Governance and Nominating Committee Meeting Agenda

Date: Wednesday, November 12, 2025
Time: 18H00 – 19H00
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Board Item	Attachment
18:00	**1. Call to Order**		
(1 min)	1.1 Confirmation of Quorum		
(1 min)	1.2 Adoption of the agenda		P. 1-2
(1 min)	1.3 Declaration of Conflict of Interest (Policy BOD.01.013.X.XX)		
18:03	**2. Report from the Last Meeting**		
(1 min)	2.1 Approval of Previous Meeting Report – October 8, 2025		P. 3-5
(1 min)	2.2 Business Arising from Report		
(1 min)	2.3 Committee Workplan Review		P. 6
18:06	**3. Matters for Discussion/Decision**		
(5 min)	3.1 Review Skills Matrix (R. Alldred-Hughes) **That the Governance & Nominating Committee recommend to the Board of Directors the inclusion of diversity information within the Board Skills Matrix and implement an annual update process as part of the regular Board evaluation cycle.**	D	P. 7-10
(10 min)	3.2 Review Performance Evaluation Questionnaire for CEO and COS (R. Alldred-Hughes) **THAT The Governance and Nominating Committee recommend to the Board of Directors the approval of the Performance Evaluation Questionnaire for CEO and COS as presented.**	D	P. 11-20
(5 min)	3.3 Review Q2 Strategic Actions **THAT the Governance and Nominating Committee review and receive the Q2 Strategic Actions report.**	D	P. 21-25
(5 min)	3.4 Documents for Review: (R. Alldred-Hughes)		
	3.4.1 Patient and Family Engagement Policy (New) **That the Governance and Nominating Committee recommend to the Board of Directors the approval of the Patient and Family Engagement Policy as presented.**		P. 26-30
18:31	**4. Matters for Information**		
(5 min)	4.1 Governance Accreditation Standard Review (R. Alldred-Hughes)		P. 31-32
(5 min)	4.2 Review Strategic Plan and Refresh		P. 33-36
18:41	**5. Date of Next Meeting**		
(1 min)	January 14, 2026		
18:42	**6. Adjournment**		

Board Item: Matters for Discussion/Decision (D) or Consent Agenda (C)

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making

A4R Action Steps

Determine and Identify

- Determine your mandate and the key question.
- Identify stakeholders and involve them in decision-making.
- Ensure alignment on the problem and question.

Clarify and Provide

- Clarify decision-making procedures (values, strategic priorities).
- Share how decisions will be made and revisited.
- Document rationale for decisions using value-based criteria.

Communicate

- Communicate decisions and their rationale with stakeholders.
- Seek input on communication strategy.

Revisit and Revise

- Revisit decisions as needed based on new evidence or stakeholder input.

Evaluate and Improve

- Evaluate success based on "accountability for reasonableness".
- Identify gaps and implement improvements for future processes.

Centre de bioéthique Champlain Centre for Health Care Ethics

HÔPITAL Glengarry Memorial HOSPITAL

REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

October 8, 2025 at 5:00PM BOARDROOM / MS Teams

Present:	L. Boyling, Chair R. Alldred-Hughes, CEO	C. Larocque	Dr. S. Robertson
Regrets:	G. McDonald	Dr. G. Raby	

Summary of Discussion

Approval of the Agenda

The agenda was reviewed.

Moved By: C. Larocque
Seconded By: Dr. S. Robertson
THAT the agenda be approved as presented.

CARRIED

Declaration of Conflict of Interest

There were no conflicts declared.

Approval of Previous Meeting Report

The meeting report from June 4, 2025, was shared.

Moved By: C. Larocque
Seconded By: Dr. S. Robertson
THAT the meeting report be approved as presented.

CARRIED

Business Arising from Report

There was no business arising from the report.

Matters for Discussion/Decision

Review Committee Effectiveness Survey Results

Over, the survey results indicate that the committee is performing well. Chair of each committee are now provided time ate the Board meeting to provide a report. Ensuring proper succession planning for Board Directors will be worked on.

