient records, financial analysis, and data analysis systems to function and operate sophisticated equipment.

Vulnerabilities in these systems threaten the ability of a hospital to deliver safe care to patients in a timely manner. While development, deployment, and operation of these systems are within management's purview, a board must apply its oversight to ensure the hospital is as prepared as possible to respond to disruption.

Cyber-attack threats add new elements to risk management requiring board oversight. Board oversight, and corresponding management accountability, are essential to fostering successful cyber risk management programs designed effectively to support the implementation of cyber risk mitigation activities. Board oversight should, at a minimum, assign senior management accountability for cybersecurity and clearly delineate who will ensure the implementation of controls and mitigation strategies throughout the organization. A board committee can be positioned to receive regular updates from senior management or the subject matter expert on the progress and effectiveness of cyber risk management strategies. Boards can also undertake training (e.g., table-top exercises), education (e.g., presentation from the insurance provider) and research to increase cyber literacy, understand challenges and risks faced by the organization, engage external experts regularly for updates and benchmarking and participate in informed discussions with management about critical cybersecurity exposures.

- **Operational and governance processes** – These processes, or their deterioration, can create significant reputational risks for the hospital and should be overseen by the board.

> **→ Find Out More**
>
> The board's responsibility for its own governance is discussed in Chapter 1.

Enterprise Risk Management

A board should be aware of the areas of risk management that are relevant to its decision-making. Sources of enterprise risk are commonly classified as follows:

- **Liabilities and losses** – Direct liability for equipment, premises and facilities, client or patient safety and protection, safe operation of hospital systems, processes and protocols, and appointment and monitoring of staff competence. Hospitals also have vicarious liability for employees.
- **Business viability risks** – Sustainability is a fundamental business risk that concerns the ability to fund commitments and ongoing services and programs. Examples of the major risks to sustainability include insufficient cash flow to meet obligations; lack of operating funds to provide for desired services; and lack of capital funds to maintain facilities or broaden services to patients.
- **Reputational risks** – The reputation of the hospital is a significant asset and may be at risk when quality of services declines (as evidenced by, for example, patient complaints or liability cases regarding quality of services or privacy breaches), or a closure of services is required; relationships with funders, donors, staff or media are strained; or other activities bring negative attention to the hospital. Impairment of the hospital's reputation may have consequences for: its support by the community; fund-raising efforts; its ability to attract professional staff; and its ability to receive government funding. A damaged reputation may also result in lost opportunities and impair the hospital's achievement of its vision or delivery of its mission.

Internal Control

A hospital's internal control systems are an integral part of its risk management program. They can detect early indicators of potential risk prior to those risks impacting operations. For hospitals, this may include quality of care indicators (e.g., data on falls or pressure wounds) in addition to traditional financial indicators.

Compliance

Hospitals operate in highly regulated environments. These legislative and regulatory frameworks affect procurement, compensation, public reporting, accountability to the government, and transparency with the community. While compliance with all details of legislative and regulatory frameworks is a management responsibility, a board must ensure it exercises oversight and understands the aspects posing the most risk to the hospital.

Board's Role in Overseeing Enterprise Risk Management

Many of the board's existing processes and policies contribute to its oversight of management's enterprise risk management program. These processes and policies likely include receipt of regular briefings on management's comprehensive approach to enterprise risk management, as well as regular oversight work through review of performance management frameworks. These board briefings should demonstrate that management has identified and considered emerging risks and changes in the external environment that could impact the ability of the hospital to deliver on the objectives of the strategic plan.

Enterprise risk management programs typically utilize combinations of probability and impact to determine which risks should be brought to the board's attention. Board briefings should focus on those risks that have been identified as posing the greatest threat to the hospital. With fewer risks to focus on, a board can review relevant prevention and mitigation strategies in greater detail. Management may also prepare risk reports and present them to appropriate board committees on a cycle permitting time to digest and discuss each risk.

A hospital's ability to respond to potential and contingent events should be considered by a board and/or its relevant committee, while reviewing management's enterprise risk management plan for preventing and protecting the corporation. A board should assure itself that management has established appropriate policies, processes and programs to prepare for, prevent and protect the hospital from probable and high-impact risks. In addition, a board should ensure its actions and processes align with organizational risk management needs. The following are examples of topics they should consider:

- **Knowledge and abilities of the board and board committees** – Boards, and board committees, should know their functions and have the knowledge necessary to effectively and efficiently perform them. A board should:
  - Ensure committees are properly mandated and include appropriately knowledgeable directors;
  - Ensure activities are in place to inform each director on the nature of the board's role and the role of the committees; and
  - Ensure directors recognize their independence to perform their duty, including asking questions of the board and in committees, being mindful of potential influence from external parties, and providing the opportunity to receive independent advice where needed.
- **Quality information and advice** – boards require quality information from a number of sources to discharge their risk responsibilities. This information and advice includes:
  - Appropriate and understandable performance management reports;
  - Access to additional advice and/or reports, such as the advice of senior management and clinical or technical leaders, and external reports (as appropriate) to keep them apprised of the trends in the sector. Boards should also have access to external advisors, where deemed necessary. This may include asking for professional opinions and receiving third-party advice directly; and

  - Management information. A board should use its common sense respecting the adequacy of the information coming before it. Where there is concern, a board can request the information be certified, and that management attests to its accuracy. (The board should understand that certification is not a guarantee that the information is accurate. It is simply a higher level of evidence that it is sound.).
- **Participation in key financial and quality oversight processes** – Boards should participate effectively in processes established to plan and manage key aspects of risk. Processes related to financial and quality oversight are critical components of this participation.
- **Question, and act in response to, information and changes** – Being knowledgeable and participating in processes is likely insufficient to ensure a hospital is prepared to adequately address risk. When the information provided indicates a significant risk to the interest of the organization, boards should consider the following actions:
  - Question the reasonableness of the assumptions and the potential risks to execution of management's strategic, financial, and other plans;
  - Seek assurance that internal control processes are robust and active;
  - Question the level of preparedness of management for contingencies and unexpected events; and
  - React quickly or direct management to respond in exceptional circumstances when events emerge that create risks for the hospital's reputation, performance or viability.

Structuring Committees

Organizational risks commonly permeate various disciplines across a hospital. Due to this, boards may already have established committees inherently dealing with risk as an element of their focus. To ensure regular risk review processes, boards should consider assigning risk management in the following ways:

- **The quality committee** – Monitors and reports to the board on quality of care issues and on overall quality of services to assist the board in fulfilling its risk management responsibilities.
- **The finance committee** – Reviews risks associated with the hospital's financial position, including adequacy of budget, efficiency relative to funding, simulations and sensitivity to revenue shortfalls, adequacy of financial reporting and controls, and need for insurance.
- **The audit committee (or finance committee**) – Reviews adequacy and implementation of risk management policies and programs related to the integrity of processes and information.

In light of these existing committee structures and focuses, a board is likely to retain oversight responsibility for risks related to stakeholder engagement, enterprise-wide threats such as cyber-attacks, and reputational risks related to human resources and compensation matters. Due to this retention of responsibility, some boards may choose to establish a dedicated risk management committee.

Access All Forms

See *Form 3.4: Risk Assessment Framework Agenda Planner*

See *Form 3.5: The Board's Response to Emergency Situations*

Whistleblower Policy

A board may adopt a freestanding whistleblower policy applicable to general wrongdoing. This may include violations of the hospital's policies (including Codes of Conduct and/or Conflict of Interest), and ethical or criminal behaviour more generally. It is common to have one policy universally applicable to all directors, officers, employees, professional staff, independent and external contract workers, students and volunteers.

Significant components of theses policy typically include:

- Identification of the standards to be met (e.g., code of conduct policies and sound ethical and business practices);
- What whistleblowers should report;
- A requirement for good faith reporting;
- Protection from retaliation; and
- Reporting and investigative procedures.

Under such a whistleblower policy, it is common for management to receive the majority of reports and perform the majority of investigations. In certain situations, however, a board committee may directly receive reports and complete investigations. For example, the audit committee may receive reports when a report implicates an executive officer or where financial practices may affect the integrity of the hospital's financial statements.

It is important that each hospital customize lines of reporting and other procedures to fit their specific organizational structures and align the policy with both the Code of Conduct and/or Conflict of Interest policy.

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See *Form 3.6: Draft Whistleblower Policy*

Function 6: Supervision of Leadership

One of the most important board functions is to ensure effective leadership to manage the organization. For hospitals, these leaders are the chief executive officer and the chief of staff. The board's role is to supervise these two leaders and ensure effective leadership within the hospital.

Hospital boards appoint and supervise the chief executive officer, who is responsible for the administration of the hospital, and the chief of staff or chair of the medical advisory committee, who is responsible for the quality of care in the hospital.

The board's supervisory responsibility in ensuring effective leadership involves the following:

- Defining expectations for the chief executive officer and chief of staff;
- Leading the chief executive officer and the chief of staff recruitment process;
- Overseeing the annual chief executive officer and the chief of staff performance review process;
- Determining the chief executive officer and the chief of staff compensation; and
- Developing and approving a succession plan for the chief executive officer and the chief of staff.

Implementing Board Supervision of the Chief Executive Officer

This section will first focus on the chief executive officer, although the same process largely applies to both the chief executive officer and the chief of staff positions. The differences in evaluation across the two positions are provided in the subsequent section titled: *Implementing Supervision of the Chief of Staff.*

Defining Chief Executive Officer Expectations

A board needs to establish clear expectations and criteria for selecting and evaluating a chief executive officer for both an initial selection process and an annual performance review cycle. These evaluation criteria should likely be mutually agreed upon by both the board and chief executive officer.

Reviewing and assessing the performance of a chief executive officer begins by reviewing the position description. A position description clearly outlining key objectives, rather than simply expected activities, provides the best series of milestones or guideposts. These key objectives may include:

- Level and quality of services delivered within approved budget;
- Strategic direction in place, clear and supported by key stakeholders;

- Cost-effective and sound administration of human, managerial, and financial resources;
- Effective and collaborative relationships with Ontario Health, OHTs, and appropriate health and related organizations in the community; and
- Respectful and effective board relations.

Each board should also determine its own set of independent evaluation criteria. While these criteria may vary across organizations, they should include consideration of the following two broad categories:

- **Achievement of annual key results** – The chief executive officer establishes annual goals, objectives and priorities relative to key result areas. Evaluation should consider the degree to which the chief executive officer achieved the stated key results. The objectives should be linked to the organization's strategic plan, quality improvement plan and other targets.
- **Leadership behaviour and/or skills demonstrated** – A board should consider whether the chief executive officer demonstrates the behaviour and skills expected of a leader in their role. These expected behaviours and competencies should be clearly articulated as criteria.

Leading the Chief Executive Officer Recruitment Process

As outlined above, the chief executive officer recruitment process begins with a board clearly articulating the characteristics and skills required to perform the role. The board commonly delegates this responsibility and process to either an ad hoc or standing committee, depending on the needs of the organization. The process of outlining the characteristics and skills required for the role should include the following steps:

- Define the profile desired, including criteria for assessment of candidates;
- Assess the internal pool of candidates, referencing succession plans (where they exist);
- Determine the scope of the search based on available internal candidates and the process for recruitment and evaluation;
- Conduct a search, led by a board committee and potentially with professional assistance;
- Evaluate the candidates; and
- Identify the proposed candidate for recommendation to the board for appointment.

For larger hospitals, the implementation of a national search, with the assistance of an executive search firm, is the common approach to recruiting new chief executive officers.

As internalized succession plans become more common, it is possible that boards will be able to narrow and simplify these recruitment processes over time.

> The OHA has established the Proximity Institute, an independent charitable organization, to enable effective leadership in Ontario hospitals. Proximity Institute's strategic ambition is to collaborate with Ontario hospitals to identify, develop and ready a robust pool of high potential talent prepared to lead the sector in the future. Learn more at www.proximityinstitute.com

Overseeing the Annual Chief Executive Officer Evaluation Process

For a board to effectively discharge its chief executive officer supervisory responsibilities, a regularly scheduled and ongoing evaluation process should be implemented. A board should establish a policy outlining this process of chief executive performance evaluation to ensure clarity, transparency, and unified procedural understandings.

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See *Form 3.7: Sample Chief Executive Officer Performance Evaluation and Compensation Policy*

The chief executive officer evaluation process commonly follows the six steps described in Figure 3.3. This process may take place over a two-to-three-month period and provides the following organizational benefits:

- Clarifies expectations between the board and the chief executive officer;
- Provides feedback to the chief executive officer as a basis for continuing positive performance or for taking corrective action, where needed;
- Forms a basis for establishing an objective, professional relationship between the board and the chief executive officer and for increasing trust;
- Forms a basis for providing the chief executive officer with developmental support, where helpful;
- Provides an objective and fair basis for compensation decisions; and
- Provides an opportunity to regularly address succession planning.

It is best practice for a board to approve the chief executive officer's annual goals at the beginning of the year and review performance at least annually.

Figure 3.3: Six-Step Process

Step 1: Establish the process

A board approves the process for chief executive officer evaluation. In developing the process, the assigned committee and board chair should work together with the chief executive officer. It is best if there is a mutually agreed-upon process (criteria, tools, sources of input and feedback process), access to information and input (privacy and confidentiality considerations), and role descriptions (chair, committee, individual directors).

Step 2: Receive the chief executive officer's annual report

Part of the process of evaluation is an annual 'state of the union' report from the chief executive officer to the board on the discharge of their duties, and the results of their performance.

The chief executive officer should present this report to the full board as part of the regular annual operational planning process. The report includes the proposed annual objectives for the following year as well as a review by the chief executive officer of the previous year's performance relative to annual objectives and priorities.

Access All Forms

See *Form 3.8: Chief Executive Officer Annual Priorities Review*

Step 3: Collect input on the chief executive officer's performance

Based on the agreed-upon process, information is collected from appropriate sources on the chief executive officer's performance and skills and includes the chief executive officer's self-appraisal.

Note: Some boards seek broad input as part of the annual performance cycle, while others conduct a separate 360-type process on a periodic basis that contributes to chief executive officer development.

Step 4: Digest feedback and dialogue

Once collected, the chair or committee needs to summarize the feedback. The committee needs to digest and discuss the meaning of the feedback and then form a conclusion and prepare a summary opinion. The summary forms the basis for a discussion between the chair and/or committee with the chief executive officer about the feedback and its implications.

Step 5: Make action recommendations

Based on the discussion, the chair and committee will make appropriate decisions or recommendations to the board. These will include:

- Recommendations related to the chief executive officer's development that responds to feedback and/or the chief executive officer's identified needs;
- Recommendations related to compensation or bonus, as provided in the chief executive officer contract or terms of employment pertaining to chief executive officer and executive compensation. In making compensation and/or bonus decisions, the committee will need to ensure that the process and recommendations are consistent with the provisions of the *Excellent Care for All Act*, the *Broader Public Sector Executive Compensation Act*, or any other applicable government legislation or directions; and
- Discussion of leadership succession.

Step 6: Report to the board

Finally, the chair and committee should report to the board advising that the process was followed as set out and propose approval for pertinent implications or recommendations regarding performance, development and compensation.

Inputs to the Chief Executive Officer Evaluation

While the board is ultimately responsible for making judgments respecting the chief executive officer's performance, input from beyond the board may also be necessary. Input may be collected from additional sources such as other directors, members of senior management and senior professional staff, or external representatives (e.g., Ontario Health, OHTs, family or patient organizations, and local health agencies).

Collecting feedback on the performance of the chief executive officer can be conducted in several ways. Those options may include:

- **Chief executive officer's self-assessment** – Input should come directly from the chief executive officer on their view of their own performance and skills.
- **Committee or panel discussion** – Input can be gathered by a committee or panel of board members through a discussion process. Each criterion may be discussed, and the group can summarize its opinions using a rating scale (e.g., exceeds expectations/meets expectations/does not meet expectations).
- **Structured evaluation survey** – A structured survey instrument can be used to canvass opinions on chief executive officer performance. This may be from the board or from a broader set of internal sources. A designated person (chair or third-party) collects and summarizes the confidential surveys. The results form the basis for a discussion with the chief executive officer.
- **Multi-rater survey instrument** – This is often referred to as "360-degree feedback." In this approach, people with different perspectives of the chief executive officer's performance (board members, senior management, and externals) are asked to provide input using a structured

questionnaire. Either the organization designs its own survey based on the criteria (competencies and leadership skills) or uses a third-party survey.

Access All Forms

See *Form 3.9: Chief Executive Officer Confidential Board Panel Appraisal Form*

Link to Chief Executive Officer Compensation

Chief executive officer compensation is also an important matter for board oversight. When establishing an employment contract with the chief executive officer, the board will define terms of compensation and any potential incentive bonuses. Since hospitals publicly disclose a chief executive officers' compensation, there is a degree of transparency in these matters not common in other corporations.

The board should establish a compensation policy and process that keeps the following principles in mind:

- Necessary competition with appropriate market comparators in order to attract strong candidates;
- Internal equity and remaining within community expectations;
- Linking pay directly to performance;
- Fiscal responsibility; and
- Compliance with legislative requirements respecting executive compensation.

In addition, the *Excellent Care for All Act* defines certain aspects of the chief executive officer's (and other executives') compensation arrangements. This includes requiring an incentive component, and ensuring it is linked to meeting quality goals included in the hospital's quality improvement plan.

The Government has also established requirements and restraints relative to executive compensation through the *Broader Public Sector Executive Compensation Act* and its regulations and directives. In 2024, the OHA developed a Policy Brief presenting a review of recruitment and retention challenges in Ontario hospital leadership, which include the effects of government-imposed compensation restraints, and ultimately suggests a principled and measured approach to interpreting legislation in the context of current economic realities.

Given this unique landscape, the board or assigned committee may require further information and advice to ensure compensation and incentive arrangements are in line with existing legislative and regulatory regimes.

There should be a strong and principled link between financial incentives and achieving performance results. That said, boards should be careful not to overemphasize the achievement of short-term (annual) results to the detriment of organizational sustainability.

Approving a Succession Plan for Chief Executive Officer

Chief executive officer turnover rates are increasing. As previous executives retire, boards should ensure there will be effective leadership continuity. This element of board responsibility is gaining additional public attention and will likely require measured and intentional board approaches.

Internalized succession plans are one way in which a board can exercise foresight with respect to chief executive officer turnover rates. The size of a hospital affects the succession planning process. Smaller hospitals are less likely to have obvious candidates for succession given their management structures and opportunities for internal development. As a result, having one or more apparent successors is less likely. Succession planning commonly has two dimensions:

- Emergency or contingent coverage for a chief executive officer; and
- The process of developing candidates for future chief executive officer roles, if necessary.

Emergency Chief Executive Succession Plans

Hospitals should have emergency chief executive succession plans in place. Such plans should consider who assumes the interim chief executive officer role, as well as how the resulting vacancies are backfilled. This form of contingency planning is less about succession and more about risk management. Boards are preparing for the unlikely—but significant—event of a chief executive officer being unable to perform their duties.

In implementing this function, a board should ensure the chief executive officer identifies one or more successors to take over in an emergency. The succession plan should also outline the steps to prepare candidates for this possibility. In some situations, it may be appropriate to keep the identities of individuals confidential and keep information sharing between the identified individual(s) and the board chair.

The board's policy for emergency succession planning should direct the current chief executive officer to prepare the candidate for the interim role. This would require the current chief executive officer to expose an interim successor to the board as well as to issues and processes usually managed at the level of the chief executive officer. Having such individuals participate in board meetings can contribute to this training and may also be required.

To ensure stability if an interim chief executive officer is put in place, a swift response is required. The board should also give advance consideration to what would go into a supporting communications plan. The issue of interim chief executive officer salary may also require board attention to ensure pre-planned process clarification.

Succession Planning Involves Leadership Development

Effective succession planning does not necessarily require a board to identify, with absolute certainty, an individual to replace the current chief executive at some undefined future point. Succession planning should be more focused on improving the depth of executive talent below the chief executive officer.

A succession plan should include a depth chart for executive management roles that identifies potential candidates for each executive position, including the chief executive officer and vice president. Such a succession plan should also include an assessment of the readiness of the identified individuals to assume the elevated role and the development efforts being undertaken to prepare them. Succession planning inevitably involves leadership development.

A succession plan may also identify one or more potential candidates for the chief executive officer role who can take over when the chief executive officer leaves an organization. That said, boards may still choose to undertake a broader search for candidates when the time comes, and this should also be considered in the succession plan. The chief executive officer should lead development of leadership talent, and the board should oversee the process to ensure it is occurring.

As outlined above, and to ensure this function is fulfilled, succession planning should be included in the chief executive officer's annual performance review processes.

Access All Forms

See *Form 3.10: Chief Executive Officer Succession Planning*

Implementing Supervision of the Chief of Staff

A board should undertake the same responsibilities relative to the chief of staff as it does for the chief executive officer. The difference in evaluation across the two positions are reviewed below together with a focus on those elements requiring consistency.

Chief of Staff Selection and Supervision

A board appoints its chief of staff (or the chair of its medical advisory committee) and, therefore, is responsible for supervising and evaluating role performance. The process for carrying out this responsibility is identical to that of the chief executive officer as shown earlier in Figure 3.3 and reproduced here.

Figure 3.4: Six-Step Process

Step 1: Establish the process

A board should approve an annual mandatory evaluation process that includes clarifying roles, evaluation criteria, and an outline of how procedural input is obtained.

Step 2: Receive the chief of staff's annual report

The chief of staff should propose and report on their annual objectives, including performance relative to the organization's quality improvement plan.

Step 3: Collect input on the chief of staff's performance

The appropriate internal group should collect additional input regarding performance and skills.

Step 4: Digest feedback and dialogue

The appropriate internal group should summarize and constructively provide feedback to the chief of staff respecting performance and development expectations.

Step 5: Make action recommendations

The appropriate internal group should determine suitable compensation and recommendations for development.

Step 6: Report to the board

The appropriate internal group should inform the board of the processes and recommendations related to chief of staff compensation or development. The approach to the chief

of staff's evaluation may vary across hospitals to reflect the unique structure of medical leadership and actual role of the chief of staff. That said, and despite the unique elements across each hospital, the following commonalities exist:

- The chief of staff is responsible for reporting on the duties and obligations carried out by the medical advisory committee. This includes the quality of the professional staff, the quality of care provided, and the supervision of clinical practice and related matters.
- The chief of staff should have annual objectives related to each of the above matters. These objectives should overlap with those of the chief executive officer, especially those concerning quality improvement. Others will be more focused on clinical care (e.g., ethics, pandemic preparation) and physician relations.

Some hospitals may also delegate certain responsibilities to senior physicians reporting into the chief executive officer, (e.g., vice president, medical affairs). These responsibilities may include continued education and development, recruitment activities, quality improvement programs, resource utilization reviews and developing a professional human resources plan. In these situations, these components are not reviewed as part of the chief of staff's role. Each hospital should address these considerations when designing their process and determining board oversight obligations.

Emerging Practices

Hospital boards are increasingly paying additional attention to the chief of staff's evaluation process, including by focusing on the following considerations:

- **Assessing leadership and development needs** – As with the chief executive officer, the chief of staff is a leadership role. Therefore, a board should include the quality of leadership in its evaluation. When evaluating the chief of staff, a board should also consider how it can support the chief of staff's continued development and support the chief of staff to effectively lead medical staff.
- **Commonalities between chief executive officer and chief of staff objectives** – Recognizing the tandem nature of hospital leadership, boards are beginning to link the evaluation processes of the chief executive officer with the chief of staff in some areas. There are common templates for completing annual objectives, the sharing of goals (quality improvement), and joint reporting. Both individuals may have the same overarching quality improvement objectives, but the chief of staff may have credentialing process improvement, and the chief executive officer may have the IT reporting systems.
- **Periodic third-party review** – In some cases, it may be helpful to have a third-party periodically (e.g., every three years) review the chief of staff's performance and leadership. These reviews are commonly led by an experienced external physician and involve input from multiple sources (including physicians and administration). This process commonly supports larger complex academic health science hospitals where the review may assist in identifying development needs for incumbents.
- **Role of chief executive officer in chief of staff evaluation** – The degree of involvement of the chief executive officer is commonly dependent on the role of the chief of staff and the degree to which the chief is playing a hospital management role requiring reporting into the chief executive rather than directly to the board. Where this is not the case, the emerging practice is for the chief executive officer to support the chief of staff evaluation committee in collecting inputs and providing comment without being a voting member of the committee.

As boards continue to pay additional attention to the role of the chief of staff, new board oversight roles and responsibilities are likely to emerge.

Access All Forms

See *Form 3.11: Sample Chief of Staff Performance Evaluation Policy and Form*

Additional Considerations Relevant to Supervision of Leadership

A board should approve the processes for selecting, supervising and compensating the chief executive officer and chief of staff. In addition, individual directors should have input into the evaluation processes and receive reports and recommendations on the results of the process.

While a board should assure itself that the chief executive officer and chief of staff are being supervised appropriately, every director should not be involved in the details of the evaluation process, which should be delegated by the board to a committee. It is common practice that the same committee reviews both the chief of staff and the chief executive officer.

Establishing a Standing Committee

Emerging best practice suggests establishing a standing committee with a focus on organization and human resources needs, including chief executive officer and chief of staff evaluation, succession planning, selection and compensation. Such a committee may only need to meet as needed (e.g., annual evaluation process), and may be composed exclusively of independent board members. It is common for the board chair, or incoming chair, to lead this process for the board by chairing the committee. These emerging committees are commonly identified as "organization and human resources committee" or "management resources and compensation committee."

Access All Forms

See *Form 3.12: Guidelines for a Management Resources and Compensation Committee*

Additional Committee Structures

Depending on the size, composition, and time and resource availability of a board, it may choose to form an ad hoc committee to exercise its leadership supervision function or utilize an existing standing committee.

- **Forming an ad hoc committee** – A board may establish an ad hoc committee to address tasks related to chief executive officer and/or chief of staff supervision. For example, an annual evaluation and compensation committee may be formed once annually to address the evaluation. A chief executive officer recruitment committee may be formed when required. Formation of ad hoc committees may permit more focused work and reserve board capacity and availability.
- **Utilizing an existing standing committee** – Smaller boards may prefer to utilize an existing standing committee to perform its role in leadership supervision. Examples include either a governance or executive committee. In these circumstances only independent directors would attend and participate in the meetings.

Function 7: Overseeing Stakeholder Relationships

Overseeing stakeholder relations has become an increasingly important board function. The concepts of accountability, transparency and engagement should inform a board's implementation of this function to reduce risk and promote good relationships and a favourable reputation. Broadly speaking, a board should ensure the corporation develops effective stakeholder relationships, so it has support for the execution of its purposes.

As was initially discussed in Chapter 1, the duty of each director is to act and make decisions in the best interests of the corporation. In exercising this duty, a board is responsible for considering the interests of multiple stakeholders. Accordingly, a director must have knowledge of all stakeholders to which the corporation is accountable and should appropriately take such interests into consideration when making decisions. A director shall not prefer the interests of any one particular group if to do so is not in the best interests of the corporation.

Stakeholder groups have an interest in the hospital's affairs and the potential to positively or negatively influence the corporation's well-being. For stakeholder relations to be effective, a board should recognize the distinction between being accountable to a stakeholder and promoting a good relationship. That said, having stakeholders agree with everything a hospital does is neither necessarily achievable, nor a measure of success. Success means that stakeholders understand the goals of the corporation, appreciate the rationale a board used in making contentious decisions, and feel that their perspective was taken into account. This is a more appropriate definition of good stakeholder relations.

→ **Find Out More**

The spectrum of stakeholder relationships is more fully discussed in Chapter 4.

Establishing Stakeholder Relation Systems

Hospitals approaches to stakeholder relations and community engagement continue to evolve, and clear consensus on best practice does not appear to have emerged. That said, the following three fundamental stakeholder relationship management principles are broadly relevant:

- **Developing a framework** – A board should approve an overall framework for discharging its accountability, engagement and stakeholder communication efforts. In doing so, a board should:
  - Identify a list of commonly relevant stakeholders;
  - Examine why and how the hospital relates with each stakeholder; and
  - Define principles outlining how the organization should relate with each stakeholder.
- **Utilize tools to ensure alignment** – A balanced approach to stakeholder relations requires careful tailoring to relevant audiences and objectives. Use of tools to solicit input, as well as to collaborate and engage with stakeholders, will assist in establishing and maintaining two-way communication and positive relationships.
- **Monitor relationship status** – A board should receive periodic reports on the status of relationships with key stakeholders.

Beyond the Annual Meeting of Members

For hospitals with non-director corporate membership, it is important to understand that exclusive reliance on annual member meetings and reports is likely insufficient to satisfy accountability obligations without broader, more active engagement with membership. The same sentiment is true for boards choosing to utilize annual member meetings to equally account to representatives of broader stakeholder groups. These approaches, if implemented without complimentary ongoing stakeholder engagement, should be considered with caution.

Board's Role in Overseeing Stakeholder Relations

While a board may be directly involved in certain aspects of stakeholder relations, it is more common for a board to provide policy direction and conduct oversight of management's execution of stakeholder relation strategies. This blended role may manifest itself in the following forms:

- The board chair and chief executive officer share or divide responsibilities for external stakeholder relations;
- The board chair is the external board spokesperson;
- The chief executive officer is the more visible hospital spokesperson; and
- The board chair and chief executive officer work closely together to ensure consistent messaging.

While hospital boards were not previously highly involved in direct stakeholder communications (with some exceptions in

circumstances involving unique challenges), this has begun to shift in light of the obligations in the *Connecting Care Act*. These obligations are more fully reviewed in Chapter 4: Hospital Accountability and Stakeholder Relations.

Government Relations

The Provincial Government has always been a significant stakeholder for Ontario hospitals. Hospitals rely heavily on public funding and are required to comply with a wide range of legislation, regulation, and governmental policy and decision-making. To effectively steer a hospital toward fulfilment of its mission, vision, and values, a board must be cognisant of government shifts and trends as they may impact short-term and/or long-term goals. These shifts or trends may include election of an entirely new government, new legislation and/or regulations, economic change or shifts in prevailing economic sentiments. In addition to board awareness, a board should ensure senior management are equally and/or more significantly monitoring and reporting on new government developments that may impact the organization's mission, vision, and values.