Review and Approve Annual Committee Work Plan

The draft committee work plan was reviewed and revision was made.

Moved By: Dr. S. Robertson
Seconded By: C. Larocque
THAT the Governance and Nominating Committee review and approve the Annual Committee Work Plan for 2025-2026 as amended.

Under Director Recruitment and Selection, review of the skills matrix will be added annually, and Directors will be asked to update their skills matrix.

CARRIED

Review all Board Committee Terms of Reference

The committee Terms of Reference were reviewed.

Moved By: C. Larocque
Seconded By: Dr. S. Robertson

THAT the Governance and Nominating Committee recommend to the Board of Directors the Board Committee Terms of Reference as presented.

CARRIED

Review Q1 Strategic Actions
The results of the strategic actions for Q1 were reviewed.

Moved By: C. Larocque
Seconded By: Dr. S. Robertson
THAT the Governance and Nominating Committee review and receive the Q1 Strategic Actions report as presented.

All items are on track and the team is progressing well with the actions identified.

CARRIED

Review the Revised Communication & Community Engagement Plan
The Accreditation standards were reviewed and the Communication & Community Engagement Plan was updated to ensure standards are met. Rather than having multiple policies, all information pertaining to communication was pulled into this document.

There is a section under CEO Communications which pertains to the Board of Directors and will be renamed Board of Directors Updates in Bi-Weekly Blitz.

Documents for Review

Meetings of Directors Without Management Policy (New)
The Meeting of Directors Without Management Policy was reviewed.

Moved By: C. Larocque
Seconded By: Dr. S. Robertson
THAT the Governance and Nominating Committee recommend to the Board of Directors the Meeting of Directors Without Management policy as presented.

No changes were made to the policy.

CARRIED

CEO and COS Performance Evaluation Policy (New)
The policy was reviewed and minor revision was made, changing the bi-annually to semi-annually.

Moved By: C. Larocque
Seconded By: Dr. S. Roberton
THAT the Governance and Nominating Committee recommend to the Board of Directors the CEO and COS Performance Evaluation policy as amended.

CARRIED

Acts, Legislations, and Compliance Reporting Policy (New)
The policy was reviewed.

Moved By: Dr. S. Robertson
Seconded By: C. Larocque
That the Governance and Nominating Committee recommend to the Board of Directors the

approval of the Acts, Legislations, and Compliance Reporting Policy as presented.

CARRIED

Matters for Information

Governance Accreditation Standard Review

The Accreditation Standard was reviewed and discussion ensued around the process for Accreditation.

Inclusion, Diversity, Equity & Anti-Racism Update

An update was shared on IDEA in which it was noted that the hospital has come a long way in terms of IDEA.