The Ontario Hospital Association, and similar advocacy groups, play key roles in stakeholder relations for the Ontario hospital sector; particularly respecting government relations. A board and management should be aware of legal constraints on certain activities, such as engaging lobbyists with public funds, and legal requirements, such as compliance with lobbyist registration rules.

> **→ Find Out More**
>
> See the OHA's *A Guide to Hospital Statutory Compliance* for additional information on legislative and regulator compliance.

Utilizing Committees

Some hospital boards have formed committees aimed exclusively at supporting the board's role in overseeing stakeholder relations. Common committee naming conventions include public relations; community advisory; community liaison; or communications committees. These committees commonly focus on:

- Reviewing communication plans and strategies;
- Advising on use of communication tools and documents;
- Broad evaluation of stakeholder relations;
- Specific medical programs and/or quality improvement;
- A specified geographic area of region with broad catchment areas; or
- Guiding the organization through large capital redevelopment projects.

It is common for committees of this nature to be led by a board member with a cross-sectional complement of individuals with relevant subject matter expertise. Depending upon the committee's focus, it may either report directly into the board or to the chief executive officer. The variance in organizational committee structure and focus is one way in which a board exercises its ability to manage its own governance.

Function 8: Managing the Board's Own Governance

As was discussed in Chapter 1: Understanding Good Governance, it is important that a board take ownership over the quality of its own governance performance. Doing so assists a board in guiding the organization toward meeting its corporate purposes. Good governance is complex and ever-evolving. That said, common elements include:

- Ensuring appropriate policies and structures are in place;
- Utilizing, and abiding by, established policies and structures;

- Ensuring board members are knowledgeable, high-functioning, and represent diverse backgrounds;
- Clearly articulating the role and function of the board;
- Clarifying the relationship between the board and management; and
- Board self-evaluation.

→ Find Out More

Foundational concepts are discussed in greater detail in Chapter 1. A detailed discussion on board composition, education and evaluation is outlined in Chapter 7.

Adopting a Statement of the Board's Role

As was discussed in greater detail in Chapter 2: Models of Governance, a board should adopt a formal statement outlining its roles and responsibilities. A formally adopted statement commonly assists with the following:

- Ensuring new directors understand the areas in which the board performs its governance role;
- Providing a reference point for planning;
- Determining which committees should be established and the terms of reference for those committees;
- Providing a framework for the board's governance role to assist with effective evaluation; and
- Signaling a proper board role as the basis for clarifying expectations.

Access All Forms

See *Form 2.1: Sample Statement of the Roles and Responsibilities of the Board*

Establish Mechanisms for Evaluating Effectiveness

A board should outline how it intends to self-evaluate its governance performance. For a more detailed discussion on board evaluation, see Chapter 7.

Access All Forms

See *Form 3.13: Assessing Board Performance*

See *Form 3.14: Governance Quality Indicators*

Organizing a Board to Manage its Own Governance

Many boards delegate initial and preparatory governance performance work to their governance committee. Governance committees often assist the board by conducting the following tasks:

- Assessing the current state of governance practices and identifying gaps;
- Developing and monitoring the quality of governance indicators;
- Developing evaluation tools for assessing meetings, committee structure and performance, director performance, and overall governance; and
- Developing draft by-laws, policies and procedures to improve and clarify governance roles.

A governance committee's output needs to be reviewed and approved by the board, and in some cases by hospital members, prior to implementation.

Special Functions of Boards - Real Estate or Development

Hospital corporations own their facilities, which are typically overseen as part of a resources or finance committee. From time to time, a hospital may need to significantly expand or redevelop its facilities, which could lead to the need to sell or buy land or facilities, redevelop and construct facilities, and, potentially, seek Ministry approvals. This requires special board attention.

Major real estate projects involve significant dollars, create significant cash flow issues and potential exposure to risk, and involve signing complex contracts with architects, developers and/or contractors. The chief executive officer and management may not have the experience and skill to deal with these aspects of the project on their own. In fact, they may not be comfortable dealing with these decisions without board support. In these circumstances, a board will frequently become more actively involved in the project.

A board will often recruit one or more directors with real estate development or construction experience when it anticipates these issues on the horizon. A board may also constitute a special committee with an appropriate mix of knowledgeable directors and others to oversee the project on behalf of the board.

The Board's Role in Integration

While integration relates closely to providing strategic direction, it cuts across other aspects of board function as well. Given the increasing importance of integration for hospitals, this section focuses on the board's role in integration.

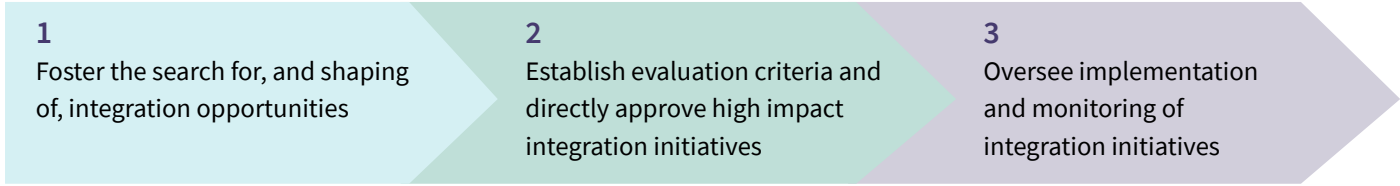
Integration Imperative

As discussed in greater detail in Chapter 4, the *Connecting Care Act* provides a statutory obligation for each OHT and each health service provider (hospital) to separately, and in conjunction with each other, identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services.[14] Integration is defined very broadly under the *Connecting Care Act* and includes:

- Coordinating services and interactions between different persons and entities;
- Partnering with another person or entity in providing services or in operating;
- Transferring, merging or amalgamating services, operations, persons or entities;
- Starting or ceasing the provision of services; and
- Ceasing to operate, to dissolve or wind up the operations of a person or entity.

A board needs to ensure the organization focuses on integration opportunities, while at the same time differentiating between the board's role and management's responsibilities in this area. Broadly speaking, the board's role covers the three aspects of integration shown in Figure 3.5 below.

Figure 3.5: Board's Integration Roles



The level of a board's participation in the development and approval of any specific initiative depends on:

- **The potential impact and type of integration** – It is clear that amalgamations or significant alliances involving the board's governance processes (joint board meetings) require board review and active consideration. Major clinical service agreements (e.g., to pool clinical support services like labs, stop a service and refer to another hospital) may also need to be authorized by the board. However, patient referral protocols and coordinating arrangements may be left to the chief executive officer and chief of staff. In those cases, the board may be informed but not need to approve.
- **The size and complexity of the hospital** – In large, tertiary care teaching hospitals, management will deal with most care coordination and shared services agreements with other hospitals and inform the board, and only obtain pre-approval if the financial or risk implications are significant. In smaller community hospitals, coordination of care agreements and shared services arrangement would likely be reviewed by the board.

Foster the Search for and Shaping of Integration Opportunities

A board should demonstrate leadership and support of management's efforts to discover integration opportunities. It can do so in a number of ways, including:

- Establishing a policy that fosters the search for integration opportunities. These may be in value statements, planning principles, or both;
- Participating in planning meetings and processes with other boards and/or OHT partners by sending board members as representatives;
- Using the strategic planning process as a means of identifying integration opportunities and engaging health organizations and other stakeholders in the process; and
- Scheduling (semi-annually or annually) a board session to hear about the integration opportunities and initiatives being pursued by the hospital. This would allow a board to shape and encourage integration initiatives.

Establish Evaluation Criteria and Directly Approve High-Impact Integration Decisions

Integration decisions should be evaluated using a common set of guidelines or criteria. A board should review and approve proposed evaluation criteria. These should be applied both to delegated decisions made by management and decisions judged to be high impact.

The criteria will likely include benefits such as quality of care, patient safety, greater service access, and system utilization, and reflect impacts on costs of service, system costs and risks.

Guidelines are needed to determine what integration actions can be delegated (dependent on the criteria being used) and which decisions require board approval. These will vary depending on the size and complexity of the proposed integration activity.

Overseeing Implementation and Monitoring of Integration Initiatives

All boards should be actively involved in integration efforts affecting the governance of the hospital, whether merger, amalgamation or the development of a governance-level alliance. For each situation, a board should develop specific processes for oversight of the implementation.

Some major shared services arrangements may also require ongoing implementation oversight. For example, a number of smaller hospitals share chief executive officers or chiefs of staff. In other cases, hospitals may pool IT or other administrative services, requiring a joint oversight committee

or board. In each case, a board would likely approve a monitoring process when decisions are made.

Some boards may wish to have an annual review of the progress of initiatives as an open discussion item on a board agenda.

Except in amalgamation situations, where a board must take a leadership role, the chief executive officer will typically lead the implementation process and report on progress where required or directed by the board.

In amalgamation or major alliance situations, a board needs to ensure the case for integration is strong and given credibility through appropriate due diligence, and that the risks are mitigated by a sound implementation process. Further, a board, working with management, should shape the communication and engagement plans so the benefit story is well-communicated and understood by stakeholders and the communities served.

Preparing the Board for Thinking 'Integration'

For some boards, integration initiatives will be primarily about modifying clinical or administrative services; for others, amalgamations or organization-wide alliances may be possibilities. No matter which approach is taken or considered, some form of integration is likely on the board's agenda. Many boards have been, or are, preparing for these discussions and decisions by:

- Considering 'system perspective' as an attribute for recruiting the chief executive officer and chief of staff;
- Considering 'system perspective' as a skill for board recruitment;
- Ensuring special emphasis in the strategic planning analysis — clinical service positioning and administrative sharing opportunities;
- Engaging in board-to-board meetings or planning sessions to gain broader perspectives; and
- Holding system education sessions before board meetings to help the board understand the interdependence of health organizations.

Chapter 4: Hospital Accountability and Stakeholder Relations

This chapter provides an in-depth review of the nature and complexities of stakeholder relationships in the hospital context. In providing this review, this chapter will reinforce the importance of board accountability and transparency as well as ensure board members are able to make challenging and complex decisions with additional confidence.

In This Chapter:

Understanding Accountability

Accountability is an important concept in public sector governance, and—while particularly complex in this context—has been defined as *"the requirement to explain and accept responsibility for carrying out an assigned mandate in light of agreed upon expectations."*

However, the same source goes on to say "… *a commitment to accountability should be thought of not only as answering to external audiences, but also as a constructive tool for organizational development, enhancing management practices, self-evaluation and strategic planning."*

In addition, the application of accountability is said to involve the following three elements:

- "Taking into consideration the public trust in the exercise of responsibilities;
- Providing detailed information showing how responsibilities have been carried out and what outcomes have been achieved; and,
- Accepting responsibility for outcomes, including problems created or not corrected by an organization or its officials and staff."

Finally, *"Accountability in the voluntary sector is multi-layered. It means accountability to different audiences, for a variety of activities and outcomes, through many different means. This multidimensional nature is the principal complexity of accountability in the voluntary sector".* [15]

Hospital Board Accountability

As outlined above, accountability is a complex and multifaceted concept. This is particularly true in Ontario's local voluntary independently governed hospital sector, where the organization is situated as an anchor civil society institution. It is important for a board to consider the broader role it plays in civil society when making its decisions.

Broader Accountability

The World Health Organization, citing the London School of Economics Centre for Civil Society's working definition of civil society with cautious acceptance, confirms civil society to be: "*the space for collective action around shared interests, purposes and values that is generally distinct from government or commercial for-profit actors.*"[16] Civil society can be further understood as the social sphere distinct from both the state and market; this includes voluntary, non-profit and independent sectors, which in Ontario includes hospitals.

Effective civil society organizations possess autonomy and a link to a constituency.[17] Autonomy is a measure of the extent to which an organization determines what it is for and whom it serves. Civil society organizations often must balance their autonomy against other desirables — funding, political engagement, credibility, and the organizational maturity necessary to deliver complex projects and employ staff. The connection a civil society organization has to its constituency can be in the form of a representative link, in which the organization engages in policy debates on behalf of others, or a link to a community that it services with a benefit or function.

When understanding hospital accountability, boards should consider how, and the extent to which, the hospital's role in civil society may inform decision-making.

Board Accountability

Boards are accountable for acting in the best interests of the corporations they serve. A board and its individual directors are not accountable to any one particular stakeholder interest or group, but rather the corporation as a whole, even when a board member feels they are solely representative of one a particular stakeholder group (medical staff, foundation, municipality etc.) As a result, a board is required to have knowledge of all corporate stakeholders to whom the corporation is accountable and should appropriately consider and, where necessary, balance such stakeholder interests when making decisions. In addition to considering stakeholder interests, a board should be guided by its mission, vision and values when making decisions. Finally, hospitals, as organizations utilizing public funding and providing services to their respective communities, are expected to adhere to the principles of transparency and accountability.

→ Find Out More

The principles of transparency and accountability are enshrined in a host of legislative and regulatory instruments. Review the OHA's *Guide to Hospital Statutory Compliance* for more information.

Accountability to Stakeholders

Stakeholder engagement adds corporate decision-making value and plays an important role in contributing to the success of an organization's mission and vision. Accordingly, a board remains accountable for ensuring the quality of stakeholder engagement processes. This requires a board to ensure it causes the hospital to discharge its accountability to its stakeholders in every decision coming before the board. A hospital board must therefore consider the interests of multiple stakeholders, including:

- Patients, their families and caregivers and the needs of the communities served;
- Obligations under its funding agreements, including service accountability agreements (formerly Hospital Service Accountability Agreements or HSAAs);
- The requirement to comply with applicable legislation including the *Public Hospitals Act*, the *Commitment to the Future of Medicare Act,* the *Connecting Care Act*, the *Excellent Care for All Act* and the *Broader Public Sector Accountability Act*;
- The role of Ontario Health (formerly the Local Health Integration Networks (LHINs));
- The supervisory and regulatory authority of the Ministry of Health (Ministry) and others, such as the Ministry of Long-Term Care and Ministry of Children, Community and Social Services;
- The interests of its employees and its medical, dental, midwifery and extended class nursing staff;
- The interests of the volunteers who provide financial support and many unpaid hours that contribute to the fulfillment of the hospital's mission;
- The contribution of its donors and financial supporters; and

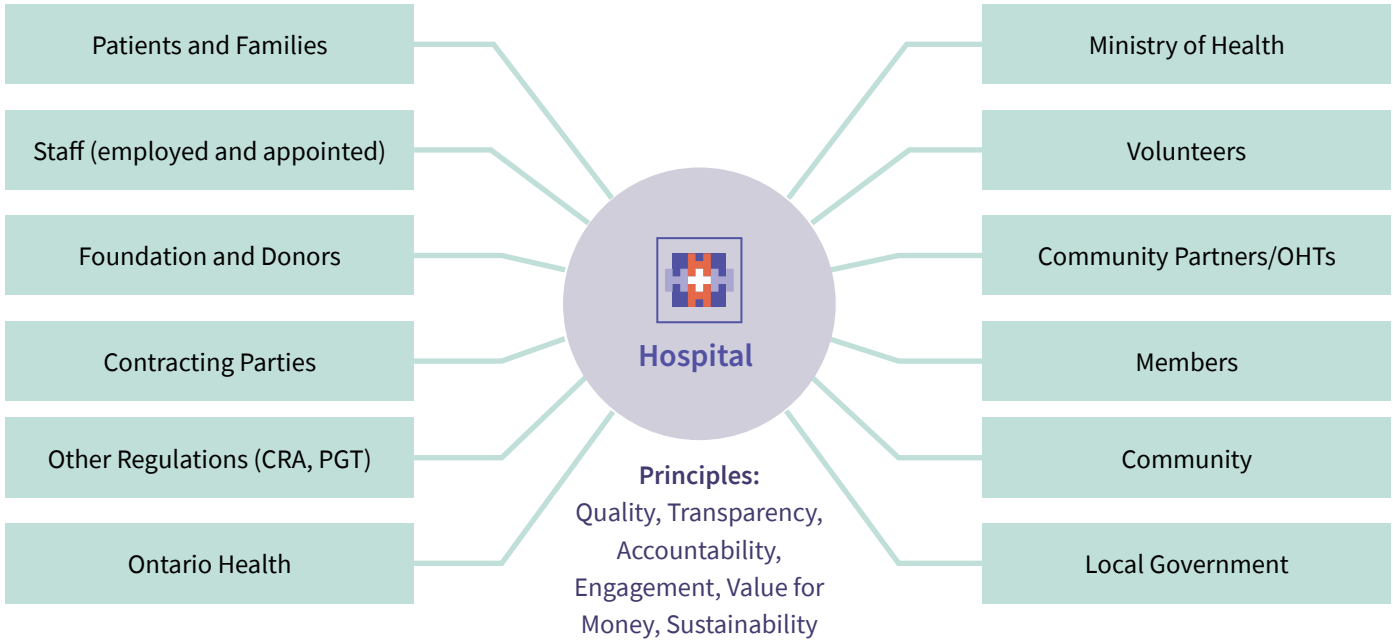
- The hospital's relationship with Ontario Health Teams (OHTs), other providers of health care, academic institutions and social services agencies along the continuum of care.

The multiple accountabilities owed by a hospital are often in conflict. In these situations, a board should take careful consideration, and remain guided by the hospital's mission, vision, values and, ultimately, the best interests of the hospital. In other cases, these multiple accountabilities may become aligned or dictated by legislative and contractual requirements. In addition, a hospital's multiple accountabilities may overlap with those of system partners, including the following quadruple aim of OHTs:

- Improved patient and caregiver experience;
- Improved patient and population health outcomes;
- Improved provider work life experience; and
- Improved value, reducing the per capita cost of health care.

A hospital's stakeholders are commonly identified with reference to three factors: the hospital's mission or purposes; its sources of funding and resources; and its regulatory authorities (e.g., those with an oversight responsibility). Figure 4.1: Hospital Accountability below outlines some of the key accountability relationships to which a hospital is subject. Each of these relationships has the potential to give rise to some measure of accountability.

Figure 4.1: Hospital Accountability



A board will face its greatest challenges when choosing between competing demands for limited resources. It is helpful for the board to develop a statement outlining the hospital corporation's accountability to guide effective decision-making.

Access All Forms

See *Form 4.1: Sample Accountability Statement*.

Accountability to Government and Ontario Health

A hospital's accountability relationship with Ontario Health (included above in Figure 4.1: Hospital Accountability) is informed by the *Connecting Care Act* and, pursuant to that legislation, service accountability (funding) agreements (formerly Hospital Service Accountability Agreements, or HSAAs).

Following the introduction of service accountability agreements, the question is sometimes raised as to whether hospitals are solely accountable to Ontario Health (formerly the LHINs). Many boards also question what it means to act in the best interests of the hospital corporation in the context of the funding, accountability, and integration principles introduced in the *Local Health System Integration Act* and continued in the *Connecting Care Act*—including the introduction of OHTs. As outlined above, acting in the best interests of the hospital means considering the hospital's multiple accountabilities, including (but not limited to) its accountability to Ontario Health and the financial accountabilities under its service accountability agreement.

Accountability with a Health System Perspective

Acting in the best interest of the hospital also means considering other health service providers (defined in the *Connecting Care Act*). These other health service providers may include:

- Ontario Health Teams;
- Other hospitals;
- Long-term care homes;
- Home and community care;
- Community mental health agencies; and
- Other health service providers.

In addition to considering other specific health service providers, a board should consider the health system as a whole; which continues to prioritize and incentivize progress toward the delivery of services in an integrated, coordinated, and efficient manner. Accountability with a health system perspective may require:

- Redefining of the hospital's mission and vision to include its role in the health system and OHTs and the effectiveness of the system as a whole;
- Concentration on existing strengths to avoid service duplication and unnecessary competition with other health service providers to ensure cost effectiveness and best patient outcomes;
- Review of board recruitment processes to consider directors who are system thinkers;
- Having individual directors and the board collectively become more involved with external organizations, including OHTs, while being mindful of potential conflicts of interest;
- Evaluation of the system implications of individual board decisions and impact on OHTs and other health service providers;
- Reconsideration of a hospital's strategic plan or objectives with a system/OHT perspective; and
- Re-examination and reinforcement of key stakeholder relationships from a system perspective.

The approach to the above health system perspective considerations should continue to evolve as community needs grow and change over time to ensure best patient care outcomes.

Achieving Transparency

Transparency involves open processes and public disclosure. Transparent processes aid in demonstrating and implementing accountability and may be achieved through several means, including:

- Public disclosure of key information – This may encompass: regular written communications such as newsletters and media releases; a robust and effective website with current and relevant information; disclosure through a community annual report; media relations policies; and information required to be disclosed (under, e.g., the *Broader Public Sector Accountability Act* and *Excellent Care for All Act*).
- Open and transparent processes – This may encompass: nomination and recruitment processes that select board candidates based on objective criteria and consider all potential applicants, and provide for participation in board committees by community members; open board meetings or public reports on board decisions and processes; annual member meetings or other "town hall" style meetings open to the public; and patient ombudsman or patient relations processes.

→ Find Out More

Hospitals are also subject to the *Freedom of Information and Protection of Privacy Act* and *Personal Health Information and Protection of Privacy Act*. Review the OHA's *Guide to Hospital Statutory Compliance* resource to learn more.

Engaging Stakeholders

Engagement is a very different concept from transparency. Engagement is commonly understood to include two-way communications that provide opportunities for input from stakeholders to enrich an organization's decision-making. Effective engagement also assists in relationship-building, and aids in demonstrating accountability. For hospital boards, there are three key questions that should be understood in connection with stakeholder engagement processes and strategies:

1. What outcomes are we seeking to achieve, and why? A board should understand the importance of engagement and its impact on hospital success.
2. Who will be engaged? A board should understand with whom they are engaging (e.g., the community, stakeholders, funders).
3. How will the board engage? A board should determine the methods the hospital will use for effective engagement with different groups of stakeholders, and for different purposes, outcomes and benefits.

Legislative Requirements

Under the *Connecting Care Act*, both Ontario Health and the hospital are required to conduct community engagement: in particular, hospitals "shall establish mechanisms for engaging with patients, families, caregivers, health sector employees and others as part of their operational planning processes".[18] In hospitals, processes for engagement are seen as compatible with models of patient- or family-/caregiver-centered care. They involve a range of participation and interactions with key impacts in areas of policy, planning, access and services. In addition, and pursuant to the *Excellent Care for All Act*, hospitals are required to conduct employee/care provider and patient satisfaction surveys, and to have in place a patient relations process.

Effective Engagement

Boards are much more involved in overseeing the status of stakeholder engagement today than in the past. It is now common for a hospital board to receive regular reports from management or a board committee, and to periodically receive survey results or meet with their community advisory committee, where applicable. A key to ensuring effective

stakeholder engagement is to establish and implement a multi-faceted approach. A hospital may wish to 'piggy-back' on other processes and opportunities to engage with stakeholders. For example, a strategic planning process provides an opportunity to gather input and opinions from stakeholders about the hospital's performance and plans.

The business case for ensuring effective engagement is related directly to patient care objectives. Good stakeholder relations—whether with the community served, internal stakeholders, regulatory authorities, health care partners or funders—impacts the way the hospital is perceived and valued by those whose support is critical to its success.

The hospital's reputation and standing in the eyes of its stakeholders can be enhanced through effective engagement. This, in turn, impacts a number of factors that each play a role in the quality of care, including staff (employed and credentialed professional staff) retention, recruitment and staff morale, donor support, funder support and the public's confidence in the hospital's quality of care. The quality and quantity of available resources, both human and financial, impact the success of the hospital in achieving its mission. Effective engagement also provides for the consideration of a wide range of views, which enhances the quality of decisions.

The stakeholder community, for engagement purposes, is defined broadly in a hospital context, and there may be different definitions for different purposes. It may mean a community based on geography—the local community served—and/or align with the "attributed population" model used in the context of developing OHTs. It may also describe user groups based on services or programs (e.g., women's health, seniors or dialysis programs). In addition to community engagement defined by those the hospital serves, engagement occurs with other stakeholders, such as other health care providers, OHTs, academic partners, regulatory authorities, local government and internal stakeholders.

Deciding how engagement will be conducted very much depends on the audience and the purpose of the engagement. For example, the structure and process for engagement will depend on whether active participation in decision-making is desired, or the process is to inform or advise and receive input.

There may be a range or continuum of objectives, from seeking input, to entering into a process of collaboration or integration in the delivery of care. The benefits of different engagement approaches should consider, among other things, the larger goal of ensuring diverse representation by employing complementary, as opposed to duplicative, engagement approaches, and the financial opportunity costs of deploying one approach versus another.

Typical forums for engagement include:

- Participation in OHTs and other local health care initiatives;
- Representation on board committees by members of the community;
- Advisory committees or councils that have a specific mandate to provide input to hospital decision makers; these may be broad-based community groups, stakeholder representative groups or organized by specific services or the needs of particular populations (e.g., mental health, seniors, or women);
- Town hall-style meetings or engagement sessions (in-person and virtual) that are open to the community/staff where there can be a dialogue and exchange of ideas with members of the community or relevant interest groups;
- Focus groups;
- Presentations to community groups and stakeholder entities;
- Rounding by senior leadership team members;

- Surveys;
- Relationship-building with key staff and community leaders and groups;
- Patient/staff feedback;
- Targeted interviews; and
- A hospital website/social media/newsletters that provide information and allow for input/feedback from the community.

Access All Forms

See *Form 4.2: Examples of Mandated and Voluntary/Optional Processes for Accountability, Transparency and Engagement*

See *Form 4.3: Community Engagement – Key Considerations in Forming Advisory Bodies*

Hospital Accountability and Relationships

A hospital board should understand the nature of its relationship with, and obligations to, its stakeholders to effectively and appropriately make decisions in the best interests of the hospital, and to determine the appropriate processes for relationship-building and engagement.

Hospitals and their Members

As a not-for-profit corporation, a public hospital has members, rather than shareholders. While most hospitals are incorporated under the *Not-for-Profit Corporations Act* (formerly the *Corporations Act*), some hospitals are created by special legislation and may not have members. There are different hospital membership models in Ontario, including those where the corporate members are the hospital's directors, and those where the corporate members include individuals admitted from the community, which is increasingly less common.

Members are not 'owners' in the same sense that shareholders have an equity ownership interest in a for-profit corporation. Members have the right to vote and to receive financial statements but are not entitled to any distribution of the surplus revenues of the corporation (dividends in a for-profit context); nor are they entitled to receive the remaining assets on dissolution of the corporation.

While the role of members is limited, it is a meaningful and potentially powerful role. Directors, other than *ex officio* directors, are elected by the members and may, in certain circumstances, be nominated and/or removed by the members. Members approve fundamental changes such as by-law amendments and amalgamations. Members are entitled to notice of, and to attend, the annual meeting of members and any special meetings, and have rights in respect of proposals.

Despite the fact that the directors are elected by the members, the duty of the directors is to act in the best interests of the corporation as a whole which, given the hospital's multiple accountabilities, may at times be in conflict with the best interests of the members.

Access All Forms

See *Form 4.4: Members' Legal Requirements and Governance Principles*

Denominational Hospitals

The role of members may be different in a denominational hospital. Denominational hospitals are those which were founded and supported by a religious organization. A denominational hospital is organized and governed in much the same way as any other public hospital, with two principal exceptions:

1. The members of a denominational hospital are typically representatives of the founding or sponsoring religious order or organization, and there may be some governance decisions that are reserved for the members; and

2. The hospital may be expected to reflect the principles of the denomination through its mission, vision and values, and in its operations.

Hospitals and the Community Served (Including Patients, Families and Caregivers)

The nature of the hospital's accountability to its community (including patients, families and caregivers) arises by virtue of legislative requirements, the services being provided, and the ultimate sources of hospital funding. Hospitals are providing a vital service to the community with taxpayers' dollars; therefore, directors of a hospital corporation must take into account a broader public interest.

There are a number of complex issues connected with the hospital's role of providing quality care services to its community. The courts have recognized that the services provided by a large urban academic hospital will not be the same as those provided by a small rural hospital. The courts have also recognized that there are limited resources with respect to health care and difficult decisions must be made with respect to resource allocation.

A hospital board should understand the general standard to which the hospital will be held accountable with respect to the scope and quality of services provided. Hospitals are required to meet the standard of care that would be expected of a similarly situated hospital. This is often described as a community standard.

Community support for the hospital at the local level has a number of positive implications, including local donor support, increased staff morale, positive impacts on retention and recruitment, and enhanced relationships with funders and partners. Recall that the *Connecting Care Act* requires hospitals to "establish mechanisms for engaging with patients, families, caregivers, health sector employees and others as part of their operational planning processes."[19] In addition to the examples of forums for engagement outlined above, hospitals employ a range of additional forms of engagement, including:

- Soliciting and sharing patient stories;
- Centering patients, families and caregivers in mission/vision/values and strategic planning, and in the process for their development; and
- Including community and patient impacts as mandatory elements in board reporting templates.

Relationship with Ontario Health

Ontario Health oversees and funds health service providers, which includes hospitals, home and community care, community health centres, long-term care homes, mental health and addiction agencies, community support service organizations, and OHTs. The mandate of Ontario Health includes the following roles and responsibilities:

- Measuring and reporting on how the health system is performing;
- Overseeing the delivery and quality of clinical care services, including cancer, renal, cardiac, palliative, mental health and addictions services;
- Managing funding and accountability for parts of the health system;
- Creating provincial digital and virtual services that will give patients and health care providers more complete health information;
- Delivering organ and tissue donation and transplantation services; and
- Setting quality standards and developing evidence-based guidelines to improve clinical care.

A Closer Look: Ontario Health

Ontario Health was established in 2019 under the *Connecting Care Act*, with purposes including "to manage health service needs across Ontario consistent with the Ministry's health system strategies to ensure the quality and sustainability of the Ontario health system" through, among other things, "health system operational management and co-ordination" and "to promote health service integration to enable appropriate, coordinated and effective health service delivery."

In 2020, management of health care services was transitioned from the 14 LHINs, as constituted under the *Local Health System Integration Act*, to Ontario Health.

Ontario Health is a non-profit statutory corporation and crown agent and is governed by a board of directors. The board may have up to fifteen members, which the government appoints by Order in Council.

Ontario Health does not directly provide health services to patients or clients, nor do they supplant the board or management of health service providers.

Under the *Connecting Care Act,* Ontario Health enters into an accountability agreement with the Ministry (the Ministry of Health - Ontario Health Accountability Agreement, previously referred to as the Ministry-LHIN Accountability Agreement, or the MLAA). Ontario Health, in turn, enters into service accountability agreements with the health service providers they fund. Hospitals continue to be governed by their own independent boards.

The *Connecting Care Act* continues a statutory obligation first established under the Local Health System Integration Act, for Ontario Health and each health system provider and OHT to separately, and in conjunction with each other, identify opportunities to integrate the services of the health system to provide appropriate, coordinated, effective and efficient services. Integration continues to be defined very broadly under the *Connecting Care Act*, and includes:

- Coordinating services and interactions between different people and entities;
- Partnering with another person or entity in providing services or in operating;
- Transferring, merging or amalgamating services, operations, persons or entities;
- Starting or ceasing the provision of services; and
- Ceasing to operate or to dissolve or wind up the operations of a person or entity.

Integration of services may take many forms and could include OHTs; networks and alliances; collaborative delivery of services; partnering arrangements; and shared service arrangements.

Relationship with the Ministry

There are several aspects to the relationship between the hospital and the Ministry helping to define the accountability relationship between the two bodies:

- The funding relationship for capital and certain services or programs;
- The supervisory role of the Minister of Health (Minister) under the *Public Hospitals Act*; and
- The Ministry's role in policy development and establishing regulatory requirements.

Under section 4 of the *Public Hospitals Act*, the Minister has an approval right in respect of certain hospital governance matters, such as amalgamation, amendments to constating documents, and use of premises for hospital purposes. The Minister has the power to intervene in the governance

of a hospital in cases where the Ministry determines it is in the public interest to do so. The Minister may recommend the appointment of a supervisor and give the supervisor the powers of the board, the members and the officers of a hospital. The Minister has also, in recent years, conducted operational reviews and appointed coaches, interveners and/or inspectors.

To the extent that a hospital corporation undertakes additional activities, it may have a relationship with other Ministries, Ministers, or regulators. For example, hospital corporations that are also long-term care home licensees will have accountabilities under the *Fixing Long-Term Care Act*.

Hospital Funding Relationships

Hospitals are accountable for funding through funding agreements—service accountability agreements (formerly Hospital Service Accountability Agreements, or HSAAs). Service accountability agreements represent a corporate obligation for hospitals that require them to be accountable for explicit performance outcomes.

The *Connecting Care Act* establishes a process for service accountability agreements to be negotiated with Ontario Health. A hospital that does not enter into a service accountability agreement can be ordered to do so pursuant to the provisions of the *Connecting Care Act*.

Access All Forms

See *Form 4.5: Entering into Accountability Agreements Under the Connecting Care Act*

In addition, section 5 of the *Public Hospitals Act* gives the Minister the ability to place terms and conditions on grants. However, this section has not historically been used expressly for the purpose of holding hospitals accountable for funding allocations, and it is expected that the Ministry will continue to rely on service accountability agreements with Ontario Health for assessing hospital performance.

While hospitals draw on numerous revenue sources to fund their operations, the Ministry, through Ontario Health, is by far the largest category of revenue for hospitals, accounting for about 85-100% of the majority of in-patient and out-patient programs. Other sources of hospital revenue include:

- Revenue-generating activities, including revenue from patients and visitors (e.g., cafeteria income and parking), and other revenue-generating activities that are permissible within the hospital's status as a registered charity;
- Revenues from organizations outside of Ontario Health and the Ministry (e.g., OHIP, the Workplace Safety and Insurance Board, another ministry, other provincial governments, or the federal government);
- Grants (e.g., research grants and donations); and
- Donations and charitable giving.

Other streams of government funding, either from Ontario Health or directly from the Ministry, include the following:

- Priority services funding for certain designated programs, for example, chronic kidney disease, cardiac rehabilitation, transplantation services, and Emergency Department pay for results (ED P4R) program;
- One-time funding resulting from government announcements or special initiatives;
- Funding to support expansion of services accompanying capital projects (post-construction operating plan funding); and
- Capital projects (new construction). That said, the Ministry requires a significant portion of a capital project to be funded by the hospital through a local share (local community giving).

A Closer Look: Funding Models

The Ontario government is using patient-based funding models for 71 community and academic and hospitals: The Growth and Efficiency Model (GEM) and Quality-Based Procedures/Bundled Care payment models. The GEM is an *allocation model* that calculates a hospital's potential share of a fixed pot of incremental base funding. The GEM estimates future expense based upon past service levels and efficiency, as well as population and health information (e.g., age, gender, population growth rates, diagnosis and procedures). The share is impacted by the hospital's efficiency (expected costs compared to actual costs) and changes in population as it impacts care delivery.

The methodology calculates expected GEM expenses that inform the hospital's allocation share for the next funding year. The ministry continues to work with Ontario Health, OHA and hospital stakeholders to enhance the methodology over time to make hospital allocations fair and equitable. For example, in 2024/25 there are enhancements to the Rehabilitation and Emergency Department (ED) modules using an updated Rehabilitation patient classification system and new adjustment variables for the ED expected cost model. Under the GEM model, hospitals will be funded based on incremental growth for patients they look after for the specific needs of the population they serve.

Quality-Based Procedures (QBPs) are specific groupings of health services (e.g., cataract, stroke) funded under a price multiplied by volume approach with allocations at specific groupings levels. In 2018, Ontario Introduced Bundled Payments approach for unilateral hip and knee replacement surgeries. The approach is based on a similar QBP approach but involves a bundled payment to fund holders for hospital and community patient services.

Hospitals and Donors

Hospitals rely to a significant extent on charitable donations to fund capital and equipment. Whether these funds come directly to the hospital or to the hospital through a foundation, the hospital is required to ensure that donor funds are utilized for the purposes for which they were given.

Hospitals and Their Foundations

While hospitals may fundraise and issue charitable receipts directly, the most common model for hospital fundraising is through a separately incorporated, non-share capital, charitable corporation (foundation) which is dedicated solely to fundraising and stewardship.

It is important that both the board of the hospital and the board of the foundation share a common understanding of their respective roles for fundraising and oversight of hospital operations. Hospitals are dependent on donor dollars and, in particular, on local community giving to provide additional resources. Typically, foundations will confine their fundraising to equipment and other capital needs, although it is rare to see provisions in a foundation's letters patent that would prohibit it from making donations to the hospital for any of the hospital's financial needs.

It is the role of the hospital to make decisions regarding its capital needs and the allocation of its financial resources. That said, it must clearly communicate to the foundation its needs and provide appropriate support to the foundation in its fundraising efforts. The hospital should also acknowledge the stewardship obligations that the foundation has to its donors. Similarly, the foundation should recognize that although the hospital could directly fundraise, it looks to and relies upon the foundation for fundraising, and therefore expects the foundation to meet the hospital's need for donor dollars.

It is important that both the foundation and the hospital put in place mechanisms to maintain communication and ensure alignment between the hospital and the foundation. A hospital and its foundation may wish to enter into a memorandum of understanding or statement of relationship principles that may include the following:

- Participation of the hospital's chief executive officer and board chair or designate at the foundation board, and vice versa;
- Requesting the foundation report at the hospital's board level;
- Clearly defining statements of relationships and roles of the hospital's chief executive officer and the foundation's executive director;
- Creating protocols for funding requests;
- Creating guidelines for communication and transparency; and
- Establishing proper dispute resolution processes.

There may also be formal licensing agreements for the foundation's use of hospital logos and intellectual property.

A Closer Look: Philanthropic Hospital Naming

The Ministry has published expectations with respect to hospital naming – most recently in the Ministry's protocol for obtaining approvals under section 4 of the *Public Hospitals Act*. The protocol requires that:

- Each hospital has a naming policy;
- Considerations respecting hospital naming require meaningful consultation with stakeholders and the community;
- A decision to adopt a new corporate or business name in recognition of philanthropy should be made where the level of philanthropy corresponds to the value of the asset; and
- Any agreement concerning the adoption of a corporation or business name should not include a term to the effect that a hospital will use a name indefinitely.

Hospitals and Their Volunteers

Hospital volunteers make valuable contributions to the success of the hospital through volunteer service hours and fundraising activities. Volunteer organizations, where not formally incorporated, usually operate through an organizational structure that may look much like a board of directors.

If volunteers are not part of a volunteer organization that is fully incorporated, then they may be better characterized as a division of the hospital, operating with the support and authorization of the hospital. Hospital management may have a role in connection with the recruitment, training and scheduling of volunteers, and in providing support to the board of the volunteer organization.

The different roles of the hospital, and the services of any board or governing committee/council of a volunteer organization, should be well-defined and understood to ensure seamless operation. As hospital board compositions move away from representative boards to independent boards, it is becoming increasingly less common to see a volunteer representative serving as a hospital board member. That said, it is important to establish regular engagement initiatives that involve the hospital chief executive officer and/or the hospital board chair meeting from time to time with the volunteer organization's leadership.

Hospitals and Other Health Care Providers

As previously noted, the *Connecting Care Act* requires hospitals to "establish mechanisms for engaging with patients, families, caregivers, health sector employees and others as part of their operational planning processes".[20] To identify opportunities for integration, and be effective in the current environment, a board should consider ways to build board-to-board relationships with Ontario Health, OHTs, and other health service providers; in other words, collaborative governance.

Collaborative governance describes the mechanisms by or through which two or more independent governing bodies can achieve a common goal. This term applies to OHTs, which commonly operate as collaborations between independent entities pursuant to contractual arrangements, leaving in place the independent governing boards of the entities that deliver health care. Hospital boards should work toward collaborative governance with OHTs and other health service providers to both comply with legislative requirements and create a system that best supports patients, their families, and quality care.

Chapter 5: The Board's Role in the Credentialing Process

Professional staff members have a direct impact on the quality of care provided in a hospital. For that reason, there must be an effective method to ensure the hospital recruits and maintains an appropriate complement of skilled professionals. This chapter provides an overview of the credentialing process, the board's role in it, and broader procedural elements for a board's consideration.

In This Chapter:

Understanding Credentialing

Although a variety of health care professionals work in hospitals, credentialing is only required for physicians, dentists, midwives, and extended class nurses with privileges. These professionals are not generally employed by the hospital. They are usually independent contractors who bill the Ontario Health Insurance Plan for their services and are granted privileges to practice in the hospital pursuant to the process set out under the *Public Hospitals Act* and/or the hospital's by-laws. Credentialed professional staff have direct impacts on the quality of care provided in the hospital. Due to this, credentialing professional staff is one of the hospital boards' most important governance roles.

Credentialing includes a range of activities and processes, such as:

- Reviewing applications for initial appointments;
- Verifying qualifications;
- Identifying the scope and nature of privileges;
- Granting privileges;
- Performing periodic reviews; and
- Conducting annual re-appointments.

Each of these activities and processes are aimed at ensuring the hospital recruits and maintains an appropriate complement of skilled professionals. The board is ultimately responsible for ensuring an effective and fair credentialing process.

→ Find Out More

More comprehensive information on the board's role in the credentialing process can be found in the OHA's *Professional Staff Credentialing Toolkit* (toolkit). The toolkit provides a detailed overview of the credentialing process as well as the roles and responsibilities of key players. In addition, the toolkit discusses the importance of a culture of patient safety and the role of responsible and respectful professional staff engagement in the context of credentialing.

Overview of the Appointment Process

Under the *Public Hospitals Act* and the hospital by-laws, the board is ultimately responsible for all appointments and re-appointments to the professional staff as well as for all suspensions, revocations and/or other alterations to professional staff privileges. These responsibilities cannot be delegated by a board. The failure to properly evaluate applicants for appointments and re-appointments exposes patients to harm and may result in hospital liability.

Physician Appointments

All privileges decisions involving physicians must be considered in the context of the *Public Hospitals Act*, Regulation 965, hospital by-laws, and case law. The *Public Hospitals Act* procedural rules for privileges apply to physicians only, and not to dentists, midwives or extended class nurses. However, Regulation 965 allows hospital boards to pass by-laws for other professional staff members and, to the extent that hospitals exercise that discretion, the professional staff by-law typically applies the same procedural rights to all groups. For example, the OHA/OMA Prototype By-law extends the procedural rights afforded to physicians under the *Public Hospitals Act* to all categories of the professional staff. All hospitals that engage the services of dentists, midwives and extended class nurses should have clear credentialing rules that apply to those groups.

The *Public Hospitals Act* establishes the following procedural requirements and powers of the board in relation to medical staff (physician) appointments and hospital privileges:

- Every physician is entitled to apply for hospital privileges and to have their application considered by the hospital in accordance with the hospital's by-laws and the *Public Hospitals Act*.
- With every application, the medical advisory committee must meet and make a written recommendation to the board.
- The medical advisory committee must give the applicant written notice of its recommendation that informs the applicant that they are entitled to request written reasons for the recommendation and to request a hearing before the board about the application.
- If a hearing is not requested by the applicant, the board may implement the recommendation. If a hearing is requested, the board will hold a formal hearing during which the medical advisory committee and the applicant will present evidence for and against the recommendation. After hearing the evidence, the board is required to decide whether to appoint the applicant to the medical staff.
- Each appointment to the medical staff is for a maximum of one year. Physicians must re-apply annually, and the re-applications are considered by the medical advisory committee and board following the same application process as new appointments.
- The board may also revoke or suspend a physician's appointment when it considers this necessary. This is referred to as 'mid-term action', and there is usually a process for this outlined in the hospital's by-laws.
- if an applicant or member of the medical staff considers themself aggrieved by a decision of the hospital board to not appoint or re-appoint them, or by a decision that cancels, suspends or substantially alters their hospital privileges, they are entitled to ask for written reasons for the decision, and to request an appeal of the decision to the Health Professions Appeal and Review Board (HPARB). HPARB is a tribunal appointed pursuant to the Ministry of Health Appeal and Review Boards Act. There is also a further right of appeal from HPARB decisions to the Divisional Court.

Other Professional Staff Appointments

As outlined above, hospital by-laws may extend the procedural rights afforded to physicians under the *Public Hospitals Act* to other categories of professional staff (dentists, midwives, and extended class nurses with privileges) including establishing a similar process for requesting written reasons and a hearing before the hospital board; however, only physicians have the right to appeal a decision of a hospital board that affects their privileges to HPARB and then on to the Divisional Court. The *Public Hospitals Act* does not extend this right of appeal to any other members of the professional staff.

The Board's Role in Credentialing

The board has six areas of responsibility respecting the credentialing process, including:

- Setting the context;
- Choosing leadership;
- Making decisions;
- Holding hearings;
- Understanding and applying the principles of natural justice and procedural fairness; and
- Ensuring processes are followed by leaders.

Setting the Context

The board has an overarching responsibility for setting the context within which the credentialing process operates. This context includes the board's approval of:

- The rules and regulations for professional staff;
- Policies and procedures applicable to professional staff;
- By-laws establishing the criteria and processes for appointment, re-appointment, and changes to privileging;
- The form of application or, if not the form, the required content of the application—in effect approving the scope of due diligence required in respect of each applicant for appointment and re-appointment; and
- The strategic directions of the hospital that will inevitably impact professional staff resource planning.

Many of these responsibilities are contained in, outlined, or enabled by a hospital's by-laws.

Hospital By-laws

Regulation 965 under the *Public Hospitals Act* requires the board to pass by-laws that provide for the organization of the medical staff, and where the hospital has dental, midwifery or extended class nursing staff, for the organization and appointment of these professional staff as well. Extended class nurses are registered nurses who are registered with the College of Nurses of Ontario as a registered nurse in the extended class under the *Nursing Act*. Many hospitals now collectively refer to these categories of staff as the professional staff, and the Medical Staff By-Laws are now referred to as the Professional Staff By-Laws.

The by-laws approved by the board and confirmed by the members of each hospital will provide for the organization of the medical staff in the hospital and, as applicable, for the organization of the dental, midwifery, and extended class nursing staff. While each hospital's by-laws will be different, in general terms, the by-laws will cover such things as:

- The qualifications and criteria for appointment to the professional staff (the medical, dental, midwifery and extended class nursing staff) of the hospital. This includes license to practice and appropriate specialist qualifications where applicable; professional liability protection (insurance); skills, training and experience for the privileges requested; ability to work and communicate with other staff in a professional manner; hospital resource plans; and the need for the professional's services.
- The process for the appointment of the dental, midwifery and extended class nursing staff is usually the same or very similar to the process for medical staff.

→ Find Out More

The OHA and the Ontario Medical Association (OMA) developed the *Hospital Prototype Board-Appointed Professional Staff By-Law* resource which may be adopted by hospitals or used as guidance for developing local hospital by-laws. The prototype by-law is available at www.oha.com

- The categories (e.g., active, associate, courtesy staff) and departments (e.g., surgery, emergency, pediatrics) of the hospital staff and the privileges and duties that attach to each category or department. For instance, active staff members typically have the privilege of admitting patients to the hospital, whereas other categories may not have admitting privileges. Also, professional staff in certain categories or departments may have on-call responsibilities, whereas others do not.
- The process to be followed to fulfill each of the requirements set out in the *Public Hospitals Act*. This includes the handling of initial applications; the processes for granting initial appointments, annual re-appointments, and changes in appointments; and the steps to be taken when it is considered necessary to revoke or suspend an appointment (including urgent mid-term action). For each of these, there will be a process set out for how the issue is to be considered by the medical advisory committee and possibly by other committees or officers of the hospital, leading to a recommendation by the medical advisory committee, and then a decision by the board.
- Administrative matters, such as granting leaves of absence, monitoring practice and transferring care from one professional staff member to another.

In addition to the above, the board is responsible for choosing the leadership accountable for implementing and facilitating the mechanisms and requirements contained in the board approved by-laws.

Choosing Leadership

In choosing leadership, the board is responsible for:

- Establishing the medical advisory committee;
- Appointing the senior officers and medical staff leaders responsible for initial appointment and re-appointment processes (e.g., chief of staff/chair of the medical advisory committee, department chiefs); and
- Determining, through the by-laws, whether the medical advisory committee will include non-medical staff members (without a vote), in addition to the voting medical staff members of the medical advisory committee.

Medical Advisory Committee

The medical advisory committee is the primary committee responsible for supervising medical and other professional staff in the hospital. It is responsible under the *Public Hospitals Act* for making recommendations to the board concerning the appointment, re-appointment, requests for changes, revocation, suspension or restriction of the hospital privileges of the medical, dental, midwifery, and extended class nursing staff. The *Public Hospitals Act* sets time limits within which the medical advisory committee must consider and make a written recommendation to the board and the process for exceptions to this limit.

The by-laws of the hospital set out the process by which the medical advisory committee makes its recommendations. For all applications, the medical advisory committee is required to make a written recommendation to the board. The professional staff member is entitled to written notice of the recommendation and can ask for written reasons for the recommendation.

The medical advisory committee assesses credentials, health records, patient care, infection control, the utilization of hospital facilities and all other aspects of health care and treatment at the hospital and may establish a credentials committee to assist with this process. The credentials committee would be responsible for investigating the qualifications and experience of new applicants, and often with assessing applications for re-appointment. In performing its duties, the credentials committee will undertake any specific investigations required by the by-laws (e.g., obtaining proof of license and other qualifications) and other investigations it considers appropriate. The credentials committee then reports to the medical advisory committee.

Where no credentials committee exists, the medical advisory committee is responsible for all aspects of the process.

The medical advisory committee will review the application and the information provided by the credentials committee. It will consider whether the applicant meets the criteria set out in the by-laws for appointment or re-appointment. It will also consider the hospital's resource plans and whether there is a need for additional professional staff members with the applicant's particular expertise.

When it is believed that some form of mid-term action (e.g., action between the annual re-appointments) is necessary relating to a professional staff member's privileges, a hospital's mid-term action process should require certain steps to investigate the issues and report to the medical advisory committee, including provision for immediate action where necessary. This commonly occurs if a professional staff member's actions are potentially putting patients at risk or otherwise adversely affecting the quality of patient care and the operation of the hospital. Once the matter is reported to the medical advisory committee, it will meet and consider whether to make a recommendation to the board for mid-term action. The affected professional staff member is often given the opportunity to attend the medical advisory committee meeting and present their answers to the complaints against them.

In establishing the medical advisory committee, and receiving its recommendations, the board exercises a portion of its oversight and engagement responsibilities respecting the credentialing process. In addition to this establishment and oversight role, boards are responsible for making decisions and holding hearings respecting credentialing.

Making Decisions

The board is responsible for making decisions respecting professional staff, including:

- Appointing and re-appointing the medical staff;
- Revoking or suspending appointments and/or canceling or suspending any member of the medical staff's privileges who no longer meets the hospital's qualifications or who contravenes any applicable by-laws, rules, regulations or statutes;
- Appointing and re-appointing other members of the professional staff (e.g., dentists, midwives and extended class nurses), where the by-laws provide for these types of board-appointed professional staff members;
- Determining the scope of any privileges granted to a member of the professional staff;
- Reviewing temporary appointments made by the CEO and recommended by the medical advisory committee to continue; and
- Making decisions about the granting of a leave of absence for professional staff where there will be a suspension or restriction of privileges (or, alternatively, approving a leave of absence policy to be administered by the chief of staff/chair of the medical advisory committee).

The medical advisory committee's recommendation will commonly be provided to the board by its chair or the chief of staff. It may be a combination of a written and verbal report. It may deal with one or more applicants or with the re-appointments of all professional staff for a particular year. The person making the report will provide some information based on the medical advisory committee's recommendation. Board members may ask questions if they wish (e.g., respecting the process that has been followed). While the board does not need to receive all the details for every candidate, it must be reassured that the processes meet legal requirements. The board is responsible for ensuring an effective and fair credentialing process.

The *Public Hospitals Act* provides that, if a hearing before the board is not requested, the board may implement the recommendation of the medical advisory committee.

The board's decision is made by way of a vote on whether to accept the medical advisory committee's recommendation. While the board is entitled to give 'great weight' to the recommendations of the medical advisory committee because

of its medical expertise[21], the board must make its own independent decision as there are additional issues that the board must consider when making privileging decisions such as: quality of patient care; patient, staff and public safety; the hospital's legal obligations; fairness to the professional staff member; the role of the hospital in the community; and the effective and efficient operation of the hospital.

Holding Hearings

If a privileges applicant requests a hearing before the board following receipt of the medical advisory committee's recommendation to the board, the board is required to appoint a time and hold a hearing to decide whether to appoint/re-appoint or revoke/suspend the privileges of the applicant.

These board hearings are formal legal hearings and, accordingly, the board is responsible for conducting them in compliance with the rules for privileges hearings established under the *Public Hospitals Act*, and in line with the principles of natural justice and procedural fairness (further outlined below). The medical advisory committee will present its case in support of its recommendation. The applicant is given an opportunity to respond. Both sides may call witnesses and present documents. The medical advisory committee and the applicant are typically represented by legal counsel. The board often has its own independent legal counsel.

When the board is required to hold a contested credential hearing, the issues the board is required to consider are highly contextual and situation-specific. The types of issues commonly addressed in these hearings may include: the competence of the professional staff member for the position; collegiality, including the ability to work with others and comply with codes of workplace conduct and other hospital policies; and human resources plans and resource allocation decisions.

Hospital privileging disputes can be extremely expensive and have negative reputational consequences for the hospital—board members must take this role seriously. Privileges hearings are unique to hospitals and board members should understand their role in this quasi-judicial process.

Understanding and Applying the Principles of Natural Justice and Procedural Fairness

Administrative law is the body of law governing agencies that have the legal authority to make decisions affecting others—such as hospital boards. For example, administrative law applies to a broad spectrum of public interfacing decision-makers, ranging from immigration decisions to landlord and tenant board decisions, to potentially broader governmental policy decisions. Directors who sit on hospital boards have been vested with important powers and must use this power responsibly to uphold certain principles, including the interrelated principles of **natural justice** and **procedural fairness**.

Natural Justice

Natural justice is a fundamental administrative legal concept rooted in a moral understanding of 'fairness'. Canadian courts have developed the following two basic principles of natural justice:

1. The decision-maker must be impartial and unbiased; and
2. The individual affected must receive, before the decision is made, sufficient notice of the case against them and the opportunity to respond to it.

Procedural Fairness

In order to ensure professional staff members receive the fair treatment to which they are entitled under natural justice, credentialing hearings must be conducted in accordance with the principle of procedural fairness; also known as due process. According to procedural fairness, the professional staff member has a right to:

- Receive notice of the allegations against them;
- A fair, impartial, open decision-making process; and

- Present their case before the board, to present witnesses, to review documentation in advance, and to cross-examine witnesses.

The requirements of procedural fairness require a board to meaningfully grapple with key issues or central arguments during a credential hearing. A board cannot act as a 'rubber stamp' of the medical advisory committee's recommendation. It must instead 'bring an independent responsible and committed approach to the review process.'[22]

Many cases before the Health Professions Appeal and Review Board (HPARB) and courts have considered how hospitals have handled physician privileging and whether the principles of natural justice and procedural fairness have been properly applied. Hospital board decisions have been overturned when it was determined that the hospital did not provide appropriate procedural protections to a physician.

When considering privilege matters under the *Public Hospitals Act*, hospital boards must abide by the twin principles of natural justice and procedural fairness. What is required often depends on the circumstances of each individual case. The board should have its own independent legal advice in this respect. The two basic principles set out in this section should always be kept in mind and followed appropriately in all appointment and privilege decisions made by the board.

Ensuring Processes are Followed by Leaders

It is the board's responsibility to monitor activities in the hospital and take measures it considers necessary to ensure compliance with the *Public Hospitals Act*, its regulations and the hospital by-laws. The board should ensure reviews are undertaken as part of the re-appointment process and that there are processes for robust, periodic reviews. The board should also receive reports and briefings from the chief of staff/chair of the medical advisory committee on the overall credentialing process to satisfy itself the process is fair and thorough. Finally, the board should review the performance of the senior officers and medical staff leaders.

→ Find Out More

Supervision of leadership is more fully discussed in Chapter 3.

Risk of Poor Credentialing

Credentialing mistakes can be costly for hospitals. The Health Insurance Reciprocal of Canada (HIROC) issued a Risk Reference Sheet acknowledging there has been increased litigation resulting from lapses in credentialing processes.[23] In the Risk Reference Sheet, HIROC identifies the following themes in litigation claims by patients against hospitals:

- Perceived/actual 'rubber stamping' of recommendations for appointment/re-appointment by health care organizations;
- Perceived over-reliance on information from provincial/territorial professional regulatory authorities to inform appointment and privileging decisions;
- Alleged multi-patient harm incidents involving the same practitioner resulting in class actions;
- Allegations that re-appointment processes did not include quality and utilization data and performance reviews;
- Lack of performance evaluation processes for professional staff and chiefs/heads;
- Alleged failure to have a robust process that asks for all pertinent malpractice claim settlements (versus those with a legal judgment) and complaints resulting in a regulatory body hearing (versus those with negative finding/undertaking); and
- Perceived lack of independent verification of information provided by applicants.

HIROC also noted the following themes in litigation claims against hospitals by their professional staff members:

- Allegations that appointment, re-appointment, privileging and disciplinary decisions were unreasonable, arbitrary and/or made in bad faith;

- Out-of-date professional staff by-laws;
- Allegations that there was a breakdown in process for revoking privileges:
  - Not previously defined and/ or not related to quality of care issues (e.g. to resolve interdisciplinary/ conflicts among practitioners); and
  - Without following due process (e.g. progressive disciplinary and natural justice);
- Perceived/actual systemic tolerance of unprofessional/ disruptive behaviour, in particular in surgical and obstetrical settings; and
- Lack of documentation of:
  - Discussions with credentialed staff regarding their unprofessional/disruptive behavior resulting in ongoing conflicts and denial of the conversations and the behaviour; and
  - The rationale to support appointment, reappointment, privileging and disciplinary decisions; and
- Perceived lack of independent verification of information provided by applicants.

Credentialing disputes can cost hospitals hundreds of thousands of dollars in legal fees. Damage awards against hospitals in Ontario for serious credentialing mistakes can be upwards of one million dollars.

Frequently Asked Questions

1. How much information does the board usually receive about the physicians that it appoints?

The board will receive a combination of written and/or verbal report from the chair of the medical advisory committee or chief of staff in their capacity as chair of the medical advisory committee on behalf of the medical advisory committee. This typically does not go into a lot of detail about individual physicians. This is detail that the board does not need to implement the medical advisory committee's recommendation, so long as it is satisfied with the process followed by the credentials committee and the medical advisory committee in arriving at the recommendation.

2. Are dentists, midwives and extended class nurses entitled to the same procedural protection as physicians under the *Public Hospitals Act*?

The provisions of the *Public Hospitals Act* apply to physicians and members of the medical staff only. The Act itself does not refer to other professional staff members. However, the regulations under the Act allow hospital boards to pass by-laws for other professional staff groups and, when hospital boards do so, the by-laws typically apply the same processes to all groups. As noted above though, only physicians have the right to appeal a decision of a hospital board that affects their privileges to HPARB and then on to the Divisional Court. Hospital by-laws cannot extend this right of appeal to other members of the professional staff. Where there is a question of what procedural protections should be afforded to an individual applicant or group of applicants, the board should consult its legal counsel.

3. Should the appointment of physicians and other professional staff members be dealt with in an *in camera* session of the board?

As these decisions deal with professional staff personnel matters, it is more appropriate to hold the meeting *in camera*. While some boards may deal with re-appointments in the open portion of a board meeting, if any re-appointment is other than routine, or if questions are asked, the matter should be moved to an *in camera* portion of the meeting. Under the *Freedom of Information and Protection of Privacy Act*, records of meetings regarding hospital appointments and hospital privileges are excluded from the right of access to hospital records.

4. Can the board appoint physicians for more than one year?

No. The *Public Hospitals Act* specifically states that the term of appointments of physicians to the medical staff can be for a 'period of not more than one year'.

5. Do all re-appointments need to come up at the same time?

Not necessarily. In most hospitals, for administrative convenience, all re-appointments are considered together, but they do not have to be. Each hospital can decide on the process that works best. There may be benefits to staggering the timing of re-appointment applications (such as by department so that different departments submit applications at different times throughout the year) to make the workload more evenly distributed throughout the year for administrative staff, the medical advisory committee, and board.