Next meeting: November 12, 2025

K-L. Massia, Recorder

Governance and Nominating Committee
Annual Work Plan 2025-2026

Deliverable	MRP	Occurrence	OCT	NOV	JAN	MAR	MAY	JUN
STRUCTURE/PROCESSES								
Review Committee Effectiveness Survey Results	Chair	Annually	✓					
Review/Recommend Governance Annual Committee Work Plan to BoD	Chair	Annually	✓					
Review/Recommend Committee Terms of Reference to BoD	Chair	Annually	✓					
Review Board Education Plan for following Board Cycle	Chair	Annually						X
Review/Revise Corporate and Professional Staff Bylaws (as needed)	Chair	Annually			X			
Review Board Member Attendance	Chair	Twice yearly			X			X
Plan AGM	Chair	Annually					X	
Review Board Orientation	Chair	Annually						X
Review CEO and COS Succession Plan	Chair	Annually			X			
DIRECTOR RECRUITMENT AND SELECTION								
Administer Board Personal Assessment Survey/Board Succession	Admin	Annually			X			
Review Board Succession Plan	Chair	Annually				X		
Review Skills Matrix	CEO	Annually		X				
Complete Skills Matrix	Board	Annually			X			
Identification of number of new members required	Chair	Annually				X		
Identification of selection criteria based on skills matrix	Chair	Annually				X		
Start recruitment process (April)	Admin	Annually				X		
Recommendation of New Directors to the Board		Annually						X
Review Following Years Committee Schedule and Membership		Annually						X
ACCREDITATION								
Governance Standards Review	Chair	Every meeting	✓	X	X	X	X	X
Inclusion, Diversity, Equity & Anti-Racism Update	Chair	Bi-Monthly	✓		X		X	
Review Communication Plan	Chair	Annually	✓					
PERFORMANCE								
Review Performance Evaluation Questionnaire for CEO and COS	Chair	Annually		X				
Review Committee Effectiveness Survey Questions	Chair	Annually			X			
Administer Committee Effectiveness Survey	EA	Annually					X	
Review Peer to Peer Survey Questions	Chair	Annually				X		
Administer Peer to Peer Surveys	EA	Annually						X
STRATEGIC PLAN AND STRATEGIC DIRECTIONS								
Review Strategic Plan and Refresh	CEO	Annually		X				
Review Progress on Strategic Actions	CEO	Quarterly	✓	X	X		X	
POLICY REVIEW								
CEO and COS Performance Evaluation (New)	CEO		✓					
Meeting of Directors Without Management (New)	CEO		✓					
Acts, Legislations, and Compliance Reporting (New)	CEO		✓					
Patient and Family Engagement (New)	CEO			X				
Signing Authority and Approval (BOD.04.005)	CEO				X			
Regular Meetings of the Board and Notice (BOD.05.013)	CEO					X		
Communication & Hospital Spokesperson (BOD.05.018)	CEO					X		
Minutes of Regular and In Camera Meetings (BOD.05.014)	CEO						X	
Board Award of Excellence (BOD.06.001)	CEO						X	
Board and Committee Expenses (BOD.04.001)	CEO							X
Board of Directors Orientation Program (BOD.05.015)	CEO							X
ESTIMATED PREPARATION TIME FOR MEETING			1H	1H	1H	1H	1H	1H

Revisions since prior report:

- Removed the two finance policies (Borrowing and Financial Planning and Performance) which were scheduled for November as these will be approved through the Finance, HR and Audit committee as new policies and then added to the schedule for regular review by the Board.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: October 24, 2025 Meeting Date Prepared for: November 12, 2025

Subject: Skills Matrix – Board Diversity & Regular Updating

Prepared by: Robert Alldred-Hughes, President & Chief Executive Officer

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

The purpose of this briefing note is to seek Board approval to (1) include diversity-related demographic information within the HGMH Board of Directors' Skills Matrix, and (2) establish an annual update process to ensure the matrix remains current and reflective of both the evolving skills and the diversity of the Board.

This enhancement aligns with HGMH's commitment to governance best practices, inclusivity, and transparency, and supports the hospital's commitment to ensuring representation and perspectives are reflective of the communities we serve.

The Diversity Data fields will include:

- Gender (Female, Male, Non-Binary)
- Languages spoken
- Ethnicity
- Indigenous identity
- 2SLGBTQ+ identification
- Person with a Disability

RECOMMENDATION / MOTION

That the Governance & Nominating Committee recommend to the Board of Directors the inclusion of diversity information within the Board Skills Matrix and implement an annual update process as part of the regular Board evaluation cycle.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

- The Board of Directors currently maintains a Skills Matrix that captures individual and collective competencies, such as, finance, governance, risk management, and human resources, etc. While this tool is valuable in supporting recruitment, succession planning, and committee composition, it does not presently include diversity-related data.
- Evolving governance standards, including those from the Ontario Hospital Association (OHA) and Accreditation Canada, increasingly emphasize diversity, equity, and inclusion (DEI) as essential elements of effective Board composition. Understanding the diversity of the Board allows for more informed recruitment, supports equitable representation, and demonstrates alignment with HGMH's strategic priorities under *People & Culture* and *Integration & Standardization*.