6. Can anyone other than the board appoint a physician? Can the board's role be delegated to a committee?

No. The *Public Hospitals Act* provides that only the board can appoint a physician. However, most hospital by-laws allow an officer of the hospital (e.g., the chief executive officer) to temporarily appoint a physician to fill an immediate need, but this usually requires board confirmation at its next meeting.

7. What if the board is considering not implementing the recommendation of the medical advisory committee?

If the board receives a recommendation from the medical advisory committee that, for some reason, it is considering not implementing, it is recommended that the board receive specific legal advice before making its decision. The issue should be deferred to the next board meeting and legal counsel consulted by the board chair in the interim.

8. Should board members sit on the medical advisory committee?

Section 35 of the *Public Hospitals Act* requires that the 'board shall establish a medical advisory committee composed of such elected and appointed members of the medical staff as are prescribed by the regulations'. The composition of the medical advisory committee is set out in section 7 of Regulation 965 under the *Public Hospitals Act*. It is clear that it is to be comprised of physicians only.

The only non-physician member provided for in the regulation is the chief of dental staff for Group A hospitals. Otherwise, only physicians can be members. Therefore, any other attendees at medical advisory committee meetings should be non-voting.

If board members sit as non-voting members of the medical advisory committee, they may acquire information that may later disqualify them from sitting as a member of the board on a hearing regarding the same matter. Section 39(4) of the *Public Hospitals Act* provides that members of a board holding a hearing shall not have taken part in any investigation or consideration of the subject-matter of the hearing. Accordingly, it is usually recommended that the medical advisory committee not include members of the board, other than as required under Regulation 965.

9. Increasingly, hospitals are moving to a common or 'joint' credentials model. What is it and how does it work?

Different circumstances arise when regional or 'joint' credentialing among hospitals makes sense, including:

- When two or more hospitals share professional staff;
- When hospital A needs professional staff to perform a service and hospital B provides the professional staff to perform that service (e.g., hospital B provides anesthesiologists to hospital A);
- When the hospitals intend to share professional staff in an under-resourced area and want to allow for streamlined credentialing; and
- To reduce the burden on professional staff who work in multiple locations.

A hospital board cannot delegate its responsibility for decisions about appointment or re-appointment. Each hospital board retains ultimate responsibility for the credentialing process and cannot fetter (meaning confine or restrain) its decision-making power by virtue of being part of a joint credentialing initiative. Any joint credentialing initiatives must be satisfactory to each hospital's board.

There may be many ways to conduct joint credentialing. It is important for participating hospitals to seek legal advice early in the process to ensure the proposal for joint credentialing meets legal requirements.

A common form of application (a Joint Credentialing Application Form) may be adopted by the hospitals to explain how the process will work and who is entitled to participate.

Sometimes, a single application form is adopted that lists every hospital in a geographic area. The applicant then indicates to which of those hospitals they are applying, and the application form is provided to those hospitals. In some models, the credentials committee and medical advisory committee at one of the hospitals take a lead role in reviewing the credentials and investigating the background of the applicant. The applicant would consent to that information being shared with the other hospitals. No applicant information should be shared amongst hospitals participating in a joint credentialing scheme without the prior written consent of that applicant.

In other models, two or more hospitals may adopt a common medical advisory committee and appoint the same individual as a chief of staff. In this model, the common medical advisory committee reviews the application and makes a recommendation to each of the boards of the independent hospital corporations participating in the common credentials model.

Regardless of which process is followed, each hospital remains responsible to ensure that it has put in place and followed a process to ensure that physicians are qualified for the privileges that they are granted. Accordingly, each board must ensure that there is a structure in place that enables the proper credentialing and recommendation process for initial appointments and re-appointments.

Chapter 6: Duties and Obligations of Individual Directors

While fiduciary duties are broadly and contextually discussed throughout the Guide, this chapter will provide board members with a more focused understanding of their individual fiduciary obligations as corporate directors.

In This Chapter:

Understanding the Duties of Directors

As was outlined in Chapter 1, directors stand in a fiduciary relationship to the hospital corporation, which means the directors are acting on behalf of the corporation. All directors, including *ex officio* directors, owe the same duties and are subject to the same obligations, regardless of how they may have been elected or appointed to the board. Fiduciary duties are owed only to the corporation and not to any third-party, including any particular stakeholder or other interest group. These duties are among the highest standard of conduct that the law imposes and encompass several elements. Among these elements is the requirement to discharge the requisite standard of care and to adhere to the rules of fiduciary conduct.

Standard of Care

The *Not-for-Profit Corporations Act* (Ontario) has established a statutory standard of care applicable to directors and officers.[24] This standard of care is objective, rather than subjective. This means that if/when a court is considering the actions or inactions of a director and/or officer, it will assess the actions or inactions against those of a fictional "reasonably prudent person" (objective) rather than what the specific director and/or officer ought to have known given their degree of knowledge and experience (subjective). The *Not-for-Profit Corporations Act* (Ontario) requires a director or officer to:

- Act honestly, in good faith with a view to the best interests of the corporation; and
- Exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances.

The *Not-for-Profit Corporations Act* (Ontario) also includes a broader duty requiring all directors and officers to comply with the Act and regulations, the corporation's articles (letters patent) and by-laws.[25]

Rules of Fiduciary Conduct

In addition to the above-outlined statutorily-enshrined standard of care, directors are required to abide by what is commonly referred to as the rules of fiduciary conduct. These rules include the following:

- Acting in the best interests of the corporation;
- Acting in good faith;
- Maintaining loyalty;
- Acting honestly;
- Respecting confidentiality;
- Maintaining solidarity (also referred to as "obedience");
- Avoiding conflicts of interest; and
- Understanding conflicts of "duty and duty."

Acting in the Best Interests of the Corporation

One of the greatest challenges facing a corporation's board of directors is determining what is in the best interests of the corporation. The test for best interests can be difficult to define in the case of a mission-driven, not-for-profit corporation such as a hospital. It is for this reason that a board needs to have a clear understanding of the hospital's mission, vision, values, and its accountabilities.

Directors must act in the best interests of the corporation as a whole and, in doing so, must take into account all relevant factors. A director breaches their duty to act in the best interests of the corporation where the director prefers the interests of a particular group, person or entity over the interests of the corporation as a whole.

This does not mean that the directors cannot take into account the interests of stakeholders who may be affected by board decisions. It does mean that directors cannot act solely in the interests of one group if to do so would not be in the best interests of the corporation as a whole.

As civil society organizations, hospitals exercise their autonomy within complex environments with competing factors—funding, political engagement, credibility, and the institutional sophistication necessary to deliver complex projects and employ staff. Directors should consider how their fiduciary duties to the hospital might intersect with the organization's broader responsibility to the community and the health care system.

> **→ Find Out More**
>
> Both the best interests of the corporation as well as the concept of civil society are discussed in Chapter 4.

Acting in Good Faith

The duty of good faith requires directors to act for a proper purpose and not to exercise their powers for a collateral purpose.

Maintaining Loyalty

The duty of loyalty requires directors to act in the interests of the hospital corporation and not in the interests of any party they may feel they represent. It is important that all directors, including executive and non-executive *ex officio* directors, recognize that their duty of loyalty is to the hospital corporation.

Acting Honestly

Directors are required to exercise their powers honestly, which includes a duty of candor. This fiduciary obligation is relevant when considering conflicts of "duty and duty." For example, a director sitting on two corporate boards may possess confidential knowledge obtained as a result of sitting on Board A that is relevant to Board B. The director is under a fiduciary obligation to keep the Board A information confidential (loyalty/confidentiality), but may also be under a fiduciary obligation to disclose the confidential information to Board B (honesty).

Respecting Confidentiality

Hospitals, like other donor and/or publicly funded charitable or not-for-profit corporations, operate with a strong sense of transparency and accountability. Accordingly, many hospital boards have adopted policies and communication practices designed to ensure the corporation is seen by those it is accountable to as operating in an open and transparent manner. Understanding the duty of confidentiality in this context may be challenging for a board, especially one with publicly open board meetings. The baseline rule is that all matters and discussions in a boardroom are confidential.

For individual board members, the duty of confidentiality means they must respect the confidentiality of matters that

are not, or will not be, disclosed to the public, especially matters that are dealt with *in camera*. It is also important for directors to recognize that the board has an official spokesperson and, notwithstanding that a meeting may have been opened to the public, only the board chair or another officer or director designated by the board can speak on behalf of the board. Directors must respect policies regarding communications with the media and, while they may see themselves (and be seen by others) as representatives of the hospital in the community, they must be careful that they do not disclose confidential information or be perceived to be speaking publicly on behalf of the board.

Directors should also be sensitive to the privacy protections provided for personal health information in the *Personal Health Information Protection Act,* 2004, as well as the protections under the *Freedom of Information and Protection of Privacy Act*. For example, directors should understand that there are public access rights to records in the custody or under the control of a public hospital, subject to certain exceptions and exclusions. This may include, for example, communications among hospital directors which are in the hospital's custody or control (e.g., emails with the hospital or through a hospital email address or board portal).

See *Form 6.1: Sample Board Policy on Confidentiality*

Maintaining Solidarity

The duty of corporate solidarity is sometimes described as the duty of board obedience.

Boards are democratic in nature. The decision of the majority governs, and all directors have a duty to support the will of the majority. A director who is opposed to a corporate decision that has been validly taken has a duty to respect and adhere to that decision and not speak against it in public.

The duty of solidarity includes obligations to ensure that the hospital operates within the laws to which it is subject, as well as the corporation's articles and by-laws.

It is the duty of the board chair to ensure that meetings and board proceedings follow a proper process and are conducted in accordance with the by-laws and rules of order. It is the duty of each board member to respect the role and authority of the chair in this regard.

Avoiding Conflict of Interest

A director must not personally profit from their position as a director. Most directors are familiar with the general prohibition on entering into a contract with a corporation they serve without first declaring their conflict of interest and refraining from voting and not attending portions of the meeting where this topic is discussed. It is well understood that a conflict of interest includes a situation where a director has a direct or indirect financial interest in a matter or transaction with the hospital. However, a conflict of interest is broader and includes improper use of information or appropriation of an opportunity that belongs to the corporation.

There are "safe harbour" provisions in the new *Not-for-Profit Corporations Act* (Ontario). Under this Act, a director or officer who is a party to a material contract or transaction, a proposed material contract or transaction, or who is a director or officer of, or has a material interest in, a party to a material contract or transaction or proposed material contract or transition with the corporation, is:

- Required to disclose, or request to have entered in the minutes, the nature and extent of the interest;
- Subject to some limited exceptions, refrain from voting; and
- Subject to some limited exceptions, not attend any part of the meeting where the contract or transaction is discussed.

Directors and officers should ensure they declare conflicts in accordance with the requirements of applicable legislation, as well as the by-laws and any board policies, which may prescribe further restrictions, and/or a process in respect of

the manner in which the disclosure is to be made, over and above the requirements of legislation.

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See *Form 6.2: General Principles Regarding Conflict of Interest*

See Form 6.3: Sample Board Policy on Conflict of Interest

Understanding Conflicts of "Duty and Duty"

While overlapping directorships are not prohibited, a director who sits on more than one board should be mindful of the potential conflicts that might arise and avoid situations that may involve a conflict of "duty and duty." This can arise, for example, where a director sits on the board of another corporation that may contract with the hospital or may seek to take advantage of an opportunity that is also available to the hospital.

As outlined above, directors may find themselves in a conflict of "duty and duty" if they learn of information in one boardroom that may be important and material to the affairs under consideration in another boardroom. In such a situation, the directors may find themselves in a position where their duties of disclosure (honesty and candour) are in conflict with their duty to hold information in confidence.

In this situation, the director should declare a conflict in both boardrooms and excuse themselves from deliberations and decisions.

It is a good governance practice to adopt a board code of conduct that sets out a director's duties. A board code of conduct deals with the behaviour of the board and individual directors inside and outside the boardroom and is to be distinguished from a corporate code of ethical behaviour and business conduct, which may also apply to the board.

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See *Form 6.4: Sample Board Code of Conduct*

Business Judgment Rule

The "business judgment rule" is a common law principle pursuant to which courts will presume decisions made by board of directors have been made on an informed basis, honestly, in good faith, and in the best interests of the corporation. In other words, the court will not second guess the decision of the directors where a proper process has been followed and the directors have met the fiduciary standard.

Directors are not accountable for an error in judgment provided they have followed a reasoned and informed process and discharged their fiduciary duties. Directors are not guarantors that every decision they make will, with the benefit of hindsight, prove to have been the best decision in the circumstances. However, and provided directors acted honestly, in good faith, and in the best interests of the hospital, they will be able to avail themselves of the "business judgment rule." Consequently, it is important for directors to follow proper meeting processes, and to document in their minutes demonstration of their consideration of issues and their decisions.

If professional advice is required for a reasoned and informed decision, it should be obtained, and the provision of such advice should be documented as part of the record of the board's consideration of an issue.

Reliance on Others

Directors are entitled to assume that those on whom they rely, particularly officers and senior management, have performed their duties honestly. Directors are not allowed to do so in the face of evidence to the contrary. In the absence of any grounds to suspect otherwise, directors are entitled to assume that officers and senior management have acted honestly in performing their duties.

The *Not-for-Profit Corporations Act* (Ontario) includes a statutory "reasonable diligence" defence to certain duties under the Act where the director can demonstrate they have exercised the care, diligence, and skill that a reasonably prudent person would have exercised in comparable circumstances. [26] This includes reliance on good faith on certain financial statements; financial reports; reports or advice of an officer or employee; or reports of a lawyer, accountant, engineer, appraiser, or other person whose profession lends credibility to a statement made by them.

The ability to rely on management, advisors, and experts does not relieve directors, and the board as a collective, of their responsibility to ensure for themselves that recommendations are well supported and reasonable and that the information on which recommendations are based is accurate. It is important that boards maintain their independence from management in the exercise of their responsibilities in an objective and prudent manner.

Director Dissent

Under the *Not-for-Profit Corporations Act* (Ontario), a director is deemed to have consented to resolutions passed or actions taken at a meeting of directors or a committee of directors unless steps are taken to record the director's dissent in the manner and within the time set out in the Act.[27] This will apply whether or not the director was at the meeting when the resolution was passed or the action was taken.

Understanding Director Liability

The OHA's annual accountability toolkit "*A Guide to Hospital Statutory Compliance*" provides a summary of director liability in the hospital context together with an overview of some key statutory obligations imposed on directors of Ontario public hospitals.

The Principle of Limited Liability and the Importance of Governance

Corporations are separate legal entities from their members and directors and, accordingly, the principle of limited liability applies. The principle of limited liability means that corporate directors and members are generally not held personally liable for corporate obligations. Only the assets of the hospital can be looked to in order to satisfy the liabilities of the hospital. This principle is reinforced in the *Not-for-Profit Corporations Act* (Ontario).

There are, however, some exceptions to the principle of limited liability. For instance, the *Not-for-Profit Corporations Act* (Ontario) provides that under specific circumstances, directors may be held personally liable for money or property distributed contrary to the Act, and for employees' wages and vacation pay. Directors may also be held personally liable if they mismanage corporate property. Directors and, in some cases, officers, can also be held personally liable if liability is imposed by statute, if civil liability is imposed upon them, or if a court chooses to "pierce the corporate veil" (more information below).

Liability Imposed by Statute

There are a number of statutes that potentially expose directors, and sometimes officers, to personal liability. The potential for personal liability arising under statute generally falls into three categories:

1. Liability for unpaid wages - this commonly arises where the corporation is insolvent.
2. Liability for amounts the corporation has failed to deduct, withhold, and/or remit under the I*ncome Tax Act*, *Canada Pension Plan*, and other similar statutes.
3. Liability for non-compliance with specific legislation or where the director or officer has authorized, consented to, acquiesced, or participated in the commission of an offence by the corporation under a specific statute such as the *Environmental Protection Act*, the *Occupational Health and Safety Act*, or the *Employment Standards Act*.

There are numerous statutes potentially exposing the directors, and in some cases officers, to liability in these circumstances.

Directors and officers may be able to avail themselves of a due diligence defence for most statutory offences, except in the case of liability arising for non-payment of wages. This means that, subject to the applicable legislation, a director will not be liable, even in circumstances where the corporation may have committed an offence, if it can be demonstrated that the director exercised due diligence to prevent the occurrence of the offence.

What steps constitute due diligence will depend on the circumstances of each case and the particular action that has given rise to the potential liability. However, effective governance practices and processes can contribute to the establishment of a due diligence defence in the event that directors are facing potential personal liability.

In addition to due diligence, directors may be protected against personal liability through insurance, though careful attention should be paid to the extent of coverage and its stated policy exclusions.

Directors may also be indemnified for certain expenses and liabilities in accordance with the *Not-for-Profit Corporations Act* (Ontario) and the hospital's by-laws.[28] There is also a limited immunity for acts done in good faith in the execution or intended execution of a duty or authority under the *Public Hospitals Act* or the regulations; or for any neglect or default in the execution in good faith of any such duty or authority.[29]

Civil Liability

Directors must exercise the care, diligence, and skill that a reasonably prudent person would exercise in comparable circumstances and may be held personally liable if they fail to uphold this standard. For example, directors who make representations they know, or ought to know, are not true can be found personally liable, even if the acts were done at the behest of the corporation. Consequently, a director acting on behalf of a hospital should ensure they have a reasonable basis on which to act for the hospital, and should ensure it is clear to any party that the acts undertaken by the director are on behalf of the hospital and not in the director's personal capacity.

Directors may be similarly protected against such personal liability through insurance, though careful attention should be paid to the extent of coverage and its stated policy exclusions.

Piercing the Corporate Veil

"Piercing the Corporate Veil" is a common law principle referring to circumstances in which a court will disregard the separate legal existence of the corporation and look to the directors personally to hold them liable for actions that have been undertaken by the corporation.

Although not likely to arise in a hospital context, a court will pierce the corporate veil when it views the corporation as a mere sham or formed for the purposes of fraud. The situations in which this will arise are usually fact-specific.

The courts may also look to the directors personally for corporate obligations when the corporation is seen as a mere agent for the directors, has been formed for the purposes of an illegal activity, or has been used for fraudulent purposes. These cases often involve situations in which the activities of the corporation have been directed by one or more shareholders. It is unlikely that the circumstances would apply to a not-for-profit corporation such as a hospital.

Duties of *Ex Officio* and Non-Voting Directors

Duties of *Ex Officio* Directors

Ontario corporations are permitted to have *ex officio* directors under the *Not-for-Profit Corporations Act* (Ontario). The term *ex officio* means "by virtue of office" and simply describes how a director comes to be member of the board. The general rule is that *ex officio* directors owe the same obligations and are subject to the same duties as elected directors. *Ex officio* directors are entitled to vote unless the articles of incorporation (formerly letters patent), by-laws, or applicable legislation provide otherwise. Regulation 965 under the *Public Hospitals Act* provides that a member of the board who is an employee or member of the medical, dental, midwifery or extended class nursing staff is not entitled to vote.[30] The same regulation also requires that the administrator of the hospital (chief executive officer); the president of the hospital's medical staff; the chief of staff of the hospital or, where there is no chief of staff, the chair of the hospital's medical advisory committee; and the chief nursing executive of the hospital be members of the board.

Duties of Non-Voting Directors

Whether a non-voting director owes all of the same fiduciary duties as voting directors or will be held to the same standard in respect of those duties, remains unclear. There is nothing at common law or in legislation that sets out the duties and obligations of non-voting board members. As outlined above, voting directors owe fiduciary duties to the corporations they serve. A director is defined as someone who governs and manages the affairs of a corporation. If the director does not vote, can they be considered to be governing and managing the affairs of the corporation?

In some very limited circumstances, the courts have imposed fiduciary duties on individuals where they have exercised the powers of directors, whether or not they had actually been elected or appointed to the board. Generally speaking, the courts will find that an individual is a fiduciary where there is scope for the exercise of some discretion or power, and that power or discretion can be exercised unilaterally to affect the legal or practical interest of another who is vulnerable to or at the mercy of the party holding the discretion or power.

The degree to which a non-voting board member may be subject to fiduciary duties may, therefore, depend on whether they are seen to perform the functions of a director or to exercise a discretion or power by virtue of their position, even in the absence of a right to vote.

Given that the *Public Hospitals Act* requires the administrator (chief executive officer), chief of staff (or chair of the medical advisory committee), president of the medical staff, and chief nursing executive to be on the board as non-voting members, it should be presumed that the legislature sees value in the perspective of these non-voting directors, and that their value can only be realized by the hospital if the board ensures that the non-voting directors engage fully in board discussion.

Non-voting board members will likely, at minimum, have a duty to attend meetings and participate in discussions, have a corresponding entitlement to notice of meetings, and to receive all materials provided to voting directors. Depending on the role performed by the non-voting directors, it is also likely that such directors will owe the duty of diligence, the duty to disclose material information to the corporation, the duty of confidentiality, and the duty to maintain board solidarity. Their power in these matters does not depend on their ability to vote. Similarly, if a non-voting director has a conflict of interest in a matter before the board, the non-voting director should declare that conflict of interest and not attempt to influence the outcome of the board decision.

In addition, non-voting board members who are employees or office holders, will owe duties to the corporation by virtue of their employment or office.

While it remains unclear whether non-voting board members will always be held to the same standard as a voting director in the discharge of their duties, it would be prudent for non-voting board members to exercise the same degree of diligence as voting directors. In particular, non-voting directors should:

- Act in good faith and in the best interest of the corporation;
- Avoid conflicts (in particular, not attending portions of meetings where the subject of the conflict is considered);
- Be diligent (i.e., attend meetings and become as fully informed as possible regarding all aspects of the corporation);
- Comply with articles or letters patent, by-laws and board governance policies;
- Disclose material information that is relevant to a significant matter before the board; and
- Maintain confidentiality and board solidarity.

Given that non-voting directors may be held to the same or substantially similar duties as voting directors, they should be entitled to the same indemnity and to have the same insurance coverage. In addition, and to ensure clarity, non-voting board members should sign yearly declarations and undertakings confirming that they are subject to the same fiduciary duties as voting board members (e.g., confidentiality, loyalty, avoidance of conflicts, good faith, etc.) and that they undertake to comply with the by-laws and all policies applicable to voting board members.

Access All Forms

See *Form 6.1: Sample Board Policy on Confidentiality*

See *Form 6.3: Sample Board Policy on Conflict of Interest*

See *Form 6.4: Sample Board Code of Conduct*

See *Form 6.5: Sample Position Description - Board of Directors*

See *Form 6.6: Tips for Directors*

See *Form 6.7: Annual Director Declaration and Consent*

Frequently Asked Questions

1. Are non-voting directors counted towards a quorum?

Section 34(2) of the *Not-for-Profit Corporations Act* (Ontario) provides that, subject to the articles or by-laws, a majority of the number of directors or the minimum number of directors required by the articles constitutes a quorum at any directors' meeting.

The *Not-for-Profit Corporations Act* (Ontario) does not distinguish between voting and non-voting directors.

Given that all hospital boards are now required to have at least four non-voting directors (chief executive officer, chief nursing executive, chief of staff and president of the medical staff), it may be advisable that a minimum number of voting directors be required to be present to ensure a fair and robust voting process.

For example, if a hospital has 12 elected directors and four *ex officio* (non-voting) directors totaling 16 directors, at least nine of the 16 directors must be present to satisfy the majority threshold. If the board elected to set its quorum at the 40% threshold, at least two-fifths (40%) of the 16 directors (i.e., at least seven directors) would need to be present. However, if all four non-voting directors were present there would be only three elected directors required to constitute quorum.

The purpose of a quorum is to avoid binding the board by a minority. As such, boards may wish to require that a sufficient number of voting directors are present. In the example of 16 directors, only 12 of whom vote, a quorum could be a majority of the board (nine) provided that a majority of elected directors (seven) are also present.

2. Given the funding relationship with Ontario Health and the Ministry of Health (Ministry), are the directors accountable to both?

The directors owe their duties to the hospital corporation and not to any one stakeholder at the exclusion of others. The hospital will have multiple accountabilities, and in discharging their duties to act in the interest of the hospital, a director will

need to take into account the obligations and accountabilities of the hospital, including those owed to Ontario Health and the Ministry. Other stakeholders include patients, the community, OHTs, donors, staff, and professional staff.

3. How does a board foster and promote a culture of respectful board behaviour?

There are two critical components to ensuring a culture of respectful board behaviour: the role and performance by the board chair, and the expectations of peers on the board.

It is best practice that there be a description of the behaviour required of a director in either the board's code of conduct or in the director's position description. These behavioural attributes need to form part of the process for recruiting directors. Accordingly, potential candidates for the board must be evaluated on their ability to contribute in a respectful manner to board processes. These behavioural expectations must then be reinforced both during the board on-boarding process and through ongoing board education sessions.

It is critically important that the whole board conduct periodic education sessions on duties and expectations of directors. An open discussion during a board meeting education session on the expectation of directors will create a standard amongst the board that will result in peer pressure being brought to bear on those individuals falling below that standard.

It is the collective responsibility of the board to set the tone and ensure the board conducts itself with an appropriate standard of respectful behaviour. The chair, as a leader of the board, does this by building relationships with individual directors, leading through example and utilizing board processes, such as peer evaluations, to provide feedback to individual board members through one-to-one discussions. The Board can also engage experienced board members in mentoring peers and support participation in education programs to assist directors who fall below the standard to improve their behaviour.

4. Should a board member sign a declaration or a written statement that the board member will adhere to the board's code of conduct and confidentiality policies?

Whether or not a director is asked to sign a declaration confirming the director's obligations to adhere to the board's code of conduct and other board policies, it is inherent in the director's fiduciary duties that those policies be followed. The fiduciary duties owed to the corporation require directors to adhere to the rules of fiduciary conduct. Adhering to the rules of fiduciary conduct is not simply a good governance practice – it is an inherent component of the director's fiduciary duties.

Accordingly, there is a risk that in signing a written declaration a director may conclude they are only bound to adhere to written responsibilities and obligations. Fiduciary duties, simply stated, are to act honestly, in good faith and in the best interests of the corporation, to act with integrity, honesty, loyalty and to avoid conflicts. It is important that a board educate its directors on the rules of fiduciary conduct and the importance of adhering to those rules.

It is also important that a board formulate written descriptions of those rules through a director position description, a board code of conduct (to be distinguished from the hospital's code of ethical behaviour and corporate conduct) and other policies such as conflict of interest and confidentiality policies.

While requiring directors to sign a declaration provides evidence that the director was made aware of the policies; it will not be sufficient to ensure that a director understands and adheres to the policies. As discussed earlier, non-voting members of the board should sign a declaration or written statement that they will adhere to the board's code of conduct and confidentiality policies.

Access All Forms

See *Form 6.7: Annual Director Declaration and Consent*

5. Does a director with a conflict of interest have to leave the room during the vote?

Yes. The *Not-for-Profit Corporations Act* (Ontario) requires a director to declare their interest and to absent themselves from any part of the meeting where the contract or transaction is discussed, with limited exceptions under the Act. The director must also refrain from voting.

Directors must also comply with any conflict of interest rules under the hospital's by-laws or policies. Many by-laws or conflict of interest policies will require a director to not only leave the room during the discussion and vote, but also to refrain from attempting to influence the outcome of the matter at issue. A hospital should also make reference to its rules of order, which may specifically address procedures to be followed when there is a conflict of interest.

6. What should be included in a hospital's conflict of interest policy?

The common practice is for the hospital's by-laws to repeat the "safe harbor" provisions set out in the *Not-for-Profit Corporations Act* (Ontario) respecting conflict of interest. Many hospitals have adopted conflict of interest policies that go beyond the requirements of the *Not-for-Profit Corporations Act* (Ontario) and include the following:

- A statement of the purpose of the policy;
- An overview of directors' fiduciary duties; and
- A definition of conflict of interest, including scope of behaviour to which the policy applies. The policy should make clear that the categories of conflict of interest cannot be exhaustively defined and should include examples of conflict of interest and conflict of duty and duty to assist the directors in determining when their behaviour falls within the policy.

The policy should set out a procedure to deal with:

- When a conflict must be declared;
- To whom the conflict must be declared;
- Specifying that a conflicted director must be physically absent from the meeting during the time in which the contract or transaction is discussed and voted on. There are limited exceptions to this rule under the *Not-for-Profit Corporations Act* (Ontario);
- Quorum at the directors' meeting where director(s) declare a conflict. The *Not-for-Profit Corporations Act* (Ontario) specifies that a director with a conflict is not to be included in the quorum, but also provides that if no quorum exists as a result of the number of directors having declared a conflict, the remaining (un-conflicted) directors are deemed to constitute a quorum (i.e., quorum "floats down");
- A requirement that the director not attempt to influence the outcome of the vote. This should apply to the director's behaviour both within the boardroom and outside of the boardroom;
- The process for others on the board to raise a perceived conflict of interest involving another director; and
- Consequences for failure to comply with the policy.

Access All Forms

See *Form 6.2: General Principles Regarding Conflict of Interest*

See *Form 6.3: Sample Board Policy on Conflict of Interest*

7. What are some examples of how directors exercise due diligence, particularly in ensuring legislative compliance?

What constitutes sufficient due diligence will depend on the context of the board, the particular issue being considered, and director involvement. There are many ways in which a board exercises due diligence to meet legislative compliance. Generally speaking, boards must rely on management to ensure that the hospital is operating in accordance with applicable legislation.

The following list describes some of the actions board's may take to ensure they have exercised their due diligence

responsibilities. This list is non-exhaustive and deliberately includes examples from across the breadth of operations as a reminder that the board is accountable for everything the hospital does.

- Understanding how the hospital maintains and monitors compliance, stays abreast of new requirements and reacts to circumstances of non-compliance;
- Exercising oversight of management and, in particular, the chief executive officer and chief of staff;
- Making the requirement for compliance part of the chief executive officer role and evaluating chief executive officer performance with reference to that role;
- Reviewing indicators that confirm compliance including sentinel events such as unusual workplace injuries or an increase in poor patient outcomes;
- Receiving periodic compliance certificates from management (e.g., a certificate that remittances and required reports or filings are made);
- Using the annual audit and external accreditation processes to verify some aspects of compliance. It is important to recognize the limits of an audit and of accreditation processes and these should not be solely relied upon to verify compliance;
- Periodically reviewing with management, usually through committees, key areas of risk and how compliance in key areas is managed. In the context of a hospital, significant areas of legislative compliance risk are environmental, building code, occupational health and safety, employment standards obligations, withholdings and remittances, and compliance with directives under the *Broader Public Sector Accountability Act* and the *Broader Public Sector Executive Compensation Act* – if any;
- Ensuring appropriate competencies for those in positions of responsibility;
- Ensuring the organization has business conduct policies that set a culture of ethical behaviour and compliance;
- Ensuring the organization has adopted an appropriate whistle-blower policy; and
- Considering conducting an external audit of selected areas of risk where appropriate in the context of the organization's activities.

Chapter 7: Board Composition, Education, and Evaluation

As was outlined in Chapter 1, effective board performance requires a board to understand and focus on board quality. Board quality includes being attentive to the value and diversity of the individuals at the table and the collective impact of their knowledge; including board composition, education, and evaluation.

In This Chapter:

Board Composition and Recruitment

The board size, composition, renewal, nomination, and recruitment processes are perhaps some of the most important governance elements and processes contributing to effective board governance.

Board Size

Legal Requirements

The *Not-for-Profit Corporations Act* (Ontario) sets out a number of composition requirements for hospital boards, including the following:

- There must be a minimum of three directors on a board;
- The organization's articles of incorporation must either fix the number of directors or provide for a minimum and maximum number of directors.
  - If the number is fixed in the articles, it may only be changed via articles of amendment.
  - If a range of directors is provided for, the number must be fixed, within the range, by the members via special resolution from time to time, or the members may, via special resolution, empower the directors to determine the number of directors; and
- Hospitals will meet the definition of a "public benefit corporation," and, therefore, no more than one-third of the directors may be employees of the hospital or any of its affiliates.

→ **Find Out More**

See Chapter 6's Frequently Asked Question #1. "Are non-voting directors counted toward a quorum" for a more detailed consideration of this requirement and some corresponding advice.

The *Public Hospitals Act* contains further permissions and requirements for hospital boards, including the following:

- Permitted appointment of life directors, term directors, and honorary directors; and
- If directors are elected and retire in rotation, no director shall be elected for a term of more than five years, and at least four directors shall retire from office every year.

Governance Principles

The board should be large enough to ensure there are sufficient individuals to manage its workload; however, a board should not be so large as to impede effective discussion. Board size should be determined according to the unique context of the hospital corporation and consider the following factors:

- Board workload, which can be variable depending upon issues facing the organization, such as capital projects or system integration;
- Knowledge and experiences required by the board, which may vary from time to time depending upon the issues and challenges facing the hospital;
- All board members should have the opportunity to provide meaningful input without unduly lengthy board meetings; and
- If a board wishes to have rotating or staggered terms and directors are elected for three-year terms, then the board must have at least 12 elected directors, plus the required *ex officio* directors, to allow four directors' terms to expire each year, as required by the *Public Hospitals Act*. (For more information on *ex officio* directors, see Other Board Composition Elements below)

Board Composition

Legal Requirements

- Directors must:
  - be at least 18 years of age,
  - meet the requirements of applicable legislation with respect to mental competency, and
  - not be an undischarged bankrupt.
- Unless the corporation's by-laws provide otherwise, directors are not required to be members of the corporation.
- The board of a hospital is to include, as non-voting directors, the administrator (chief executive officer), chief of nursing executive, chief of staff (or chair of the medical advisory committee), and the president of the medical staff.
- An employee or a member of the medical, dental, midwifery or extended class nursing staff who is a member of the board, must be non-voting.

Governance Principles

Ontario's hospital sector is committed to inclusion, diversity, equity, accessibility, and anti-racism efforts in their own operations and in their services to patients. One way hospital boards can demonstrate this commitment is in greater diversity and inclusion in their own composition. Diversity promotes the inclusion of different perspectives and ideas, mitigates group think, and improves oversight, decision-making, and governance. Diversity on the board demonstrates the hospital's commitment to diversity throughout the organization.

Diversity among board members means the board is comprised of individuals with the knowledge, qualities, and diversity of experiences and perspectives that are appropriate for the hospital's mission, objectives and strategic directions. This includes recruiting people from the broad range of communities that access the hospital's services, considering geography, age, gender, ethnicity, culture and history, sexual orientation, and other personal characteristics.

The knowledge, experience and qualities of individual directors are important elements in governance. All of these attributes should be considered in nomination and election processes. While experience and knowledge can be objectively assessed or measured, personal or behavioural qualities are more subjective and, therefore, more difficult to assess.

- **Knowledge** - Individual director skills refer to the area of expertise or proficiency that an individual director possesses. There are some areas of knowledge that a board will always need: financial literacy; legal; and governance are typical requirements. Other skills may be required as a result of an issue unique to that hospital. With overriding responsibility for patient safety and quality improvement, and consistent with the obligations under the *Excellent Care for All Act*, it is important to ensure knowledge in these areas. In addition, anticipated issues or activities may require a specific knowledge for a limited period of time, e.g., a capital project may require construction/project management expertise.

The importance of certain knowledge in the context of committee composition is discussed in Role and Functions of a Board.

Access All Forms

See *Form 7.1: Sample Board of Directors' Knowledge and Experience Matrix and Inventory*

- **Experience and diversity** - Not every quality that is required or desired will be based in knowledge. Experience in areas in which the board requires assistance or performs a governance role is also important; including reflecting the diversity of the communities served. While best practice in hospital governance is to recruit a knowledge-based board that is independent of any one interest group, effective board composition would also include those with experience in the different communities that comprise the hospital context and a variety of perspectives to ensure diversity of thought in board deliberations.
- **Qualities** - It is important to recruit directors who possess behavioural qualities that are required for all directors. The nature of a director's fiduciary duties requires that, at a minimum, every director possesses integrity, loyalty, honesty and good faith. Other desired board member qualities may include:
  - Ability to work respectfully in a team;
  - Commitment to the workload;
  - Absence of apparent conflicts;
  - Leadership potential; and
  - Ability to think strategically and communicate effectively.

While it may be harder to objectively identify a director with the required qualities, the recruitment and selection processes should recognize the importance of these qualities.

Access All Forms

See *Form 7.2: Sample Guidelines for Director Selection*

Other Board Composition Elements

Ex Officio Directors

Board members who are appointed based on other positions they hold are called *ex officio* board members. The trend continues to be a reduction or elimination of the *ex officio* positions other than those required by statute.

Since 2011, Regulation 965 under the *Public Hospitals Act* has required that:

- the chief executive officer/administrator, the chief nursing executive, the chief of staff, or where there is no chief of staff, the chair of the medical advisory committee and the president of the medical staff be included on the hospital board as non-voting directors; and
- if employees or members of the medical, dental, midwifery or extended class nursing staff are members of the board, they must be non-voting.

The vice president of the medical staff is not required to be a member of the board, but there is no restriction on their membership in a non-voting capacity.

Historically, many hospitals included representatives from the hospital's volunteer association and foundation as *ex officio* members; academic hospitals may also include the dean of medicine. Board representation is one way to maintain strong links with key partners, but it is not a substitute for other actions that must be taken to ensure the hospital stays aligned with entities such as its foundation and volunteer association.

→ Find Out More

See Chapter 3 and Chapter 4 for a broader overview of effective stakeholder relationship management.

There are some risks associated with *ex officio* directors:

- there is a greater potential for conflicts of interest which can impact the board's ability to govern effectively. This is particularly evident where members of local government who are *ex officio* board members feel a conflict between a duty to the electorate and a duty to the hospital.
- when there are significant numbers of *ex officio* positions on the board, the number of elected directors will be impacted, or the board will potentially become an unmanageable and ineffective size.

It is important that the board has sufficient independence from other interests and duties so they may act in the best interests of the hospital while taking into account the perspectives of all stakeholders. In its 2008 Annual Report, the Auditor General of Ontario recognized the challenging position in which *ex officio* directors are placed when the interests of the group they represent are in conflict with the best interests of the hospital and the community. The Auditor General recommended minimizing the number of non-legislative *ex officio* positions. This remains a relevant consideration for hospitals. Boards should question why they have specific *ex officio* positions as well as whether other actions might be more appropriate to maintain strong stakeholder relationships.

Board Member Terms

Legal Requirements

There are legal requirements respecting the number and length of a director's term. Under the *Public Hospitals Act*, where directors are elected for rotating terms:

- no term may be longer than five years;
- if directors are elected in rotation (i.e., for terms of greater than one year), the terms of at least four directors must end each year (subject to re-election); and
- no maximum term is set out and directors, therefore, have no limit on the number of terms they may serve unless the by-laws so provide.

The *Not-for-Profit Corporations Act* (Ontario) is silent with respect to a director's maximum term and provides flexibility when electing directors. Under the *Not-for-Profit Corporations Act* (Ontario):

- Directors may be elected for terms of up to four years;
- Not every director need be elected for the same term at the same meeting;
- There is no requirement to have an election every year; and
- If no term is specified when a director is elected, the director is deemed elected until the close of the next annual meeting of members.

The provisions of the *Public Hospitals Act* respecting rotating terms of office (five years) continue to apply despite the *Not-for-Profit Corporations Act* (Ontario) (four years). In addition, and if directors are elected in rotation (i.e., for terms of greater than one year), the terms of at least four directors must end each year (subject to re-election), despite no similarly applicable provision under the *Not-for-Profit Corporations Act* (Ontario).

Governance Principles

While every elected director could be indefinitely re-elected, the better governance practice is to set a maximum number of years of service. Common practice is no more than 12 years and no less than 6; with the usual maximum term being in the range of 6 to 9 years, to allow for board renewal and rejuvenation. In setting both the individual director term (where terms of more than one year are permitted) and the total length of service, a board needs to balance the following factors:

- **Acquiring organizational knowledge** - There is a learning curve for a new director who must learn not only about the organization and its governance structure, but also about the health care sector generally.
- **Meeting increased governance expectations** - A good director will be in a continuous learning mode and will become a more skilled governor with more time on the board.
- **Ensuring mentors for new board members** - Continuing board members can provide a valuable mentoring role to new board members.
- **Meeting board leadership requirements** - It may take more than one initial term as a director to prepare directors for board leadership positions such as the chair and vice chair.
- **Balancing continuity with fresh thinking** - A board needs to ensure there is appropriate continuity in the boardroom; however, without mandated renewal, there may be insufficient opportunities to recruit new board members who will contribute fresh thinking and new perspectives.
- **Availability of candidates** - The availability of potential new board members can vary among hospital communities and organizations, and may facilitate a shorter term for some boards, while allowing a longer maximum term for others.

Recruitment, Nomination and Election

Legal Requirements

Directors (other than *ex officio* directors) are elected by the members of the hospital corporation. There are some exceptions that permit the board (where there is a quorum in office) to appoint directors (e.g., to fill a vacancy).

The *Not-for-Profit Corporations Act* (Ontario) allows nominations from members by way of a "proposal" that follows the process set out in the *Not-for-Profit Corporations Act* (Ontario) and requires signatures from five percent of the members entitled to vote (or such lower percent as may be set out in the by-laws).

Subject to applicable legislation, a corporation's by-laws or articles may provide for persons to become directors *ex officio* in lieu of election.

Under the *Not-for-Profit Corporations Act* (Ontario), directors are required to consent in writing to their election or appointment within 10 days of the election or appointment, except in circumstances where there is a re-election or re-appointment with no break in continuous service. Until the consent is obtained, the director is deemed not to have been elected or appointed. A later consent in writing can remedy the failure to obtain consent within the required 10-day period.

Governance Principles

A corporation's recruitment, nomination and election process must take into account the following two fundamental governance principles:

1. Members elect directors (other than the *ex officio* directors); and
2. The board is responsible for the quality of its own governance, which includes leading board succession planning.

One of the board's key governance objectives is to recruit a knowledgeable, skills-based, independent, diverse, and qualified board whose members are identified through a transparent, board-approved selection process and elected by the members. The process outlined in the OHA's Prototype Corporate By-law is drafted to reflect this. The nomination and election processes should:

- Ensure the board understands it is responsible for the quality of board succession and establishes a committee (governance or nominating) to oversee the process on behalf of the board.

→ Find Out More

In January of 2024 the OHA updated its Prototype Corporate By-Law to fully reflect the requirements contained in the *Not-for-Profit Corporations Act* (Ontario) and provide for a closed membership model. More specifically, the By-Law also includes provisions respecting board recruitment, nomination, and election.

- Identify gaps in board knowledge, diversity of perspectives, and experience. Current board members should possess the knowledge, perspective, and experience required to enhance the governance processes of the board as it oversees the hospital. Key steps would include:
  - Maintaining an up-to-date inventory of current board members' knowledge and experience;
  - Maintaining a list of agreed-upon qualities that all board members must possess (while recognizing that subjectivity in assessing qualities could lead to excluding potential candidates due to historic or unconscious bias); and
  - Surveying current board members for intentions with respect to term renewal;
- Consider board and individual director evaluation results with respect to determining available and required knowledge and experience;
- Make publicly available the number of board vacancies and the steps the board will follow to recruit directors;
- Employ a variety of means to identify board candidates, including:
  - Advertising for directors (e.g., through local newspapers, social media, websites, postings in the hospital, contacting agencies that maintain rosters of volunteer directors, or the services of a recruitment agency); and
  - Employing search protocols that extend beyond the networks of existing board members to enable the identification of candidates who will add to the diversity of experience and perspective on the board.
- Require all prospective candidates to complete an application form;
- Disclose the steps in the process to all applicants;
- Interview short-listed candidates;
- Apply objective evaluation criteria;
- Conduct personal background and criminal reference checks;
- Ensure candidates are aware of what is expected of a director;
- Make descriptions of candidates available to membership in advance of the annual meeting of members;
- Ensure, where appropriate and subject to member rights under applicable legislation, that only candidates recommended by the board (on recommendation of a board-appointed committee) are placed before the annual meeting. A board may choose to recommend only the number of candidates for whom there are vacancies or a greater number of candidates than vacancies;
- Disclose the recruitment, nomination and election process to members;
- Maintain a roster of candidates who were vetted and qualified through the regular recruitment process to fill board vacancies that occur mid-term;
- Direct the governance or nominating committee to recruit candidates consistent with the board approved requirements and eligibility criteria; and
- Where a board has chosen to recommend more candidates than vacancies, ensuring that there is a process to conduct the election. The process needs to contemplate what happens in the event that no candidate receives a majority of votes on the first ballot (e.g., the candidate with the least votes is dropped), or how a tie will be managed.

Access All Forms

See *Form 7.1: Sample Board of Directors' Knowledge and Experience Matrix and Inventory*

See *Form 7.2: Sample Guides for Director Selection*

See *Form 7.3: Sample Application for Board Membership – Long Form*

See *Form 7.4: Sample Application for Board Membership – Short Form*

See *Form 7.5: Sample Director Recruitment and Selection Process*

See *Form 7.6: Sample Board of Directors Nominations and Election Policy*

See *Form 7.7: Overview of Director Election Processes*

Board Member Onboarding, Orientation and Education

Directors have a duty to be knowledgeable about not only the affairs of the hospital, but also about the board's governance processes, and their rights, duties and obligations as directors. The board is responsible for ensuring that new directors and committee members receive the information they need to fulfill their duties.

Mandatory onboarding sessions for directors are a critical part of the recruitment process and all candidates need to be made aware of the requirement to attend. Given the importance of onboarding, boards should allocate sufficient resources for these activities.

Board Onboarding

Governance Principles

The board should periodically review the quality and content of its onboarding program, which should cover the following critical topics:

- Health sector environment;
- Hospital operations;
- Stakeholders and key relationships; and
- Hospital governance and board operations.

Day-long orientation sessions for new board members have historically been the norm, but current best practice is to hold multiple, shorter sessions. Shorter sessions (60-90 minutes each) that cover less material make it easier for directors to assimilate new information. Sessions can be held virtually, with a final session in person, which could include a facility tour and an opportunity for directors to ask questions of management and board leadership.

Materials supporting onboarding should be reviewed annually and refreshed as needed. Posting materials on the board's portal allows directors to refer to materials throughout their term as matters arise.

In addition to the requirement that all new directors attend, sessions should also be open to current directors. Directors commencing a renewal term should be strongly encouraged to re-attend sessions to refresh their knowledge and to serve as a resource to new board members.

Access All Forms

See *Form 7.8: Sample Board Onboarding Topics and Materials*

Committee Onboarding

Governance Principles

Where a board assigns community/non-board members to committees, a general orientation program to the hospital and the role the committee plays in the board's governance should be developed. Directors or non-board members who are newly assigned to a board committee should receive information about the committee, particularly for issues currently being considered. In the model recommended above, new committee members would be included in the

onboarding sessions related to the work of their committee and could be invited to the final in-person session.

Board Education

The board is responsible for ensuring directors have the supports they need, such as ongoing education, to maximize their contributions to the corporation. Candidates should be made aware of any expectations regarding attendance at mandatory educational activities during the recruitment process.

Directors should be encouraged to attend educational programs that are relevant to their role as directors. Education sessions relevant to the issues coming before the board should be brought board member attention in sufficient time for them to attend.

Education sessions may be conducted, as a portion of a regularly scheduled board meeting, to focus on operations of the organization or broader sector issues. It may also be fitting to focus on board governance and director's duties and obligations. Many boards have adopted a practice of having at least one annual education session focus on the board's governance role.

Given the importance of ongoing education, boards should allocate sufficient resources for these activities. A board should take into account the director's participation in educational sessions as part of the director's evaluation and consideration with respect to renewing the director's term of office.

Governance Principles

Director education should be facilitated through:

- Board education sessions at regular board meetings and as part of board retreats;
- Ensuring that the content of education sessions includes the external health sector environment, the hospital's operations and the board's governance obligations;
- Regular distribution to all board members of appropriate education and information materials;
- Ensuring that directors are aware of Ontario Hospital Association educational programming and other director learning programs; and
- Establishing a policy that permits and encourages directors to attend educational programs with reimbursement of reasonable expenses.

Board Evaluation

A board should implement ongoing evaluation processes contributing to the continuous improvement of its own governance. Evaluations should be undertaken at a point in the board's year when the information distilled from such an evaluation may be acted upon to improve governance.

Board members should understand how the information generated from any board evaluation will be compiled and shared with the entire board. It will often be the role of the governance committee to ensure the results of the evaluation are presented to the board as a whole and that results particular to any one committee or board officer have been brought to their individual attention. The governance committee should also be charged with developing a work plan based on survey results to ensure that any areas for improvement are acted upon.

Governance Principles

The purpose of ongoing board evaluation is to ensure the maintenance and improvement of governance processes. A board should first determine what it intends to do with the results of such evaluations. Processes should be in place to permit the results of an evaluation to be acted upon. For example:

- **Board Committee Evaluations**: Board committees are typically reconstituted following the annual meeting of members. Accordingly, the evaluation of board committees should take place prior to the annual meeting of members so the board or governance committee is able to consider the evaluation results when deciding which committees should continue and how committee terms of reference should be modified.
- **Committee Composition**: An evaluation of a committee's performance should be done prior to the annual meeting of members so the results of that evaluation can be considered in assigning board members to committees.
- **Board Retreats**: A board retreat evaluation should be conducted immediately following the retreat but does not need to be considered until planning for the next retreat begins.
- **Director Performance**: Evaluations of director performance, whether part of a peer review or self-evaluation, should be conducted sufficiently in advance of the expiry of a director's term to allow that director to act on the information and improve performance.
- **Onboarding**: Evaluations of the board's onboarding program should be conducted after the new directors have attended two or three board meetings to assess the value of the program in preparing new directors for participation on the board.

Similar decisions should be made respecting every evaluation tool the board chooses to utilize. The following are areas for potential supplementary or additional board evaluation:

- Individual director performance;
- Collective board performance;
- Board chair performance;
- Board meeting evaluation;
- Committee member evaluation;
- Committee chair performance;
- Committee meeting evaluation;
- Board retreat evaluation; and
- On-boarding program evaluation.

The following matters and frameworks should be considered in each potential area of board evaluation:

- What is the purpose of the evaluation?
- Who should participate in the evaluation?
- Will the process be anonymous?
- How will the results be shared?
- What process will be established to ensure the results are acted upon?

A board evaluation routinely conducted without a plan to act upon the results does not further the purpose of continuous board improvement.

Evaluation of an Individual Director's Performance

A director's performance can be self-assessed, evaluated by peers, or done through a combination of both. Board leadership needs to set an example with respect to the importance of self-evaluation and board evaluation. The chair should be open to evaluation of their performance and to acting upon feedback.

Peer evaluations are becoming the standard in for-profit corporations and have been adopted by some not-for-profit organizations. A peer evaluation involves every member of a board evaluating the performance of every other board member. Results of peer evaluations should be provided in confidence to each board member by the board chair or incoming board chair (depending on annual timing). Some boards hire third-party resources to assist with this process, which can enhance the perception of impartiality and the confidentiality of results.

Access All Forms

See *Form 7.9: Sample Board Peer Assessment Questionnaire*

The chosen board peer performance evaluation tool should, at minimum, assess performance in the following areas:

- Participation in discussions at board and committee meetings;

- Understanding of the board's governance role;
- Application and contribution of the individual director's expertise; and
- Behaviour both inside and outside the boardroom.

The information gleaned from peer performance assessments may be reviewed by the governance committee, or full board, and used in a number of ways, including:

- Anonymized, compiled results of self-assessments indicating the need for a collective response, such as an education session on a specific topic;
- Resources such as coaching and mentoring could be provided to Individual directors whose evaluations indicate an opportunity for performance improvement; or
- When considering renewal terms for incumbent directors, the results of the individual director evaluations could also be taken into account.

Evaluation of Collective Board Performance

There are a number of differing evaluations, surveys and questionnaires used by corporations to evaluate collective board performance. Generally speaking, these surveys and questionnaires evaluate the board in the following areas:

- Board composition and structure;
- Board systems and processes;
- Board committees;
- Board meetings; and
- Board performance and effectiveness.

It may also be appropriate to periodically undertake a more extensive evaluation or audit of the board's governance practices using an independent audit tool.

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See *Form 9.2: Sample Governance Audit Questionnaire*

Each year, a board should carefully review the questions that are asked on its evaluation survey to ensure that they are appropriate and aligned with the board's goals and objectives for the year. In addition, care should be taken with the way some questions are asked. For example, asking an individual director if the board shares a common vision of its role may not in fact reveal that the board misunderstands its role. Rather, the board may share a common misunderstanding of its role. Accordingly, while it may take longer for individuals to complete such a survey, it may be important, from time to time, to design a survey that requires narrative responses so that the responses can be compared to see if there is, in fact, a common vision among the board members.

If the board survey also contains a component of self-evaluation, it is common practice to provide the director with a comparison of how they have ranked themselves against the rankings of the board as a whole.

Another opportunity to gather information about the board's culture and performance is for a board leader to conduct an exit interview with each departing board member. This interview could provide an opportunity for a candid discussion of the departing director's experience of the board, suggestions to improve board culture, and observations about the board's effectiveness. If the board conducts peer evaluations, these interviews could include feedback from those evaluations for the departing director.

Frequency and Timing

The volume and frequency of evaluations undertaken over the course of a year may impact efficacy. This may be particularly true with frequently completed evaluation tools, such as those conducted at the end of every board meeting. Completing these evaluations may become rote, leading them to not yield the desired information or impacts. As such, it is important to conduct evaluations judiciously.

Access All Forms

See *Form 7.10: Board Evaluation Process Overview*

Assessing Evaluations

The board should periodically assess:

- The types of evaluations it is undertaking;
- The appropriateness of the tools it is using;
- Its processes for sharing survey results; and
- Its processes for providing resources to ensure the results can be acted upon.

It is particularly important that a board review its evaluation to ensure questions are relevant to the board's most recent annual work plan. For example, where a corporation has undertaken a capital project, it may be important to include questions directed specifically at the board's performance around exercising its major capital expansion oversight role.

Access All Forms

See *Form 7.11: Guideline for Creating a Board Self-Assessment Survey*

See *Form 7.12: Sample Committee Self-Assessment Survey*

Frequently Asked Questions

1. What is the meaning of "*ex officio*"?

Ex officio simply refers to the means by which an individual takes an office. It usually refers to members of the board (directors), but it can also refer to members of the corporation. For example, directors may be identified as *ex officio* members of the corporation – that means a person who is elected director automatically becomes a member.

A hospital board is required to include, as *ex officio*, non-voting board members, the administrator (chief executive officer), chief of staff (or, where there is no chief of staff, the chair of the medical advisory committee), chief nursing executive and president of the medical staff.

Ex officio membership (either as a director or member) includes all of the rights, duties and obligations of the office. An *ex officio* director has the same duties, rights and obligations (including the right to vote) as any other director, subject to any provisions in the by-laws or applicable legislation. In the case of a hospital, any employee or member of the professional staff who is a director must be non-voting. This is a requirement of Regulation 965 under the *Public Hospitals Act*.

Ex officio directors and members are permitted for corporations subject to the *Not-for-Profit Corporations Act* (Ontario).

2. Can a board provide for a minimum and maximum number of directors?

The *Not-for-Profit Corporations Act* (Ontario) permits the articles to provide for a minimum and maximum range of directors (sometimes called a floating board). Where the articles provide a range of directors, the members may fix the number by special resolution or the members may, by special resolution, authorize the directors to "fix" the number within the range.

Where a range of directors is permitted by the articles and the members have authorized the board to fix the number of directors, the size of the board can be easily changed within that minimum and maximum number by ordinary resolution of the board with no need for member approval. It is suggested that the board fix the number by resolution, annually. This regular process ensures that, when the number changes, the board remembers to formally approve the change.

3. Is there a difference between the roles of a trustee, governor or director?

Corporations may use the term 'trustee' or 'governor' to describe the individuals who serve in the capacity of directors of the corporation. If the legal entity is a corporation, then describing the members of the governing body as trustees or governors, as opposed to directors, does not change the duties, rights or obligations of the individuals who comprise the board. There may be an argument that directors of charitable corporations are held to a different standard from directors of other not-for-profit corporations on the basis that they are akin to a trustee of charitable assets.

There are a number of legal cases that have addressed this issue, and a corporation may wish to obtain the advice of legal counsel when questions arise with respect to whether the duties of a director would be different from the duties of a trustee of a charity.

The preferred term of the Ontario Hospital Association is 'director'.

4. Can directors vote by proxy or send substitutes to board meetings if they are not able to attend?

No. The obligations of a director are individual to that director and cannot be the subject of a proxy or other delegation to another individual.

5. Can employees of the hospital be directors?

There is no prohibition in the *Not-for-Profit Corporations Act* (Ontario) on who may serve as a director of a corporation other than the requirement that the director be an individual 18 years of age or more, not be an undischarged bankrupt, and meet the mental capacity requirements as described in applicable legislation.

Pursuant to Regulation 965 under the *Public Hospitals Act*, hospitals are required to have the administrator (chief executive officer), chief nursing executive, chief of staff (or, where there is no chief of staff, the chair of medical advisory committee) and president of the medical staff as non-voting members of the board. Other employees or members of the medical, dental, midwifery or extended class nursing staff may be board members and must be non-voting.

Under the *Not-for-Profit Corporations Act* (Ontario), no more than one-third of the directors of a public benefit corporation may be employees of the corporation or its affiliates. It is common practice to have certain categories of eligibility criteria that preclude employees and perhaps their family members from serving on the board of directors. These criteria are established in order to ensure independence of the board and to avoid perceived and actual conflict of interest.

6. What is the minimum time commitment expected of a director?

When considering preparation time and attendance at meetings, directors may be expected to commit in the range of 10 to 15 hours per meeting cycle, with a greater time commitment for board officers.

Directors are expected to attend all board meetings. Many corporations have either formally or informally adopted a practice of requiring absences to be discussed in advance with the chair, addressing repeated absences with directors, and considering whether resignation is desirable if a director fails to attend a minimum number of board and committee meetings in circumstances where decision-making suffers as a result, without permission having been granted by the board or by the chair.

Directors are also expected to participate on board committees, with the expectation that a director will participate in at least one or perhaps two board standing committees.

7. Is it inconsistent with members' rights if by-laws provide that only candidates recommended by the board are eligible for election?

One of the board's core governance roles is to be responsible for the board's own governance. This includes the composition of the board and succession planning. Provided a board has adopted good governance practices with respect to identifying board needs, and objectively and openly recruited and evaluated candidates, then having only candidates approved by the board be eligible for election is consistent with good governance practices and in the best interests of the corporation. The election processes may provide that members may still reject the nominees who have been put forward and require the board to repeat its process for some or all of the nominees, but cannot substitute individuals who have not met the criteria identified by the board as required for its effective functioning.

This practice is appropriate for hospital corporations which are mission-driven, publicly funded, and have multiple accountabilities. This practice of restricting eligibility to board-approved nominees is subject to members' proposal rights with respect to director nomination under the *Not-for-Profit Corporations Act* (Ontario).

8. Where the hospital has multiple sites or covers a large geographic region, or has distinct accountabilities or stakeholders, should the directors be representative of the geographical area or interests served?

There is no legal requirement that specific geographic regions or stakeholders have a proportionate representative voice on the board. However, this diversity is important and should be taken into consideration. In its recruitment and succession planning, the board has responsibility to ensure that the diversity of experience and perspectives of the population it serves are included in board deliberations. This includes looking at the full geographic area, demographic groups, cultural constituencies, and other distinguishing characteristics that could affect a community's experience of the hospital. In addition, all directors must understand they are obliged to act in the interests of the hospital as a whole rather than representing a specific area or constituency.

In any event, directors should also be educated about the broader catchment area or stakeholder interests. Hospitals may also establish advisory committees to ensure there is input to the board in an advisory capacity from local communities and specific stakeholders.