- Further, as Directors develop new skills or gain additional experiences through Board or professional activities, the current static matrix may not fully reflect their evolving capabilities. Introducing an annual update process will ensure the matrix remains dynamic and accurate.

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

Option 1 – Maintain Current Matrix (Status Quo)

- *Advantages:*
  - Minimal administrative effort; no change to current process.
- *Disadvantages:*
  - Limits visibility into Board diversity; lacks alignment with DEI best practices; data becomes outdated over time; may impede succession planning and reporting.

Option 2 – Add Diversity Data and Update Matrix Annually (Recommended)

- *Advantages:*
  - Supports transparency, equity, and inclusive governance practices.
  - Aligns with OHA and Accreditation Canada expectations.
  - Enables evidence-based recruitment and succession planning.
  - Reflects evolving skills and experiences of current Directors.
- *Disadvantages:*
  - Requires modest additional administrative coordination annually.
  - Some Board members may be hesitant to self-identify; however, participation will be voluntary.

Option 3 – Add Diversity Data Only (Without Annual Updates)

- *Advantages:*
  - Captures a point-in-time snapshot of Board skills.
- *Disadvantages:*
  - Skills and experiences may become outdated;
  - limits longitudinal tracking and adaptability of governance planning.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

Impact Analysis

Implementing the proposed change will enhance governance transparency, inclusivity, and succession planning. It will also demonstrate to stakeholders that HGMH values representation and equitable participation at the governance level.

Risk Assessment

Voluntary Disclosure: Individual data will be collected on a voluntary basis.

Engagement: Clear communication about the purpose of collecting diversity data, along with framing the initiative as part of HGMH's commitment to inclusive excellence, will help to mitigate any potential discomfort or misunderstanding among Board members.

Administrative Load: The additional administrative effort is expected to be minimal. Updates can be completed annually as part of the Board's regular process, ensuring efficiency and consistency.

Decision Criteria

The decision to implement these changes aligns with HGMH's values and vision of "Providing your care, your way." It advances inclusive governance and ensures that leadership representation reflects the diversity of the community we serve. The approach complies with emerging best practices in hospital governance and accreditation standards. Finally, the process is sustainable and easy to implement as part of existing Board evaluation activities.

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- If approved, the revised skills matrix will be sent to Board Members to complete in December to ensure it is update with diversity information, and at the same time Board Members may amend their current skill level within the skills matrix as required.
- Following this initial review, annual amendments will be completed in line with the Governance Committees workplan.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Revised Skills Matrix

Board Directors		Finance	Business Mgmt	Human Resources Mgmt	Health Care Admin & Policy	Clinical	Government & Gov Relations	Political Acumen	Construction & Project Management	Legal	Strategic Planning	Risk Management	Information Technology	Accounting	Education	Research	Quality & Performance Management	Labour Relations	Board & Governance	Public Affairs & Communications	Ethics	Patient & Health Care Advocacy	Diversity Issues	Quality & Patient Safety Management	Stakeholder Engagement
Name	Year Joined																								
Dr. Stuart Robertson	Jun/21																								
Louise Boyling	Jun/21																								
Charlotte Nagy	Mar/22																								
Carole Larocque	Jun/22																								
Doug Elie	Jun/25																								
Francois Desjardins	Jun/24																								
Dr. Genevieve Raby	Oct/23																								
Gerard McDonald	Jun/24																								
Gordon Peters	Jun/23																								
Heidi Salib	Jun/24																								
Dr. Raynald Cardinal	Jun/23																								
	Jun/24																								
Average:																									
Max for elected members:		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Board Directors	S. Robertson	L. Boyling	C. Nagy	C. Larocque	D. Elie	F. Desjardins	G. Raby	G. McDonald	G. Peters	H. Salib	R. Cardinal
Gender - M/F/Non-Binary											
Languages											
Ethnicity, Indigenous, 2SLGBTQ+											