9. How does a hospital ensure it follows an objective, open and transparent board recruitment process?

The following represents some practices that encourage open and transparent board recruitment processes:

- Identifying board needs and making such needs (knowledge, diversity of perspectives and experience) part of the recruitment process;
- Making publicly available the number of board vacancies and the steps the board will follow to recruit directors;
- Advertising for directors (e.g., local newspapers, social media, websites, postings in hospital, and through a recruiter) on the basis of needed attributes;
- Broad-based recruiting by contacting local groups or service agencies;
- Applying objective evaluation criteria;
- Disclosing the steps in the process to all applicants;
- Providing a summary of the process at the annual meeting of members; and
- Maintaining a roster of candidates who were vetted and qualified through the regular recruitment process to fill board vacancies that occur mid-term.

A board may also wish to consider the composition of its nominating committee and include non-board members (community members) who can attest to the fairness of the process.

Chapter 8: Board Structure and Processes

As outlined in Chapter 1, the board establishes governance structures and processes that contribute to its overall effectiveness. The *Not-for-Profit Corporations Act* (Ontario) and *Public Hospitals Act* contain specific requirements relating to these structures and processes (for example, required vs. optional committees). Other governance structures and processes are determined by each hospital board and incorporated into its by-laws and other organizing documents.

In This Chapter:

Board Leadership

Board officers hold key leadership positions. A board should examine how it recruits and selects its board officers, determines their term of office, and plans for their succession. It is also vitally important for all directors to understand and support the role of the board chair. These components are explored below.

Board Officers

The *Not-for-Profit Corporations Act* (Ontario) and the *Public Hospitals Act* both outline a number of requirements respecting board leadership. These include:

- A director must be appointed as chair of the board and carry out such duties in accordance with the corporate by-laws. No other officer is required under the *Not-for-Profit Corporations Act* (Ontario). The board may: designate other officers; appoint officers; specify their duties; and delegate to them powers to manage the activities and affairs of the corporation (except certain non-delegable duties).
- The hospital is required to pass by-laws setting out the various officers of the board and their functions and responsibilities. Unless the articles or by-laws say otherwise, an officer may hold more than one office.
- The board of a hospital is required to appoint an administrator. The *Public Hospitals Act* provides that the administrator is the person who has, for the time being, the direct and actual superintendence and charge of the hospital and is responsible for taking such action as the administrator considers necessary to ensure compliance with the *Public Hospitals Act*, the regulations thereunder and the by-laws of the hospital. To meet these requirements, the administrator must be the chief executive officer.

→ Find Out More

See the OHA's *Not-for-Profit Corporations Act* and *Public Hospitals Act* compliant prototype by-law.

In addition to the legal requirements contained in the *Not-for-Profit Corporations Act* (Ontario) and/or *Public Hospitals Act*, a number of governance principles apply to ensuring strong board leadership, including the following:

- Separation between the role of the administrator/chief executive officer and the role of the chair of the board is necessary to ensure appropriate oversight and governance by the board.

- While the secretary may be a distinctly held office, many boards look to the office of the chief executive officer to perform the secretarial function and, accordingly, the chief executive officer usually is designated as the secretary.
- Where a board member is identified as secretary, a recording secretary also may be designated. The role of a recording secretary can be formalized in the by-laws or provided by giving the secretary the right to delegate to a recording secretary. This practice also recognizes that the board chair may need, from time to time, to be able to deal directly with someone other than the chief executive officer with respect to calling meetings and other board requirements.
- There is no requirement to set out all of the officer roles in the by-laws. This provides flexibility for the board to determine appropriate officers and their duties from time to time without by-law amendment. The most common practice is to reference the chair, one or more vice chairs, the president and chief executive officer and secretary.
- The by-laws do not need to specify in detail the duties of any of the officers; however, the basic responsibilities should be set out. The basic duties of officers as set out in the by-laws can be supplemented by the board through the adoption of a position description from time to time. This allows the board to amend or modify the role of its officers without requiring amendments to the by-laws.
- There is no requirement to have a treasurer and there is no role that must be performed by the treasurer. The title of treasurer may be given to the person who acts as chair of the committee that has primary responsibility for assisting the board with oversight of financial matters.
- A board should designate who will act in the absence of the chair. This is usually done by the appointment of one or more vice chairs. Where a vice chair is appointed, the vice chair's duties should include acting in the absence of the chair and such other duties as the board may assign from time to time.

Board Chair

In addition to the board chair's broader fiduciary duties as a director, the role carries many specific responsibilities including leadership of the board and stakeholders as well as responsibility for board meetings. At all times, and in all activities, the chair's powers must be exercised toward the best interests of the hospital.

Leadership of the Board

As leader of the board, the chair ensures the board operates effectively and oversees the quality of the board's governance processes. This includes:

- Participating in recruitment and leading on-boarding for new directors;
- Encouraging appropriate engagement by all directors in meeting discussions;
- Ensuring board policies and practices are implemented and support the role of the board;
- Leading board evaluation processes;
- Guiding management on board engagement; and
- Establishing tools and resources to support the board.

Hospital boards commonly appoint governance committees to implement the above processes and propose necessary amendments to governing documents to support ongoing alignment with effective governance practices.

The chair is also the board's primary liaison with management. The chair must develop collegial relations with the chief executive officer while maintaining sufficient distance to enable the board's oversight role—this relationship is commonly summarized as "friendly, but not friends."

The board chair will also sign documents binding the hospital, following formal board approval, in alignment with hospital policies, which should reserve certain decisions for the board (e.g., approval of large contracts).

Leadership with Stakeholders

The board chair is the primary spokesperson for the board. When significant board decisions are communicated to the public, employees, professional staff, volunteers, and others, the chair will commonly be part of those announcements or engagement sessions. Consideration should be given to internalizing the expectations and processes around a board chair communicating publicly with stakeholders.

This role is distinct from the chief executive officer's role as spokesperson for the hospital. For example, when a hospital chief executive officer retires or resigns, the board chair would speak on behalf of the board in appreciation for the executive's leadership and describe the board's actions to appoint and/or recruit a successor. When an infrastructure failure affects the hospital's operations, the chief executive officer will be at the forefront of reports and updates to the community about steps taken to minimize the impact on patient care and the expected duration of the change.

Some situations require the board chair and management to work together to provide leadership and accountability to the community for the organization.

The chair is not involved only when "something happens". The chair should have a regular role in stakeholder engagement with the community, elected representatives, boards of related organizations, and other community leaders to foster good relationships for the hospital.

Board Meeting Responsibilities

The board is a collective that only has authority when it meets. This means meetings are the only time the board may exercise its leadership and accountability for the governance of the hospital. The chair presides overboard meetings. Presiding involves ensuring meetings are conducted in accordance with:

- Applicable legislation;
- Articles of incorporation, amendment, etc. (formerly letters patent);
- The by-laws of the corporation;
- The corporation's governance policies; and
- Rules of order (if any).

The chair should understand the purpose of each agenda item and the board's role in its execution. To support effectiveness in this role, the chair will commonly:

- Approve agenda items;
- Approve the time allocated for discussion of agenda items; and
- Set required standards for information provided to the board to support its deliberations.

During meetings, it is important for the chair to:

- Ensure varied perspectives are heard by enabling the engagement of directors in discussion;
- Pay careful attention to the discussions, to ensure they understand how the group, as a whole, wishes to proceed; and
- Confirm their understanding of the will of the group before concluding discussion or calling for a vote.

Not all board discussions end with a vote. Often the board provides advice and input to guide management in:

- Developing a program, project, or other matter;
- Executing on a previous board decision; or
- Evolving a proposal that the board will consider at a later meeting.

It is common practice for the chair to review draft minutes of a meeting and approve them for verification by the board at a subsequent one.

Member Meeting Responsibilities

Member meetings are held annually, and whenever special business requires members' approval to proceed. The chair presides over the members' meeting and ensures proper process has been followed to convene the meeting (e.g.,

proper notice was given to all members; quorum present in person, virtually).

The chair reports to members at each annual meeting on behalf of the board. Such reports normally provide highlights of the past year and may look ahead to important initiatives and opportunities facing the corporation in the future. It is also common for the chief executive officer to report to members alongside the board chair and the messages on behalf of the corporation may be divided between the two speakers.

Qualities Required

As the leader of the board, the chair should possess the ability to:

- Influence opinion and behaviour, a skill acquired by virtue of having been a strong contributing member of the board;
- Recognize when compromises are required and to bring parties who are in dispute to an effective resolution in a way that will further board business in the best interests of the hospital;
- Inspire board members to contribute their diverse perspectives, experiences, expertise, and talents to the board—another leadership quality often set by example;
- Engage directors in a dignified and respectful manner—the board chair must be prepared to have difficult conversations with board members who do not adhere to the rules of fiduciary conduct, follow board policies, or meet the contributory or behavioural expectations adopted by the board;
- Develop a respectful and collegial working relationship with the chief executive officer and chief of staff, while maintaining the relationship of accountability that will allow the board to supervise management effectively; and
- Inspire the board toward a vision for the organization.

To support a common understanding among board members of the role and expectations for the chair, the board should adopt a role description of the board chair that includes the qualities they seek in their leader and expectations for term length and renewal.

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See *Form 8.1: Sample Board Chair Role Description*

See *Form 8.2: Sample Board Chair Selection Process Guidelines*

See *Form 8.3: Tips for the New Chair*

Term limits

Terms limits are intended to balance the needs of the organization for continued leadership with the importance of maintaining board independence from management. The ability of a long-serving board chair to exercise appropriate due diligence and authority could be compromised through long-term relationships with management.

It is usual to have an initial term of one or two years, renewable for an additional term or terms. This allows both the chair and the board to confirm that the individual is right for the role. Although it might be difficult for a board not to renew the term of an incumbent chair, the best interests of the hospital should be the primary consideration.

Some hospital boards will permit a third term in exceptional circumstances and may require a confidential ballot vote requiring 75% to 80% of the directors to approve the additional term. This practice allows directors to express their opinion without fear of reprisal and requires a very high level of support for the incumbent continuing in the role. Hospital by-laws may also have conditions or restrictions on maximum terms.

Board Committees

Boards establish committees to assist with their work. Unless legislatively required, a board has discretion to shape the number of committees, their terms of reference, and their composition.

Required Committees

Hospitals are legislatively required to have certain board committees. The *Public Hospitals Act* (PHA) and Regulation 965 require hospital boards to establish both a fiscal advisory committee and a medical advisory committee.

Fiscal Advisory Committee

- The *Public Hospitals Act* requires the board to establish a fiscal advisory committee that makes recommendations through its chair (the chief executive officer or their delegate) to the board respecting the operation, use, and staffing of the hospital. This committee is an operations committee.
- While the committee is required to provide recommendations, there is no statutory requirement for the hospital to obtain recommendations from, or consult with, the fiscal advisory committee. There are also no requirements that meetings of the fiscal advisory committee occur on a regular schedule.

Medical Advisory Committee

- The *Public Hospitals Act* requires that a medical advisory committee exist that makes recommendations to the board concerning certain matters set out in the Act.
- The *Public Hospitals Act* also requires that the medical advisory committee hold at least 10 monthly meetings in each fiscal year.

Quality Committee

- The *Excellent Care for All Act* sets out: the requirement to establish a quality committee as well as its composition and roles, including: overseeing quality improvement plans; best practice knowledge translation and monitoring for employees; making recommendations to the board on quality improvement initiatives and policies; and monitoring and reporting to the board on quality issues and overall service quality.

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See *Form 8.4: Overview of Committees Referred to in Legislation*

See *Form 8.5: Sample Quality Committee Terms of Reference*

Optional Committees

In addition to legislatively mandated committees, some committees are merely permitted as optional in respective legislation; including the following:

Audit Committee

The audit committee supervises the external auditors, sets the scope of the audit, and receives the audit report and any accompanying recommendations respecting management and internal control matters. However, there are no legislative requirements to have an audit committee. If a hospital board chooses to appoint one, the *Not-for-Profit Corporations Act* (Ontario) requires that the committee reviews the financial statements of the hospital before they are approved by the board. In addition, the committee must be exclusively composed of directors, and the majority of the directors comprising the committee must not be officers or employees of the corporation or any of its affiliates. Unless the board committee responsible for business and/or financial matters performs a management function, individuals on that committee, or one of its sub-committees, may also be members of the audit committee, provided its composition complies with the *Not-for-Profit Corporations Act* (Ontario).

Management Committee

The *Public Hospitals Act* permits the establishment of a management committee with delegated board powers; however, the composition of a management committee is not set out in the *Public Hospitals Act*. Member approval of a by-law to establish a management committee is not required.

Nursing Advisory Committee

There is no legislative requirement to have a nursing advisory committee. In cases where a hospital's by-laws provide for such a committee, the *Public Hospitals Act* sets out membership requirements and addresses the duties.

Other Common Committees

Creating a committee does not relieve a board of its oversight accountability; committees are a resource to assist in the board's fulfillment of its governance role. The most common standing (permanent) board committees at hospitals are:

- Governance and nominating;
- Finance (may be combined with audit committee if membership is restricted to directors only);
- Human resources (may also be combined with finance); and
- Community liaison.

Boards may also appoint special committees with specific, time-limited mandates. For example, a committee may be created to lead the development of the hospital's strategic plan. This committee may include board members and members from stakeholder groups, or may consist entirely of board members, with a robust stakeholder engagement program to support its work.

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See *Form 8.6: Sample Committee Responsibilities: Governance and Nominating Committee*

Additional Considerations

The *Not-for-Profit Corporations Act* (Ontario) does not require any specific corporate committees to be constituted. It does, however, permit the board to appoint, from among the directors, a managing director or a committee composed entirely of directors and delegate to either of them all of the powers of the directors, except for certain non-delegable powers. These non-delegable powers include:

- Submitting to the members any question or matter requiring approval of the members;
- Filling any vacancy among directors, the auditor, or appointing additional directors;
- Issuing debt obligations, except as authorized by the directors;
- Approving financial statements;
- Adopting, amending, or repealing by-laws; or
- Establishing contributions to be made or dues to be paid by members under the Act.

In addition to these non-delegable powers, there is no requirement that a board committee be set out in the by-laws, or that the members approve board committees. The better practice is for the by-laws to contain language empowering the board to establish, amend and disband committees, from time to time.

Apart from the Quality Committee, the Medical Advisory Committee and the Fiscal Advisory Committee, the number of committees and their terms of reference are within the sole discretion of the board.

A board establishes committees to assist the board with board work. This means committees support and supplement the work of the board and do not supplant the work of the

board. The principal purpose for establishing a committee is to empower a small group of directors to perform detailed governance work and make recommendations to the board for its consideration. In so doing, committees assist the board with its work, which enables the full board to focus on strategic matters and overall direction and accountability.

Creating committees does not relieve the board of its due diligence responsibilities. It allows the full board to consider reports and recommendations from committees to ensure that full review was conducted and to bring its unique collective view to the recommendations.

Committee mandates are approved by the board. Written terms of reference for each committee will provide the expectations from the board and clarity about committee discretion, if any. For example, the board may establish a nominating committee to implement a board-approved recruiting policy that provides the framework for the process for recruiting.

Committees also provide a training ground for future board leaders and enable longer discussion and more in-depth analysis of a specific agenda item than is possible during a board meeting.

Normally, committee appointments are for one year and can be renewed as appropriate to meet the expertise requirements of the committee and to ensure exposure of board members to the full scope of the board's work. As needed, on-boarding to the work of the committee should be provided at the start of the board year.

The Board can either appoint committee leaders or empower the board chair or the committee to select the chair (and vice chair, if any).

Committees should adopt a work plan that enables them to meet their responsibilities to the board in a timeframe that aligns with the board's work plan and meets the board's expectations for distribution of reports to the board.

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See *Form 8.7: Committee Principles and Rules and Regulations*

See *Form 8.8: Sample Format for Committee Terms of Reference*

Board Meetings

There are a number of elements in a board's meeting processes that contribute to its effective governance, including:

- Frequency of meetings;
- Process for establishing agendas;
- Order in which matters are dealt with on agendas,
- Availability of supporting materials,
- Quality of minutes,
- Conduct of the meeting by the board chair, and
- Processes for open and *in camera* meetings.

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See *Form 8.9: Comparison of Meeting Requirements*

Notice

Under the *Not-for-Profit Corporations Act* (Ontario), directors may meet on any notice set out in the by-laws. If the purpose of the meeting is to deal with business identified in the Act as matters that may not be delegated by the board (see Additional Considerations immediately above), the business must be identified as such in the notice. Notice of a board meeting must be given in accordance with the by-laws and articles. If the by-laws are silent, notice should follow the rules of order adopted by the corporation.

There are no formalities in the *Not-for-Profit Corporations Act* (Ontario) or the Public Hospitals Act respecting the form or manner of delivery of notice of a board meeting. That said, notice of telephonic or electronic meetings must include instructions for attending and participating in the meeting

by telephonic or electronic means, including instructions for voting by such means at the meeting.

In addition to the requirements contained in the *Not-for-Profit Corporations Act* (Ontario), a hospital's by-laws should specify the manner of giving directors notice of a board meeting and the required amount of notice for calling meetings of the board. It is also a good governance practice to provide the agenda together with reports and information sufficiently in advance of the meeting to allow directors to come to the meeting prepared for the board discussion. Many hospitals commit to their board that materials will be distributed one week in advance of meetings.

It is common practice for a hospital's by-laws to:

- Allow for the board to set a regular date and time for board meetings for which no additional notice is required once general notice has been given. The by-laws should not specify when the regular meeting is held, but rather empower the board to adopt, from time to time, a date and time for regular board meetings (e.g., the second Thursday of the months of September, December, March and June).
- Provide for the amount of notice required for special board meetings—usually five to seven days.
- Allow for meetings on short notice in situations of urgency. (Anywhere from 24 to 48 hours is the usual practice.)

Notice of a meeting can be waived in accordance with the by-laws or the rules of order adopted by the hospital. Given that a board or committee meeting may be held virtually, it is less common to require directors to waive notice of a meeting and more common to include provisions in the by-laws allowing for the holding of a meeting on short notice. Directors should provide the board secretary with up-to-date contact information so that they can be reached to participate remotely in a board meeting if they are unable to attend in person.


Access All Forms

See *Form 8.10: Sample Format for Board Briefing Report*

Number of Meetings

While applicable legislation does not require a minimum number of board meetings, boards should develop an annual board work plan and set the number of regular board meetings based on that annual work plan.


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See *Form 8.11: Sample Board Annual Work Plan*

Quorum

The *Not-for-Profit Corporations Act* (Ontario) specifies that, unless the articles or by-laws otherwise provide, a majority of the number of directors—or of the minimum number of directors set out in the articles—constitutes a quorum at any meeting of directors.

Meeting Agendas

Board meeting agendas are the responsibility of the board chair and are usually prepared by the board secretary with input from the board chair and the chief executive officer. Specific elements incorporated into the creation of an agenda include the following:

- **Time allotted for discussion** – The time given to each agenda item should serve as a guide only. The chair should apply flexibility to both the time allowed for individual meeting items and the order in which the agenda is presented.
- **Approval of the agenda** – The board is not required to formally approve the agenda. It is, however, a good practice to ask whether there are any additional items for inclusion in the agenda at the opening of the meeting so that the chair can take those items into account in considering the order of the agenda and the time allotted for various agenda items.

- **Different types of agenda items** – Agendas should clearly distinguish between items requiring decisions, items that are provided for information only, and those items that are for discussion with an anticipated decision at a future meeting or to guide management action.
- **Items requiring a decision** – Directors are expected to attend all board meetings for their duration. When this isn't possible, the board chair should ensure items requiring a decision are dealt with while the majority of members are in attendance (i.e., once latecomers have arrived, and before those who need to depart early have left).
- **Decision support documents/board briefing notes** – Board members should be provided with background information in advance of the meeting so they can come prepared for the discussion, having reviewed the factors relevant to the matter under consideration.
- **External advisors** – Where the board will be relying on the reports of external advisors, the board chair should ensure those external advisors have either been invited to the meeting or will be available to participate in the meeting virtually to answer questions and provide additional information to the board.
- **Conflict of interest** – there is no requirement for the agenda to include an opportunity for declarations of conflict of interest; directors are expected to self-declare their conflict. It is, however, a good practice to include this item to provide a reminder to directors of this obligation. Declared conflicts should be recorded in the minutes.

> → **Find Out More**
>
> See Chapter 6 for a more comprehensive review of conflict of interest requirements.

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See *Form 8.12: Sample Board Agenda Development Policy*

See *Form 8.13: Sample Board Agenda*

Consent Agendas

Many boards have adopted a consent agenda process to improve the efficiency of board meetings. Consent agenda matters are those that are of a routine or recurring nature or those where no debate is anticipated; such as verification of the minutes. As board members read the materials related to the consent agenda matters, they should assume there will be no debate or discussion on those matters.

There may be differing consent agenda process practices, but generally speaking the following principles apply:

- **Preparing the agenda** – The agenda will have a heading such as 'Consent Agenda Items/Business' or 'Matters to be Approved on Consent'.
- **Supporting materials** – All supporting materials distributed with the agenda package relating to the consent agenda matters will be clearly marked.
- **Request to remove items** – A director may request an item be removed from the consent agenda portion and placed on the regular agenda. No motion is required to remove an item. Boards set their own policies with respect to the notification period for such requests. Some boards have a policy that directors will notify the board chair in advance of the meeting (e.g., 48 hours ahead) to request an item be removed from the consent agenda, while others allow this at any point up to approval of the agenda during the meeting. The meeting chair decides when the board will consider the item.
- **Dealing with items on the consent agenda** – There are various acceptable processes for dealing with the items in the consent agenda. These include one motion to approve the entire agenda, which will be deemed to include adoption of the items in the consent agenda; a motion that relates specifically to the consent agenda business; and the chair declaring the consent business to be approved by saying: "If there are no requests to remove an item, we will take the consent agenda business as adopted by the board." (The verb "adopted"

is used as there will likely be items in the consent agenda that do not require approval).

- **Recording in minutes** – Any motions in the items included in the consent agenda will be set out in full in the board minutes.

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See *Form 8.14: Consent Agenda Policy*

Meeting Minutes

Under the *Not-for-Profit Corporations Act* (Ontario), minutes must be kept for all directors' and committee meetings. This includes portions of meetings that are held in private or a closed session (*in camera*). Hospitals should develop an open meeting policy and consider how *in camera* minutes will be distinguished from minutes for the open portion, and how those minutes will be distributed and retained in such a policy.

In addition to the requirements contained in the *Not-for-Profit Corporations Act* (Ontario), consideration should be given to the fact that minutes become the permanent record of meetings and are kept beyond the life of the corporation. Minutes demonstrate that the board exercised due diligence in its consideration of matters affecting the hospital and document its decisions. Other important considerations respecting minutes:

- Minutes will include the full text of any motions in the items included in the consent agenda (see Consent Agendas below for more information).
- The board should verify minutes of its meetings to confirm that they are an accurate record of the meeting.
- Minutes can only be verified by the body whose meeting they document; the board cannot verify minutes of committee meetings.

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See *Form 8.15: Meeting Minutes Best Practices*

Resolutions in Writing

Under the *Not-for-Profit Corporations Act* (Ontario), a resolution signed by all directors entitled to vote on that resolution is as valid as if it had been passed at a respective director or committee meeting. This enabling element of the *Not-for-Profit Corporations Act* (Ontario) is commonly utilized between regularly scheduled board meetings when a board resolution may be required to address an urgent or new concern.

Virtual Meetings

The *Not-for-Profit Corporations Act* (Ontario) allows for remote participation in board and committee meetings. Meetings may be held entirely by telephonic or electronic means, or by any combination of in-person and remote attendance. The hospital's articles or by-laws may establish limits or specify additional requirements beyond the *Not-for-Profit Corporations Act* (Ontario).

All persons entitled to attend Board meetings remotely must be able to communicate with each other "simultaneously and instantaneously."[31] Notices of meetings do not need to specify a place if the meeting is to be held entirely by telephonic or electronic means.

Attendance at Meetings and *In Camera* Meetings

A director has both the duty and the right to attend all board meetings and the meetings of all committees to which the director is appointed. Accordingly, a director cannot be excluded from a board meeting unless required under the conflict of interest provisions of applicable legislation or the by-laws or a board-adopted policy (such as the conflict of interest policy).

Under the *Not-for-Profit Corporations Act* (Ontario), a director with a conflict is required to absent themselves from any

portion of the meeting during which the matter is being discussed. They also cannot vote on the matter.

> **→ Find Out More**
>
> See Chapter 6 for a more comprehensive review of conflict of interest requirements.

Unless applicable legislation requires open board meetings, no persons other than the directors are entitled to attend a meeting of the board. There is currently no legislation applicable to public hospitals requiring board meetings to be open to the public or media. Any other attendees at board meetings are considered guests of the board. Guests may attend board meetings either:

- On invitation of the chair;
- With the consent of the entire board; or
- In accordance with a board-adopted policy (e.g., a policy with respect to "open meetings" or the attendance of the public at meetings of the board).

Open board meetings are a mechanism that hospitals have used to support efforts to be transparent and accountable to those whose interests it serves. It is, however, not the only means by which transparency and accountability can be achieved. Many hospitals will have processes that allow individuals to raise issues for resolution. As an example, as part of its patient relations process, a hospital may have an 'ombudsman', patient relations representative, or similar office, to deal with individuals who have issues relating to the services provided by the hospital. Transparency may also be achieved through good communication practices (e.g., newsletters, websites and town hall-style meetings).

If a hospital decides to allow the public or media to attend a portion of its board meetings, the board should adopt a policy with respect to the parameters for attendance of the public at its board meetings, including the business that can be discussed in an open or public session. The procedures with respect to the attendance of the public and the board's ability to move *in camera* should be set out by the board in a board-approved policy that can be amended and modified by the board from time to time. Such a policy should include the following (subject to compliance with any provisions of any statute that requires open board meetings):

- **Notice of board meetings** – The policy should address how the public will be made aware of board meetings. Good practice is to provide that notice will be posted at the hospital and on the hospital's website, rather than through advertisements and local news;
- **Meetings open to public** – The board may want to provide that only its regular meetings are open to the public. Special meetings are more likely to be called to discuss matters that can only be dealt with *in camera*; a policy should not require these meetings be open to the public.
- **Distribution of agenda** – It is advisable to provide that the agenda will be made available from the board secretary at the meeting, rather than undertake an obligation to circulate the agenda—it may change prior to the meeting and providing revised copies can be an administrative burden.
- **Distribution of other materials (minutes and board supporting material)** - The materials provided to directors to prepare for deliberations and decisions would contain information that may not be appropriate to make available publicly. As well, the default position is that only a director is entitled to see directors' minutes. That said, some boards have decided to post the minutes of the open portion of the board meeting on their websites. The board should therefore give careful consideration to how minutes of an open portion of a board meeting or other supporting materials will be made available to the public.
- **Submission or presentation to the board** – Some boards provide that members of the public may attend but not speak. Others allow members of the public to address, but not to ask questions of, the board. In other cases, the public may question the board. Where members of the public are permitted to address the

board, there is usually a requirement that they give prior notice of the subject matter. The policy may also state that the board is not obligated to hear from members of the public, and that there is a time limit on presentations that have been permitted. There may also be limits on the number of times in a 12-month period the board may be addressed on the same issue by the same person.

- **Excluding the public** – A board that holds portions of its meetings publicly should move *in camera* when the potential harm from public disclosure is greater than the benefits of transparency. "*In camera*" refers to a closed proceeding of the board. The board should adopt a policy that provides for both the process to move *in camera* and the subject matters that must be dealt with *in camera*. Matters that would typically be dealt with *in camera* include:
  - Human resource issues and employment matters, including the performance evaluations of the chief executive officer or chief of staff;
  - Professional staff re-appointments and any matters relating to suspensions, revocations or alterations to privileges;
  - Matters that are or may be the subject of litigation;
  - Legal advice that is subject to solicitor-client privilege;
  - Negotiation of material contracts;
  - Matters involving property; and
  - Some board governance matters, such as peer review or self-evaluation results.

Again, there is currently no legislation applicable to public hospitals requiring board meetings to be open to the public or media.

Boards should be aware that their records, including email communications, agendas, notes and minutes of board meetings, may be subject to disclosure under the *Freedom of Information and Protection of Privacy Act* (to the extent that they are within the custody or under the control of the hospital). The Act provides a number of exemptions and exclusions which may be also available.

Access All Forms

See *Form 8.16: Sample Board and Committee Meeting Attendance Policy*

See *Form 8.17: Sample Policy for Open Board Meetings*

See *Form 8.18: Checklist for Developing a Policy for Open Board Meetings*

See *Form 8.19: Procedure for Members of the Public Addressing the Board*

Member Meetings

Notice

Notice of a members' meeting must comply with the requirements of applicable legislation. Under the *Public Hospitals Act*, notice of a members' meeting is considered sufficient:

- Where it is published in a newspaper (or newspapers) circulated in the municipality (or municipalities) in which members of the hospital corporation reside; and
- When the notice appears at least once per week for two successive weeks before the date of the meeting.

Amendments to the *Public Hospitals Act*'s notice provisions received Royal Assent in 2016 but have not (as of publication) been proclaimed into force. When, and if, these amendments take effect, notice may also be considered sufficiently given if it is published on the hospital website for at least two continuous weeks prior to the day of the meeting.

The *Not-for-Profit Corporations Act* (Ontario) contains additional requirements and points of consideration, including:

- Requiring hospitals to give notice of the time and place of a meeting of members in accordance with the by-laws;
- Requiring hospitals to give notice not less than 10 days and not more than 50 days before the meeting;
- Requiring hospitals to give notice to the members entitled to receive notice, each director, and the auditor;
- Allowing hospitals to establish a record date for the purposes of determining members entitled to notice. The record date must not be more than 50 days before the day of the event or action to which it relates. If no record date is fixed, then the record date for determining members entitled to receive notice of a members' meeting or to vote at such meeting shall be the close of business on the day immediately preceding the day on which the notice is given or, if no notice is given, the day on which the meeting is held;
- Requiring hospitals to describe the nature of any special business (as defined under the Act) that is to be conducted at the meeting in enough detail that members are able to form a reasoned judgment on the business; and
- Requiring hospitals to state the text of any special resolution to be submitted at the meeting.

Number of Meetings

A hospital must hold an annual meeting of members:

- Within 15 months of the date of the previous annual meeting; and
- Between April 1 and July 31.

When considering the number and timing of meetings, it is important to note that directors are required to lay before the annual meeting of members certain financial statements for the period ended not more than six months before the annual meeting. Directors may call a special meeting of members at any time.

Virtual Meetings

The *Not-for-Profit Corporations Act* (Ontario) allows for remote participation in member meetings. Meetings may be held entirely by telephonic or electronic means, or by any combination of in-person and remote attendance. The hospital's articles or by-laws can establish limits or specify additional requirements.

All persons entitled to attend members' meetings must be able to "reasonably participate" in the meeting.[32] Notice of meetings does not need to specify a place if the meeting is to be held entirely by telephonic or electronic means. Notice of telephonic or electronic member meetings must include instructions for attending and participating in the meeting by the telephonic or electronic means that will made available at the meeting, including instructions for voting by such means at the meeting.

Quorum

The *Public Hospitals Act* does not specify a minimum quorum for a members' meeting. Under the *Not-for-Profit Corporations Act* (Ontario), a quorum is a majority of the members entitled to vote, unless the by-laws otherwise provide. The quorum must therefore be specified in the corporation's by-laws. If a quorum is present at the opening of the meeting of members, the members present may proceed with the business of the meeting even if a quorum is not present throughout the meeting, unless the by-laws otherwise provide.

In addition to the requirements contained in the *Not-for-Profit Corporations Act* (Ontario), it is a good practice to set the quorum at a number that will ensure quorum is always present. There may be years in which the attendance at members' meetings is low and if the quorum has been set too high, it may be difficult to meet the quorum requirement. Accordingly, many boards will use a quorum number that is less than the full number. Provided all directors are *ex officio* members, and most of the directors come to the meeting, the quorum requirement should be achieved.

Meeting Materials

Pursuant to the *Not-for-Profit Corporations Act* (Ontario), not less than 21 days, or a prescribed number of days, before each annual meeting, or before signing certain resolutions in lieu of the annual meeting, the hospital shall provide a copy of certain documents, including the approved financial statements and the report of the auditor, to all members who have informed the hospital that they wish to receive copies of those documents.

Annual Meetings

Annual meetings provide an opportunity for members of the corporation to demonstrate accountability and to exercise their limited rights. These limited rights are:

- To receive the financial statements;
- Appoint the auditor;
- Elect directors; and
- Approve fundamental changes, such as amendments to by-laws.

Many hospitals have moved to a closed membership model where the directors are the only members of the corporation. These hospitals may conduct the formal business of the annual meeting privately and hold a public "annual meeting" as an opportunity for community engagement and to communicate with stakeholders. These versions of annual meetings are open to the public, or to invited stakeholders, and include matters that go beyond the minimum legal requirements. These matters may include honouring the service of retiring directors, recognizing the contribution of volunteers, and the presentation of awards to staff.

While there is no requirement for the board chair, the chief executive officer, or chief of staff to deliver reports at the annual meeting of members, it is one way in which the hospital can further its role in communicating with the community that it serves or with its key stakeholders.

There is also no requirement for the members to approve the financial statements or to approve any of the reports that may be delivered by the board chair, the chief executive officer, the chief of staff or other board officers.

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See *Form 8.20: Annual Meetings of Members – Frequently Asked Questions*

Special Business

The *Not-for-Profit Corporations Act* (Ontario) provides that any business, other than the following, is special business:

- Consideration of financial statements;
- Consideration of the audit report;
- Election of directors;
- Re-appointment of the incumbent auditor; and
- An extraordinary resolution to have a review engagement instead of an audit, or to not have an audit or a review engagement.

Where a members' meeting includes special business, the meeting notice must:

- State the nature of that business in sufficient detail to permit a member to form a reasoned judgment on the business; and
- State the text of any special resolution to be submitted to the meeting.

Voting by Proxy

Under The *Public Hospitals Act* members **may not** vote by proxy.

Frequently Asked Questions

1. Does the board chair have a vote?

The general rule is that the board chair, as a director, has the right to vote on any matter coming before the board, unless the by-laws or rules of order adopted by the board otherwise provide.

Some by-laws may provide that the chair only votes in the event of a tie. In other cases, a chair may have the right both to vote on the original motion and to cast a second vote to break a tie. If the by-laws are silent on this issue, the chair votes in the same way as any other director, subject to the rules of order adopted by the board. Where a hospital's by-laws do not preclude the chair from voting, some chairs may take the view that their role as chair should preclude them from voting other than in the event of a tie.

Under the *Not-for-Profit Corporations Act* (Ontario) there is no provision to give an automatic second or casting vote to the chair at a meeting of members. Governance best practice principles suggest that if the chair does not, and/or is not entitled to, exercise a casting vote to break a tie, the motion fails and status quo continues as there was insufficient agreement among voters to approve the change.

2. Is the chair subject to a higher standard of care than the other members of the board?

All directors and board officers are subject to the same standard of care. The chair, however, has an expanded scope of duties and must apply the standard of care to the performance of those duties.

3. What factors should be considered in deciding who should be the board officers, and who should be on board committees?

A board should have a designated chair, administrator and chief executive officer (president), and a secretary, and will usually have one or more vice chairs. The role of the vice chair is to perform the duties of the chair in the absence of the chair. A vice chair position can also be useful for preparing a future board chair.

Previous subject-matter experience with the mandate of the committee can be beneficial but is not necessarily required. Generally speaking, leadership attributes should be emphasized when recruiting among directors for officers and committee assignments.

Some boards have a formal or informal process for canvassing directors' interest in serving as officers and/or on certain committees in order align interest and experience with assignments, subject to the needs of the board. Board members could, for example, be assigned to different offices/committees in order to meet the board's needs, or succession planning requirements (some hospitals might require board members to have served on a number or type of committees, or in certain roles, in order to be eligible for other board leadership roles).

4. Is there a requirement to have a treasurer or the office of past chair?

While a former board chair should be available to the current chair as a resource, there is no formal role for that office and the continuation of that individual on the board can sometimes impede a new chair from bringing their own style to the role.

In some not-for-profit corporations that have limited resources and where the board is a working board, the title of treasurer may be assigned to a board member who is responsible for financial record-keeping. Hospital boards, however, rely on management for financial record-keeping. There is a trend away from hospital treasurers. In many cases, the individual

who holds a "treasurer"-type role is appointed as chair of the board committee responsible for assisting the board with oversight of financial matters.

The most compelling reasons to have officers outside of the usual offices (chair, president and secretary) is succession planning for the office of board chair and to have individuals who are available to sign on behalf of the corporation those documents that require a board officer signature.

5. Is the chair required to be an *ex officio* member of all board committees?

There is no requirement for the board chair to be an *ex officio* member of all board committees although it is a common practice in recognition of the role the chair plays in connection with the board. Some boards will have both the chair and vice chair (especially if the vice chair is the incoming chair) as *ex officio* members of all committees. The chair and the vice chair then share the workload by deciding which committees they will each attend. The chief executive officer is also often an *ex officio* member of all board committees other than the audit committee which is usually composed entirely of independent directors.

6. Should the president be the secretary?

It is a common practice in hospital corporations to appoint the president and chief executive officer as secretary. The board looks to the office of the president and chief executive officer for support with the board's secretarial functions. When appointed secretary, the president and chief executive officer will usually designate a recording secretary who will attend meetings and take minutes.

From time to time, the board, and in particular the chair, will need to be able to communicate directly with a person who performs the board's secretarial function without involving the president and chief executive officer. Accordingly, if the president and chief executive officer is also designated as the secretary, a recording secretary or other board support person with whom the chair can communicate directly, should be identified and this person should be instructed that they may take directions from the board chair.

In large organizations, the secretary may be another full-time employee, often the in-house legal counsel. Other organizations have a designated employee to administer governance matters or staff of the president's office provide support to the board and committees. In many cases, the chief executive officer is the corporate secretary and delegates certain of those functions to management but retains accountability for these functions.

7. How does the board select its chair and what processes are available for a board to deal with an underperforming chair?

The first step in recruiting a chair is developing a position description for the chair and defining the qualities required in the board chair. Not every member of the board will have the leadership qualities required of the board chair. However, in recruiting to board positions, some emphasis should be placed on the ability to develop leadership potential not only for the position of chair, but also for the positions of committee chairs. Those directors who appear to have the qualities required to be an effective chair should be provided the opportunity to demonstrate their abilities by being assigned the role of committee chair and eventually, vice chair.

There should be a defined selection process for the position of chair. In many cases, this responsibility is assigned to either the executive committee (without the participation of the current chair) or the board governance committee. Commonly, board evaluations or individual director assessments contain a question that allows a director to indicate their willingness to assume a board leadership position. An additional step in the process would involve asking all board members to identify individuals who they

believe could be effective board leaders. When a consensus emerges on a short list of potential candidates, those individuals should be contacted to determine not only their willingness to take on the role, but also their ability to commit the time that will be required. The selection of the board chair is a decision for the board as a whole and the recommendation needs to be brought to the board (with the potential candidates absent) for approval.

In the case of an underperforming chair, it is often very difficult for the board to remove the chair prior to the expiry of their term. The best way of addressing an underperforming chair, is by developing an appropriate and comprehensive position description and following a rigorous recruitment process, thereby minimizing the risk of an individual not living up to expectations. If, despite all best efforts, the individual who takes on the office of board chair is not suitable to the task, having a board culture where renewal is not automatic can be useful. Having a one-year term, renewable for an additional term, provides the chair room to improve performance, or the opportunity for a graceful and dignified exit from the position at the expiry of the term.

8. Can non-directors serve on committees (other than a committee that has been delegated a board decision-making power)?

Yes, non-directors can serve on committees. However, to the extent that the board wishes to delegate certain delegable powers of the board to a committee, that committee must be composed of only directors (e.g., an executive committee). There are a number of factors a board should consider when determining whether or not to appoint individuals who are not directors to a board committee.

Advantages

- May provide an opportunity to evaluate potential new board members or to broaden the diversity of experience and perspective applied to governance of the hospital.
- May allow the board to access specialized expertise required of a committee, particularly where the board may have had challenges recruiting a required skill to the board. The time commitment for committee participation is lighter than the time commitment required of a board member and may attract a broader base of potential candidates.
- May contribute to public engagement, patient experience exposures, and transparency.

Disadvantages

- Committee members who are not also on the board do not see the whole picture.
- There may be some committees, such as the governance committee, where it is not appropriate to have non-directors participate because they will not be familiar with all members of the board, or see all of the board's processes.
- The fiduciary duties to which a director is subject are clear, including the duty of confidentiality and the duty to avoid conflict. It is less clear whether individuals who are not members of the board are subject to the same fiduciary duties when serving on a committee.

Non-directors serving on committees should be asked to sign confidentiality and conflict of interest agreements with the hospital and should be required to adhere to policies applicable to members of the board. Particular attention should be paid to the orientation of non-board committee members to ensure they have the background information required to participate in the work of the committee.

In keeping with the principle that committees assist the board with its work, it is a good practice for board committees to be composed of a majority of board members and to be chaired by a member of the board.

Such a director-chair also eases committee reporting to the board as this person would be present at board meetings to introduce committee recommendations and able to move related resolutions.

Access All Forms

See *Form 6.7: Annual Director Declaration and Consent*

When appointing non-board (community) members to board committees a board should consider a number of questions including:

- Do community committee members vote?
- How is quorum to be calculated? Do community members count to quorum? Is there a minimum number of board members that must be present?
- How will community committee members be onboarded to the roles of the board and the committee and informed about expectations on them?
- Will community committee members attend board retreats?
- Can community committee members serve as committee chair? May they chair a meeting in the absence of the committee chair?
- Do community committee members have a maximum number of years of service, and how often are they appointed and re-appointed?

The answers to some of these questions may be covered in a general statement of committee principles and rules and regulations.

9. Should the audit committee be composed of persons who are either external to the corporation or external to the finance committee?

No. Under the *Not-for-Profit Corporations Act* (Ontario), corporations are not required to have an audit committee, but if they choose to have one it must be exclusively composed of directors. In addition, the majority of the directors composing the committee must not be officers or employees of the corporation or any of its affiliates.

Non-directors with finance or audit expertise may attend audit committee meetings as invited guests without a vote where necessary to ensure that the audit committee has sufficient expertise to perform its function. Typically, the audit committee does not include any members of management, including the chief executive officer, as voting members of the committee.

10. What is the best way for a committee to report to the board? Should committee minutes always be provided to the board?

Generally speaking, committee reporting to the board is important for two reasons:

- To bring specific recommendations to the board for the purposes of the board making a decision; and
- To ensure that the board exercises oversight of the work of the committee.

It is important to distinguish between the board's role in exercising oversight of the committee and the board simply relying on the committee. In addition, boards should consider whether it is merely re-doing the work of the committee; defeating its ultimate purpose and being inefficient. Routinely providing the minutes of the committee to the board may invite the board to re-do the work of the committee.

Given that boards establish committees to perform preliminary work on behalf of the board and work that the board does not have time to do, the format for committee reporting to the board should ensure that these purposes for establishing the committee are honoured by the board. In summary, a best practice for committee reporting to the board would be:

- Adopting a form of committee report that summarizes the matters that were reviewed;
- Relying on a decision support document or board briefing report to be used for all recommendations coming to the board – both from committees and from management; and
- Making committee minutes accessible to directors but do not require directors to read the committee minutes as the only way to prepare a director to discuss committee recommendations at the board meeting.

Access All Forms

See *Form 8.10: Sample Format for Board Briefing Report*

11. Can committees make decisions that bind the board?

Certain powers of the board may be delegated to a committee composed entirely of directors. Under the *Not-for-Profit Corporations Act* (Ontario), there are certain decisions that cannot be delegated to a committee of directors or a managing director and must remain with the full board. Powers that cannot be delegated to a committee include submitting to members questions or matters that require the approval of members; filling vacancies among directors and in the position of auditor; appointing additional directors; issuing debt obligations (except as authorized by the directors); approving financial statements; adopting, amending, or repealing by-laws; or establishing contributions to be made or dues to be paid by members.

Outside of these non-delegable decisions, a board may expressly authorize a committee composed of directors to make a decision that is binding on the board. In providing such express authorization, the board is subject to the same standard of care that applies to any board decision. It must be reasonable and prudent and in the best interests of the corporation for the committee to have the authority to make a decision binding upon the board. Accordingly, a committee would likely only be given such decision-making authority subject to parameters or limitations set by the board. For example, a committee of directors might be authorized to conclude the terms of a material contract within specified limitations with respect to price, term, scope of services, etc.

It is important to recognize and remember that the board's responsibility for overall governance of the hospital supersedes delegation to committees and the board remains accountable for all decisions.

12. Can staff members vote as members of a committee?

The committee terms of reference should specify which committee members may vote. While there is no rule that says staff members may not vote on committees, the decision as to whether staff members should vote should be carefully considered. Firstly, allowing members of management to vote may blur the distinction between 'management work' and 'board work'. Secondly, there may be a risk that, depending upon the quorum requirements and committee attendance numbers, the staff could outvote board members. The better practice is to allow only board members and community members of committees to vote on committee decisions.

13. Does the principle of board solidarity apply to a board committee?

The general practice is that committees are advisory. The board receives recommendations from the committee, and then, if a decision is required by the board, a vote is taken by the board. A committee member is not bound to vote with the majority of the committee when the matter comes to the board. A committee member should, however, not blindside their committee chair in the boardroom. If a committee member who disagrees with a recommendation of a committee wishes to make a 'minority report' to the board,

the committee member should advise the committee chair and the board chair in advance. Any such report should be done in a way that is respectful of the work of the committee.

14. Can committees meet virtually?

Yes. The ability for a committee to meet virtually is expressly authorized under the *Not-for-Profit Corporations Act* (Ontario).

15. Can any board member attend any committee meeting?

There is no prohibition against directors who are not members of a committee attending that committee's meetings (subject to any provisions in the hospital's by-laws or governance policies). However, attendance by non-committee members should be limited and discouraged, as it can be disruptive, particularly if they attempt to participate in discussions of matters they have not previously been present for and therefore lack full context. Directors should respect the committee assignments made either by the board chair or by the governance committee. Generally speaking, committee meetings are not open to the public; even for those hospitals that have adopted a practice of open board meetings.

16. Can a non-voting member of a committee move a motion?

Subject to the rules of order that have been adopted by the hospital, board policy and the terms of reference of the committee, the general rule is that only a voting member of a body may move a motion or second a motion before that body.

17. Should a board have an executive committee? What is the common practice?

An executive committee can add value to a board's governance processes if it has clear terms of reference and does not usurp the role of the board.

An executive committee adds value when it provides a forum for advice and counsel to the chair and chief executive officer, aids in planning the board's annual work plan, and ensures the board maintains a focus on strategic directions. The executive committee also may add value when it undertakes certain work on behalf of the board, such as the evaluation of the chief executive officer, provided it does so subject to the direction and final approval of the board, and in accordance with the *Not-for-Profit Corporations Act* (Ontario).

If the executive committee begins to pre-consider matters before the board and present recommendations with the expectation that the board will adopt them without discussion, it will impede the board's contribution to governance. Adopting clear terms of reference for an executive committee that sets out its authority and limitations on that authority can support the board in ensuring that the role and responsibilities of an executive committee are well understood. In creating the mandate for an executive committee, board will need to be mindful of the non-delegable acts discussed under question 11.

Hospitals have mixed practices with respect to the establishment and role of an executive committee. A hospital that has experienced an executive committee that became a 'board within a board' where board members felt excluded from deliberations and decision-making will often have strong views against the establishment of an executive committee or may establish one only for the purpose of making decisions in an emergency where a meeting of the board cannot be held. Practically speaking, as virtual meetings are both permissible and more common, there are fewer situations in which a full board meeting cannot be held.

It is important to recognize and remember that the board's responsibility for overall governance of the hospital supersedes delegation to committees and the board remains accountable for all decisions.

18. Recommendations for governance practices in the for-profit sector often include a recommendation that the board, or the independent directors on the board, meet without management. When should this practice apply to a hospital?

It is a good practice for the independent directors to occasionally meet without members of management present for the purposes of overseeing the board's relationship with management and, in particular, assessing the quality of the information that the board is receiving from management. These sessions also provide the board with an opportunity to consider its own behaviour and culture and the quality of its governance practice.

It is important to distinguish these meetings without management from *in camera* or "closed" board meetings as they are not, in fact, "board meetings" at all. To the extent that these meetings exclude members of the board (other than in the context of a formal declaration of conflict), they should not be considered to be board meetings, and no formal board action should be taken at them.

These meetings should, however, be considered as one of the processes that the board uses to oversee management. Some boards have adopted a process of beginning or ending every board meeting with a short session at which only independent directors are present (no management, related directors or members or the public are present). When they occur after the board meeting, these discussions also allow the board to consider the quality of its governance practices during the meeting, such as whether a variety of voices were heard and whether behaviour was aligned with the board's culture.

The purpose of these meetings will include independent oversight of management; therefore, the board will need to determine which directors may be considered as 'related' to management. The decision about whom to exclude will be made in the context of the composition of each board. The board chair should meet with the chief executive officer immediately following the session to convey any concerns, advice or positive feedback discussed.

The chief executive officer and, as appropriate, the chief of staff (or chair of the medical advisory committee) may be asked to remain for a portion of the meeting without management at the discretion of the chair.

These sessions are not part of the board meeting and, therefore, while the chair may keep notes to facilitate communication with the chief executive officer, no formal minutes will usually be kept; this is in contrast to *in camera* sessions or meetings, where minutes are kept. The principles above with respect to respectful behaviour apply equally to meetings without management.

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See *Form 8.21: Sample Policy for Meeting without Management*

19. How does a board ensure that it fosters a culture of respectful behaviour in its boardroom?

Fostering a board culture of respectful behaviour begins with the board identifying the desired attributes it seeks in a board director. Beyond expertise, experience and perspective, they should also address qualities such as integrity, loyalty, ability to work as part of a team and the ability to express ideas and disagreements constructively. Accordingly, the recruitment process must identify those qualities and include some measure of evaluating a candidate against those qualities.

The second step for ensuring respectful boardroom behaviour involves training. Board on-boarding must include training with respect to the affairs of the hospital, the role of the

board, and the duties and behavioural expectations of a director. Adopting a director position description that addresses required behaviour is an important step for a board to take.

Ultimately, it falls to the chair to maintain a culture of respectful behaviour in the boardroom. The chair does this both through the management of the meeting (declaring certain behaviour out of order), and by ensuring that director evaluations are performed and that results are constructively conveyed to directors. Assigning a continuing director as mentor to a new board member also can enable new directors to be coached in the culture and behavioural expectations of the board.

An important aspect of setting expectations with prospective and new directors is to ensure that they understand that re-election is not automatic and board behaviour is one factor that will be taken into account in determining whether or not a director will be able to serve more than one term on the board. The last resort for a board is to request that a director resign before the expiry of their term or, failing that action, recommend to members that a director be removed from the board.

It is also important to minimize the number of *ex officio* positions. When the board cannot select for the experience, expertise and qualities or behaviour of the individual that holds an *ex officio* office, there is greater potential for the individual's behaviour to be disruptive to the board.

The board's code of conduct should make it clear that where a director fails to adhere to their fiduciary duties, and is an *ex officio* director, the board chair may approach the organization that the director represents and request that the director be removed.

20. Is a hospital required to have board meetings that are open to the public and, if so, what matters should be dealt with *in camera*?

In addressing this question, it is helpful to start with some general principles:

- Hospitals are not required to have meetings open to the public.
- The only persons entitled to attend a board meeting are the directors. All others are guests and are there at the pleasure of the board, usually on invitation by the chair or the chief executive officer, or in accordance with the board-approved policy.
- Boards that have chosen to have open board meetings usually pass a policy setting out the parameters for attendance by the public, including media. Such policy does not create an irrevocable right for the public to attend board meetings, subject to applicable legislation. There is currently no legislation applicable to public hospitals requiring board meetings to be open to the public or media. The policy can be repealed or amended by the board, subject to any provisions that may have been included in its by-laws.

Based on the above principles, the concept of *in camera* is used to describe that portion of the meeting during which some or all of the 'guests' are excluded. Directors – including non-voting and *ex officio* directors – are not excluded from *in camera* meetings (unless there is another reason for their exclusion – e.g., a specific conflict of interest).

Boards that permit the public to attend board meetings will often have a two-stage *in camera* portion of the meeting where the public leaves the room for certain sensitive issues and management remains, followed by a second *in camera* portion of the meeting where only the directors remain, including *ex officio* directors and directors who are members of management.

It is a good governance practice to have well-understood rules for when the board will move *in camera*. Some matters, such as the board receiving privileged legal advice or dealing with human resource issues, must clearly be dealt with *in camera*. In other areas, the board may make its own decision.

A good test for whether a matter should be dealt with *in camera* is this: Will the benefits that come from open discussion (transparency, accountability and enhanced public confidence in the board) be outweighed by the harm of public disclosure of the matter at hand? Many times, the issue is one of timing. In other words, the question for the board may not be whether or not the matter should be dealt with in the public portion, but when it should be disclosed to the public.

An *in camera* portion of a board meeting should not be confused with the process of independent directors meeting without management or related directors present as described in response to question 18. Minutes of *in camera* board meetings should be kept as these are duly constituted sessions of the board that consider work of the board in the governance of the hospital.

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See *Form 8.17: Sample Policy for Open Board Meetings*

See *Form 8.18: Checklist for Developing a Policy for Open Board Meetings*

21. Who is responsible for ensuring that board meetings are effective?

Every board member has a duty to contribute to the effectiveness of board meetings. It ultimately falls to the board chair to ensure that meetings follow a proper process and to facilitate the business of the board. The board chair can only do so, however, if the appropriate ingredients have been put in place. Those ingredients require proper identification of the expertise, experience, perspectives, and qualities required on the board; sound recruiting processes to ensure that there is a qualified board; initial board orientation and ongoing education with respect to operations, the board's role, the director's fiduciary duties and obligations, and resources to improve board performance. Those ingredients may or may not be in place when a board chair assumes office.

The board chair does, however, have an over-arching responsibility for the quality of the board's governance and can institute practices in each of these areas to improve board performance. The board chair is also responsible for maintaining the discipline of the board during the meeting to ensure that the board focuses on governance issues and does not unduly delve into areas that more properly belong to management. The board chair also has responsibility to intervene and counsel board members whose behaviour does not adhere to the fiduciary standards expected of a director.

Finally, the board chair, with input from the chief executive officer and the assistance of the board secretary, structures the agenda in order to ensure that the board focuses on areas that are consistent with the board's annual work plan, are in furtherance of the strategic directions of the organization, and deal appropriately with matters within the purview of the board (rather than management matters).

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See *Form 8.22: Sample Meeting Effectiveness Survey*

See *Form 8.23: Sample Meeting Evaluation*

22. What is a consent agenda and how is it used?

The consent agenda process is used to expedite the board's business by creating more time for consideration of substantive matters. A consent agenda is a process used during a board meeting to adopt items that are of a routine or recurring nature and not expected to be contentious or require discussion. The items are identified on the agenda and a single motion is moved to adopt these items. Subject to board policy, any board member may request either before or at the meeting, that an individual item be moved out of the 'consent' portion to be discussed by the board. It is the responsibility of the board chair to determine when the board considers the item.

An important element of the consent agenda process is that board members review the materials related to the consent agenda matters with the expectation that there will be no discussion or debate on such matters. Such materials, when circulated with the board package, should be clearly marked as being part of the consent agenda. It is important to recognize and remember the board's responsibility for overall governance of the hospital and accountability for all decisions.

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See *Form 8.14: Consent Agenda Policy*

Chapter 9: Developing Effective Governance

A board's ultimate goal should be the creation of a culture of good governance. A culture of good governance lays the foundation for improved board function, organizational efficiency, and effective oversight. A culture of good governance should develop, follow, and reinforce the practices, policies, and behaviours specific to the needs and best interests of a hospital's stated purposes. To achieve and maintain a culture of good governance, boards need to adopt leading practices and continually review and assess the state of their governance. Some boards face challenges that impair the quality of their governance. This chapter identifies some of these key signs of "trouble," together with recommendations to address likely causes.

In This Chapter:

Creating a Culture for Effective Governance

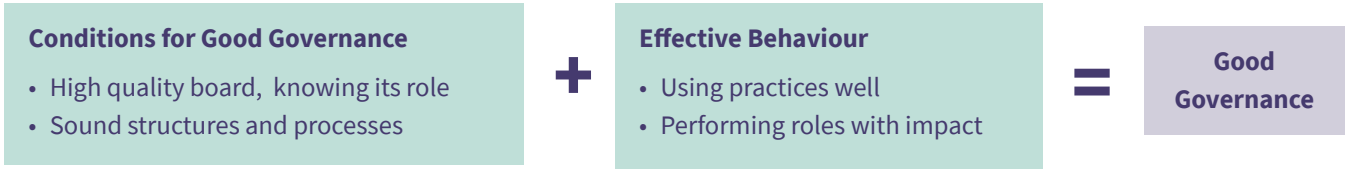
As outlined in Chapter 1, a board actively seeking to understand, implement and achieve good governance is more likely to demonstrate good board culture. When policies and best practices are followed, corporate and internal structures are observed, and the board maintains a consistent focus on good governance, good board culture is more likely to exist. However, while these are all necessary components, they are not on their own sufficient to ensure good culture.

Boards, and each individual director, also need to exhibit appropriate behaviours to create a culture of good governance and achieve effective board performance (See Figure 9.1: Components of Good Governance).

In developing good board culture, boards should consider the following:

- **Governance is a team activity** – Boards are comprised of individuals with diverse backgrounds, experiences, knowledge and styles. The board's culture needs to support a commitment to equity, diversity, inclusion, and anti-racism (EDI & AR); open, constructive dialogue; independent thinking and actively seeking dissenting opinions; the airing of differences while respecting the opinions of others; a search for consensus; and a focus on what is best for the hospital; and
- **The importance of shared expectations** – All board members should have shared expectations about acceptable and unacceptable behaviour and be responsible for promoting positive—and addressing negative—behaviour within the board.

Figure 9.1: Components of Good Governance



A culture of effective governance goes beyond how board members function among themselves. How the board interacts and engages others, inside and outside the boardroom, is equally important. The board must create a constructive, open and engaging relationship with the chief executive officer, chief of staff, senior management, and others within the organization. This will help shape the internal culture of the corporation.

> **→ Find Out More**
>
> Consider the commentary from Chapter 3 and Chapter 8 respecting the board's role in supervising leadership and the importance of developing collegial relationships while maintaining oversight functions.

As outlined in Chapter 4, the board also engages with external stakeholders, including other boards, funders, municipalities, the Ministry of Health (Ministry) and the Ministry of Long-Term Care, Ontario Health, Ontario Health Teams, community representatives, and members of the public. It is important that board members, individually and collectively, exhibit behaviour consistent with effective governance in these settings.

Adopting Twelve Best Practices for Good Governance

Good governance is not absolute—it should be assessed in the context of each hospital's current status and needs. As outlined in Chapter 2, even a board's foundational governance model may shift in response to unique circumstances. That said, below are some general governance best practices that may assist a board in keeping good governance within its focus to assist in fostering a culture of good governance.

1. **Understand mission, vision, values and accountabilities** – The objective of corporate governance is to ensure the organization fulfills its mission, moves towards its vision, operates in a manner consistent with its values, and discharges its accountabilities. In addition to the organization's statement of mission, vision and values, the board should expressly adopt a statement of accountabilities identifying a hospital's accountability relationships.
2. **Understand the board's role** – Under the *Not-for-Profit Corporations Act* (Ontario), boards are charged with managing, or supervising the management of, the corporation. In exercising this function, hospital boards hire leaders and delegate responsibility for operations to those leaders. A board retains responsibility for overseeing and guiding management as well as ultimate accountability for the actions of the leaders it oversees.
3. **Understand directors' expectations** – The board should adopt a statement of the roles and responsibilities, duties and expectations of individual directors. Understanding the fiduciary duties and performance expectations of directors will help the board identify the knowledge, experience, and qualities it requires in its directors.
4. **Enhance director performance** – The board should adopt policies that support and emphasize directors' duties and behaviours. The fiduciary duties that a director owes to the hospital should be reflected in, and reinforced by, formally adopted board policies, such as a conflict of interest policy, code of conduct, attendance policy, education policy and confidentiality policies.
5. **Determine board size for effective governance** – The board should periodically assess its size. It should ensure that the number of directors (elected and *ex officio*) will allow the board to have the knowledge, experience qualities, and attributes, such as diversity of perspectives and thought, required to manage the workload, and not be so large as to prevent individual directors from contributing effectively.
6. **Create a skilled and qualified board** – The board should take explicit responsibility for its recruitment and succession planning processes. These processes should ensure the necessary knowledge, experience, qualities

and attributes are recruited to the board and eliminate or minimize risk of single-issue candidates being elected to the board.

7. **Educate new directors** – The board should ensure that it takes responsibility for preparing new directors to contribute and should conduct a high quality, mandatory on-boarding program. This program should cover four areas: governance (including fiduciary responsibility for the whole hospital) and board operations, hospital operations and activities, the health care environment, and key stakeholder relationships. In addition to this internal onboarding and education, supplementary ongoing external education and training should be provided to board members.
8. **Appoint qualified board leaders** – The board should ensure that all board leaders, and particularly the board chair, are selected pursuant to a process that ensures those best suited will assume leadership positions. The board should develop a position description for the role of board chair, set criteria, and develop a selection process. Caution should be exercised to ensure that criteria do not inadvertently exclude consideration of board members who would bring different perspectives or types of leadership from that seen previously. The board should ensure that members, individually and collectively, understand and support the role of the chair.
9. **Ensure board independence** – The board should ensure it understands and discharges its role of independent oversight of management. There are a number of processes that will ensure a board operates independently of management, some of which have been explored in previous chapters. These processes include considering board chair terms to ensure relationships with leaders remain appropriately collegial; ensuring the board meets without management; and that committees understand their role and their relationship to management.
10. **Establish and use board committees appropriately** – The board should ensure that it establishes its committees with reference to sound governance principles. Committees support and assist the board in the performance of board work. Committees undertake more detailed reviews of matters than would be practical by the full board due to time expectations. Committees also provide opportunities to supervise management and allow members to contribute their knowledge and experience in a smaller forum.
11. **Ensure meetings enhance board performance** – The board should ensure that its meeting processes contribute to board effectiveness. The board must take responsibility for all aspects of board meetings, including agenda setting, distribution of materials, the provision of expert advice, attendance policies, virtual and in-person meetings, and quality of board minutes.
12. **Commit to continuous improvement** – The board should explicitly state its commitment to continuous self-improvement through ongoing education and evaluation and should adopt processes to improve board performance. The board needs to commit to education concerning the organization, the health care system, and hospital environment and board governance. The board needs to conduct evaluations and implement recommendations from them as part of its commitment to continuous board improvement.

Each of the above components, individually and collectively, contribute to good governance and, when kept in a board's focus, will contribute to creating an appropriate and healthy board culture.

Regularly Assessing Governance to Promote Development

As stated in Chapter 1, boards are responsible for their own governance. As part of that responsibility, a board needs to periodically review, audit or evaluate its performance and practices, including examining if the board's governance work is making a difference to the organization, its staff, patients

and community. Clearly assessing the quality of governance provides a basis for taking steps to develop and improve governance. There are many ways for a board to approach the task of governance assessment. For example:

- **Board evaluation and feedback tools** – Establish and use appropriate board evaluation and feedback tools on an ongoing basis. Chapter 7 provides examples of these tools. The results of such tools may help the chair or governance committee assess current practices and identify opportunity for practical improvements.
- **Annual review and assessment** – Assign the governance committee the task of undertaking an annual review and assessment of governance. Typically, the committee will select prescribed parts of governance (or establish a cycle) to review each year.
- **Periodic board discussions** – Hold periodic board discussions of the board's governance performance that identify improvement objectives.
- **Comprehensive governance review** – Conduct a special comprehensive governance review from time to time based on identified governance improvement objectives.

While there are many ways for a board to approach the task of governance assessment, it should be founded upon measuring and assessing impact. Boards should assess how their governance practices have made a difference to the organization, its staff, patients and community.

Comprehensive Governance Review Process

This section outlines a systematic approach to conducting a comprehensive governance review for boards that determine such reviews are required.

- **Purpose and scope** – A comprehensive governance review enables a board to assess the degree to which its governance structure and processes are effective in supporting board performance and the degree to which they reflect leading governance practices. There are varying levels of governance review. Evaluating meeting effectiveness at the end of a board meeting is an example of a limited process. A comprehensive review would involve looking at every aspect of governance including board composition; recruitment and nomination practices; committee composition; committee terms of reference and reporting; board meeting agendas and processes; and the qualifications, selection and evaluation of officers.
- **Sources of governance documentation** – A board's governance processes are documented through a variety of instruments. The principal sources that define a board's governance processes are its relevant legislation, articles of incorporation (formerly letters patent), by-laws, board policies and rules of order. Note that some governance processes are not formally documented and may simply be reflected in the board's common practices.
- **Determine the assessment process** – The process for conducting a governance review should include the following steps:
  - Conduct an inventory of relevant governance processes and practices – this is an information-gathering phase and would include an examination of governance documents and policies. It may also include a survey of board members;
  - Evaluate current governance practices against both legal requirements and best practices applicable to similar corporations;
  - Consider whether the documentation on governance processes reflects actual practices;
  - Assess areas where change may be appropriate; and
  - Consider whether there are any gaps in the board's governance processes.
- **Consider implementation requirements** – Based on the completed assessment, the board can develop a work plan to address areas for improvement or identified gaps. Consideration should be given to matters that may require stakeholder support and/or member approval, and a process for engaging and ensuring support should form part of the implementation plan. If the governance changes will require by-law amendments, the process

for notice and member approval should be part of the timeline for implementing the governance improvements.

Generally speaking, if a by-law amendment is required, it will need approval by the board and confirmation by the members by ordinary (majority) resolution. However, some changes may require approval by special resolution (majority of the board plus two-thirds of the members). A timeline for implementation should be developed as some changes may require a phased implementation (e.g., a reduction in board size may be implemented as directors' terms expire).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See *Form 9.1: Sources Documenting a Board's Governance*

See *Form 9.2: Sample Governance Audit Questionnaire*

See *Form 9.3: List of Matters that Require a Special Resolution under the Not-for-Profit Corporations Act (Ontario)*

Working Toward Improvement

Boards may identify areas where governance practices can be improved and must work constructively as a team to implement such improvements. When governance challenges are not addressed early, a board may become dysfunctional. The underlying issues and causes of such dysfunction are often intertwined and complex. If not addressed, these issues may become chronic and impact the board's ability to perform its role.

Signs of Governance Problems

Signs of trouble often disguise underlying causes. The following is a list of symptoms that may suggest an underlying or deeper governance concern.

- **Unplanned director turnover, difficulty recruiting and low attendance** – These are all potential signs that directors are no longer interested in serving on the board and may indicate that some directors find the board to be a negative place.
- **Passive meetings** – At meetings, participants "go through the motions," but there is little energy, passion or substance to the conversations. The focus of board discussion becomes limited to detailed operational questions without any "meaty" issues or policy implications. If this continues during a period of time where it is clear the corporation is facing challenges, it could be a sign that the board is out of touch, that the important discussions are happening elsewhere, or that management is trying to limit the board's involvement in substantive issues. It could also indicate an executive committee that is exercising too much power and leaving little opportunity for full board input.
- **"Parking lot meetings" after the board meeting or side conversations** – Parking lot discussions and follow-up calls to the chair about issues not addressed during the meeting suggest the meetings are not allowing for effective discussion, or that the dynamic among board members, or between the board and management, is limiting candor.
- **Dysfunctional board dynamics** – There may be interpersonal conflict or factions, which result in disrespectful conversations, personal barbs or bullying comments. Instead of passive meetings, the meetings are antagonistic, awkward, or unproductive because the conversation goes underground. Poor team relationships can undermine the process of decision-making at the board.
- **Meetings not productive** – Beyond interpersonal conflicts that destroy the effectiveness of meetings, there may also be other reasons which make the meetings unsatisfactory for the participants. The meetings may chronically run over time yet still not deal fully with matters on the agenda. Complaints emerge about information presented at the meetings and too little time is allowed for discussion. There may be too much rehashing of committee minutes and too little warning of, or preparation for, agenda items. The way in which meetings are chaired may be weak and ineffective.

- **Charismatic chair** – A charismatic chair can stifle board discussion or directors may follow the chair without challenging ideas.
- **Individual rogue director** – In some cases, one director engages in disruptive behavior such as challenging the agenda, finding picky points in the minutes, challenging staff reports, demanding special reports, and not supporting board decisions after the fact. This behaviour can extend to actions outside of meetings, such as directly debating with staff members, holding meetings with external stakeholders and lobbying with selected directors.
- **Board/staff relations are strained** – At meetings, the board frequently challenges members of senior management, is critical and looking to find fault. Senior management does not provide proactive briefings at committee meetings. The chief executive officer or chief of staff begins to intervene by delivering the presentations and responding to specific questions instead of relying on members of senior management. Complaints from board members about late and inadequate information reports begin to increase.
- **Aggressive/dominant chief executive officer or chief of staff** – A strong chief executive officer or chief of staff can become too dominant and control the board agenda and process. In meetings, they may dismiss matters without discussion, intimidate directors and dominate the discussion with jargon and technical details. Directors become passive and don't question matters that should be further discussed. In these cases, the chair may simply accept the chief executive's or chief of staff's leadership and follow their lead.

Keys to Turnarounds

It is not easy to course-correct once a board begins experiencing governance problem—although it can be done. Turning such situations around requires the following:

- **Leadership** – One necessary ingredient is leadership, which normally comes from the board chair and/or the chair of the governance committee. It is the chair's role to ensure the board is high-functioning, and part of this responsibility includes acknowledging the existence of problems. The most significantly troubled boards lack this leadership from the chair and may possibly face a chair resistant to acknowledging issues.
- **Recognition of problems** – The board, at some point, needs to take responsibility for the problems. There needs to be a clear recognition by a majority of the board that there are deficits in governance that need to be addressed.
- **Assessment of causes** – Governance problems can be complex and multifaceted. There needs to be an assessment of the root causes, followed by a shared understanding of how to take action to turn the issues around. Is there a problem with the documented policy or process? Or is it primarily a behaviour and practice problem—we know what we need to do, but we just aren't doing it?
- **Focus on the feasible** – In deciding on strategies to address problems, there needs to be a focus on what is feasible in the timeframe. Changing the members and profile of the board takes time and, although such longer-term fixes can be initiated, other changes may be needed to make improvements in the short term.

Remedies for Typical Troubles

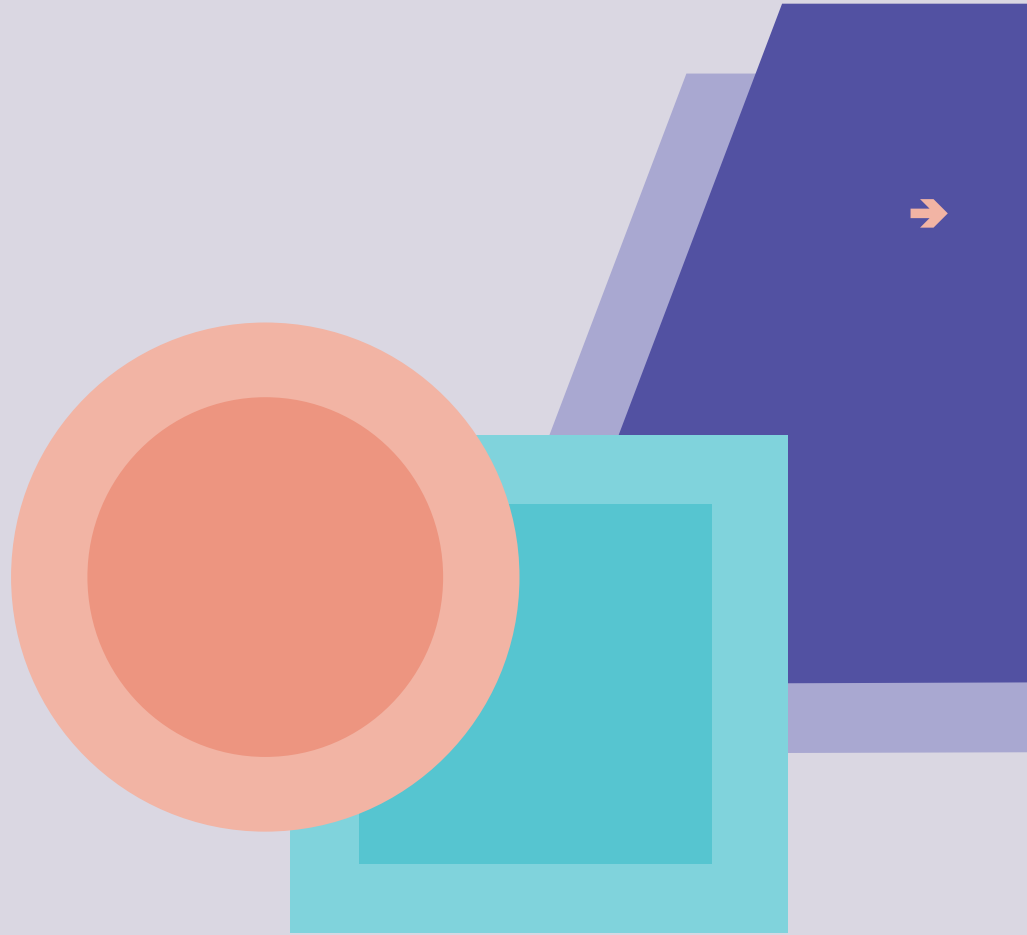
Recall that there are legislative provisions governing and/or applicable to hospitals which permit, for example, the Minister to intervene where there is evidence of a troubled board. It is better for the board to address governance problems proactively. Suggested remedial approaches to typical problems are discussed in Figure 9.2: Remedies.

Figure 9.2: Remedies

Nature of Governance Problem	Remedies
Individual Director	• Where there are problems with individual directors (such as rogue behaviour, passivity, or lack of respect for others), it commonly falls to the chair to intervene, generally with the involvement of the chair of the governance committee. • It is easier to not re-appoint a director than it is to remove them. In the meantime, the chair and/or chair of the governance committee can discuss the problem behaviour with the director privately, offer educational sessions if appropriate, or mentorship. • It is helpful if the board uses self-evaluation tools and peer evaluation tools to allow issues involving individual director performance to be identified and managed.
Group Dynamics	• The chair needs to lead this process. It might be helpful to conduct a third-party assessment or survey to identify the problem and get group acknowledgement that it exists. • Once it is accepted that there is a problem to be addressed, a special meeting/retreat may be held. Any number of approaches could be helpful. The meeting could simply be an open discussion about interpersonal issues causing problems or could undertake a team-building exercise. For some groups, creating a stronger common goal—strategic plan or priorities—can bring about stronger focus on the substance and less on the interpersonal aspects. In some cases, a third-party experienced facilitator can assist the process and enable the board leadership to participate fully in discussions.
Re-defining or Clarifying Board Composition Perspectives	• Many of the problems cited above can be improved by creating a more appropriate attributes matrix for the board's composition. Introducing new people with specific attributes can alter the nature of board conversations, the dynamics among the team, members' expectations for board meetings and individual behaviour. While that may take time, much can be accomplished by introducing the right new qualities and perspectives at the earliest opportunity. It is important that the composition of a board include directors with appropriate knowledge coupled with diverse experience in the communities served by the hospital and with qualities, such as integrity and honesty, that support and enable effective governance. This requires close attention to the director recruitment process to ensure such talent is attracted.

Nature of Governance Problem	Remedies
Enhancing Substance of Board Meetings	• While having the "right" people around the table is key, other steps can enrich the agenda and the expectations of the conversations. • The governance committee can be asked to review past agenda items compared to a sound role/function description (including ones discussed in this Guide), identify issues that ought to be on the board agenda, consider effective use of consent agendas, and propose an annual board work plan for review and modification by the board. • The board could consider a group discussion on the board's role and nature of the governance role, perhaps with the assistance of a governance expert and/or facilitator. • The meeting format or processes could be adjusted to promote discussion. For example, for some longer agenda items involving major topics, the board could split into two or three small groups for discussion and then regroup to compare what was discussed.
Getting Meeting Processes Right	• If meetings are poorly organized and managed, the governance committee—with the chief executive officer's or chief of staff's support—can redesign them: make information formats clearer, establish agenda order to ensure time for key items, enforce content and delivery expectations for board packages, and so on. • A practice of holding meetings without management at the end of each board meeting provides an opportunity for governance issues to be raised.
Dealing with Domineering Chief Executive Officer or Chief of Staff	• If the chair accepts the chief executive officer's or chief of staff's dominance, the chair's leadership is neutralized. In this case, processes that afford directors a chance to reinforce that the board supervises the chief executive officer and chief of staff and controls its own agenda are key. The annual approval of chief executive officers' and chief of staffs' goals and the annual evaluation process, especially where there is input from the board through surveys, create opportunities for this. • To reinforce the board's role, it is also helpful to hold a meeting of independent directors without the chief executive officer and chief of staff present, following the regular board meeting. This time can be used to discuss governance processes and is where the chair of the governance committee can play a leadership role in lieu of the board chair to address and moderate the situation.

Appendices



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Endnotes

1 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 21.

2 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 15(1).

3 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 15(2).

4 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 16(1).

5 *Public Hospitals Act*, RSO 1990, c P40.

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7 Richard P. Chait, William P. Ryan & Barbara E. Taylor, *Governance as Leadership: Reframing the Work of Nonprofit Boards* (New York: John Wiley and Sons, 2005).

8 *Connecting Care Act*, 2019 SO, c 5 Schedule 1, s 30.

9 *Excellent Care for All Act*, SO 2010, c 14, s 3.

10 O Reg 445/10, s 1(3).

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12 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 83(3).

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15 Panel on Accountability and Governance in the Voluntary Sector, Building on Strength: Improving Accountability in Canada's Voluntary Sector, (Panel on Accountability and Governance in the Voluntary Sector, 1999), at 11.

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17 World Health Organization, Regional Office for Europe, European Observatory on Health Systems and Policies, *Civil Society and Health*, (United Kingdom: World Health Organization, 2017) at 9-10.

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19 *Connecting Care Act*, 2019 SO, c 5 Schedule 1, s 44(1).

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21 *Re Sheriton and North York General Hospital* (ON Hospital Appeal Board, 1973), referred to in *Pratt v. Fraser Health Authority* (BCSC, 2007).

22 *Cimolai v. Children's and Women's Health Centre of British Columbia,* [2006] B.C.J. No. 2199 (S.C.), at 60.

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24 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 43(1).

25 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 43(2).

26 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 149(1).

27 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 147.

28 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 46.

29 *Public Hospitals Act*, RSO 1990, c P 40, s 13.

30 RRO 1990, Reg 965, s 2.

31 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 34(8).

32 *Not-for-Profit Corporations Act*, SO 2010, c 15, s 53(6).

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Acronyms

Acronym	Full Term
A	
AHAC	Aboriginal Health Access Centres
AODA	*Accessibility for Ontarians with Disabilities Act*, 2005
ACO	Accountable Care Organization
ASPE	Accounting Standards for Private Enterprise
A/R	Accounts Receivable
AMHO	Addictions Mental Health Ontario
ASO	Administrative Services Only
AHC	Alliance for Healthier Communities
AHF	Alternate Health Facilities
ALC	Alternate Level of Care
APP	Alternative Payment Plan (for physicians)
ACSC	Ambulatory Care Sensitive Conditions
AI	Artifical Intelligence
ADM	Assistant/Associate Deputy Minister
AMO	Association of Municipalites of Ontario
AGO	Auditor General of Ontario
B	
BFE	Base Funded Expense
BRIF	Biosciences Research Infrastructure Fund
BLG	Borden Ladner Gervais LLP
BBR	Broad-Based Reconciliation
BPS	Broader Public Sector
BPSAA	Broader Public Sector Accountability Act, 2010
BPSECA	*Broader Public Sector Executive Compensation Act*, 2014
C	
CABG	Coronary Artery Bypass Graft
CADTH	Canadian Agency for Drugs and Technologies in Health
CAF	Canadian Armed Forces
CAMAP	Canadian Association of MAID Assessors and Providers
CAMH	Centre for Addictions and Mental Health
CCC	Complex Continuing Care
CCCS	Canadian Critical Care Society
CCHL	Canadian College of Health Leaders
CCO/OH	Cancer Care Ontario/Ontario Health
CCO-ATC	Cancer Care Ontario's Access to Care
CCS	Community Support Service (Agencies)
CCSO	Critical Care Services Ontario
C.Diff	Clostridium difficile Infection
CDPC	Communicable Disease Prevention and Control
CEO	Chief Executive Officer
CFHI	Canadian Foundation for Healthcare Improvement
CFMA	Commitment to the Future of Medicare Act, 2004
CFO	Chief Financial Officer
CFPC	College of Family Physicians of Canada
CHAO	Catholic Health Association of Ontario
CHC	Community Health Centre
CHF	Congestive Heart Failure
CHRO	Chief Human Resources Officer
CHT	Canada Health Transfer
CIHI	Canadian Institute for Health Information
CIO	Chief Investment Officer/Chief Information Officer
CKD	Chronic Kidney Disease
CMH&A	Community Mental Health and Addictions
CMHA	Canadian Mental Health Association
CMI	Case Mix Index
CMOH	Chief Medical Officer of Health
CMPA	Canadian Medical Protective Association
CNE/CNO	Chief Nursing Executive/Officer

Acronym	Full Term
CNO	College of Nurses of Ontario
COPD	Chronic Obstructive Pulmonary Disease
CPO	Chief Prevention Officer
CPSI	Canadian Patient Safety Institute
CPSO	College of Physicians and Surgeons of Ontario
CRA	Canada Revenue Agency
CSHP	Canadian Society of Hospital Pharmacists
CUPE	Canadian Union of Public Employees (represents some hospital workers)
CWC	Choosing Wisely Canada
D	
D&O	Directors' and Officers' Liability Insurance
DPRA	Drug and Pharmacies Regulation Act, 1990
E	
EGQPS	Effective Governance for Quality and Patient Safety Program
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMRAM	Electronic Medical Record Adoption Model
ED	Emergency Department
ED LOS	Emergency Department Length of Stay
ED-PIP	Emergency Department Process Improvement Program

Acronym	Full Term
EMCPA	*Emergency Management and Civil Protection Act*, 1990
EMS	Emergency Medical Services
ER	Emergency Room
ER/ALC	Emergency Room/Alternate Level of Care
EFB	Employee Future Benefits
ESA	Employment Standards Act, 2000 (Ontario)
EOL	End of Life
ERM	Enterprise Risk Management
EDI &AR	Equity, Diversity, Inclusion and Anti-Racism
ECFAA	*Excellent Care for All Act*, 2010
EOI	Expressions of Interest
F	
FES	Fall Economic Statement or Ontario Economic Outlook and Fiscal Review
FHG	Family Health Groups
FHN	Family Health Networks
FHO	Family Health Organization
FHT	Family Health Team
FLTCA	*Fixing Long-Term Care Act*, 2021
FDA	Food and Drug Administration
FOI	Freedom of Information
FIPPA	*Freedom of Information and Protection of Privacy Act*, 1990

Acronym	Full Term
FLS	French Language Services
FLSA	*French Language Services Act*, 1990
FTE	Full Time Equivalent
G	
GAAP	Generally Accepted Accounting Principles
GHS	Globally Harmonized System of Classification and Labelling
GTA	Greater Toronto Area
GPO	Group Purchasing Organizations
GPP	Group Purchasing Program
GEM	Growth and Efficiency Model
H	
HARP Act	*Healing Arts Radiation Protection Act*, 1990
HSAC	Health and Safety Advisory Committee
HBAM	Health Based Allocation Model
HC	Health Canada
HCCA	*Health Care Consent Act*, 1996
HCW	Health Care Worker
HHR	Health Human Resources
HIMMS	Health Information and Management Systems Society
HPPA	*Health Protection and Promotion Act*, 1990
HSP	Health Service Providers
HIROC	Healthcare Insurance Reciprocal of Canada

Acronym	Full Term
HOOPP	Healthcare of Ontario Pension Plan
HKA	Hip and Knee Arthroplasty
HCO	Home Care Ontario
HLDAA	*Hospital Labour Disputes Arbitration Act*, 1990 (Ontario)
HSAA	Hospital Service Accountability Agreement
I	
IMS	Incident Management System
IPN	Indigenous Patient Navigator
IPAC	Infection Prevention and Control
IPC	Information and Privacy Commission (of Ontario)
IHI	Institute for Healthcare Improvement
ISMP	Institute for Safe Medication Practices
IHPME	Institute of Health Policy, Management and Evaluation (University of Toronto)
ICHSC	Integrated Community Health Services Centres
ICHSCA	*Integrated Community Health Services Centres Act*, 2023
IFM	Integrated Funding Models
IP	Intellectual Property
ICU	Intensive (Critical) Care Unit
IEN	Internationally Educated Nurses
IDS	Integrated Decision Support

Acronym	Full Term
J	
JCB	Joint Centre for Bioethics
JHSC	Joint Health and Safety Committee
K	
KPI	Key Performance Indicators
KT	Knowledge Transfer
KTE	Knowledge Transfer and Engagement
L	
LRA	*Labour Relations Act*, 1995 (Ontario)
LOS	Length of Stay
LGIC	Lieutenant Governor in Council
LSAA	Long-Term Care Home Service Accountability Agreement
LTI	Lost Time Injuries
M	
MBC	Measurement-Based Care
MAC	Medical Advisory Committee
MAID	Medical Assistance in Dying
MPP	Member of Provincial Parliament
MHA	Mental Health and Addiction
MERS	Middle East Respiratory Syndrome
MCU	Ministry of Colleges and Universities
MOF	Ministry of Finance
MOH	Ministry of Health

Acronym	Full Term
MOL	Ministry of Labour
MLTC	Ministry of Long-Term Care
MSAA	Multi-Sectoral Accountability Agreement
N	
NACI	National Advisory Committee on Immunization
NACRS	National Ambulatory Care Reporting System
NAPRA	National Association of Pharmacy Regulatory Authorities
NSERC	Natural Sciences and Engineering Research Council of Canada
NGO	Non-Governmental Organization
NPO	Non-Profit Organization
NAICS	North American Industry Classification System
NFP	Not-for-Profit Organization
NP	Nurse Practitioner
NPLC	Nurse Practitioner-Led Clinics
O	
ONCA	*Not-for-Profit Corporations Act*, 2010 (Ontario)
OHS	Occupational Health and Safety
OHSA	*Occupational Health and Safety Act*, 1990
OCC	Office of the Chief Coroner of Ontario
OAG	Office of the Ontario Auditor General
OBIO	Ontario Bioscience Innovation Organization
OCC	Ontario Case Costing

Acronym	Full Term
OCFP	Ontario College of Family Physicians
OCP	Ontario College of Pharmacists
OCSA	Ontario Community Support Association
OCHU	Ontario Council of Hospital Unions (CUPE)
OH	Ontario Health (Agency)
OHAH	Ontario Health atHome (formerly Home and Community Care Support Services - HCCSS)
OHDP	Ontario Health Data Platform
OHT	Ontario Health Teams
OHRS	Ontario Healthcare Reporting Standards
OHA	Ontario Hospital Association
OHIP	Ontario Health Insurance Plan
OHRC	Ontario Human Rights Commission
OLRB	Ontario Labour Relations Board
OLTCA	Ontario Long Term Care Association
OMA	Ontario Medical Association
ONA	Ontario Nurses' Association
OPS	Ontario Public Service
OPSEU	Ontario Public Service Employees' Union (represents some hospital workers)
ORCA	Ontario Retirement Communities Association
P	
PFAC	Patient and Family Advisory Committee
PBF	Patient Based Funding
P4P	Pay for Performance
P4R	Pay for Results (MOH program)
PHI	Personal Health Information
PHIPA	*Personal Health Information Protection Act*, 2004
PPE	Personal Protective Equipment
PSW	Personal Support Worker
PHP	Physician Health Program (OMA)
PSA	Physician Services Agreement
PCOP	Post Construction Operating Plan
PCO	Primary Care Organization
PIA	Privacy Impact Statement
PARO	Professional Association of Residents of Ontario
PIDAC	Provincial Infectious Diseases Advisory Committee
PHO	Public Health Ontario
PHA	*Public Hospitals Act*, 1990 (Ontario)
PSSDA	*Public Sector Salary Disclosure Act*, 1996
PSHSA	Public Services Health and Safety Association
Q	
QA	Quality Assurance
QBP	Quality Based Procedures
QI	Quality Improvement
QIP	Quality Improvement Plan
QCIPA	*Quality of Care Information Protection Act*, 2004
R	
RFP	Request for Proposals
RISE	Rapid Improvement Support and Exchange
RNAO	Registered Nurses Association of Ontario
RPN	Register Practical Nurse
RPNAO	Registered Practical Nurses Association of Ontario (WeRPN)
S	
SRG	OHA's Services, Resources and Guidance Bulletin
SAA	Service Accountability Agreement
SEIU	Service Employees International Union (represents some hospital workers)
SSO	Shared Services Organization
SDOH	Social Determinants of Health
SSHRC	Social Sciences and Humanities Research Council of Canada
SOGC	Society of Obstetricians and Gynaecologists of Canada
SWOT	Strengths, Weaknesses, Opportunities, and Threats
SCC	Supreme Court of Canada
T	
TLP	Temporary Locum Program
ToR	Terms of Reference (e.g., for Committees)

Acronym	Full Term
TAHSN	Toronto Academic Health Science Network
TPA	Transfer Payment Agreement
U	
Unifor	Union that represents some hospital workers
V	
VON	Victorian Order of Nurses
W	
WHMIS including GHS	Workplace Hazardous Materials Information System incorporating Globally Harmonized System of Classification and Labeling of Chemicals
WSIA	Workplace Safety and Insurance Act, 1997 (Ontario)
WSIB	Workplace Safety and Insurance Board
WVP	Workplace Violence Prevention
WHO	World Health Organization
Y	
Y/Y	Year-over-Year
YTD	Year-to-Date

Ontario Hospital Association