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee - Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: November 2, 2025 Meeting Date Prepared for: November 12, 2025

Subject: CEO and COS Evaluation Questionnaire Review

Prepared by: L. Boyling, Chair of Governance and Nominating Committee

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- The Governance Committee annually reviews the performance evaluation questions for the CEO and COS and recommend any changes to the Board of Directors.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

- As part of our commitment to robust corporate governance, it is imperative to evaluate the performance of key executives, namely the CEO and COS, on an annual basis. This evaluation process serves several critical purposes:
  - Performance evaluations hold executives accountable for their responsibilities and strategic goals outlined in their job descriptions. This ensures that leaders deliver measurable results in alignment with their personal business commitments.
  - The evaluation process provides a structured mechanism for feedback on both strengths and areas requiring improvement. Constructive feedback fosters professional development and enhances leadership capabilities, contributing to the long-term success of the organization.
  - Assessing executive performance against strategic objectives ensures that the leadership team remains focused on driving the organization towards its long-term vision. This process helps identify any misalignments and allows for adjustments to be made in real-time.
- The evaluation questionnaires are to be carefully crafted to encompass key performance indicators, leadership competencies, and the specific responsibilities outlined in the job descriptions of the CEO and COS. The questions are designed to gather both quantitative and qualitative data, providing a comprehensive view of executive performance.
- It is important to highlight that the questionnaires are answered anonymously, and results are kept confidential between the Board Executive and the Executives individually.
- When answering the questions, it is important to take into consideration information being shared at the Board level as a means to evaluate work being done.
- It is important to note that while Governance reviews the questionnaires, the Executive Committee of the Board gather the results and will go over these with the CEO and COS individually.

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Revise any questions if needed.
- Executive Assistant to send out the questionnaires as appropriate in March 2026 with results compiled by April 2026 for review at the Executive Committee meeting.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- CEO Evaluation by Board
- COS Evaluation by Board

HÔPITAL Glengarry Memorial HOSPITAL

2025 CEO Survey by the Board of Directors

HGMH is committed to "delivering outstanding care for our communities" and "improving engagement by investing in the organizations people and empower a caring and positive culture for all". We will achieve this commitment through setting clear expectations and providing opportunities for open and honest feedback regarding individual performance.

Demonstration of HGMH Core Values
The hospital's values are our 'PACT' which is our promise to have Passion for what we do, Accountability for our role, Compassion for those we serve, and Teamwork for each other, and this at the heart of all we do, every day.

Using the ratings below, let us know how well you think the CEO is demonstrating the core values of the hospital.

1. The CEO demonstrates Passion for what they do.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

2. The CEO demonstrates Accountability for their role.

Performance Needs Development	Performance usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

3. The CEO demonstrates Compassion for those we serve.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

4. The CEO demonstrates Teamwork for each other.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
◯	◯	◯	◯	◯

Comments:

LEADS in a Caring Environment Performance Evaluation Tool
For each competency area, please assess the CEO using the rating scale below. Comments may be added to provide examples or context for ratings.

5. Lead Self (Demonstrates self-awareness, self-management, and integrity in leadership, fostering personal and professional growth while supporting others.) The CEO:

-Demonstrates self-awareness by understanding strengths, limitations, and impact on others.
-Manages self effectively under pressure and models professionalism.
-Seeks feedback and engages in continuous personal and professional development.
-Consistently demonstrates integrity, accountability, and ethical leadership.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
◯	◯	◯	◯	◯

Comments:

6. Engage Others (Engages others by fostering the development of individuals and teams, creating healthy work environments, communicating effectively, and building commitment to shared goals.) The CEO:

-Supports and mentors others to reach their full potential.
-Contributes to creating a respectful, inclusive, and collaborative organizational culture.
-Communicates clearly, transparently, and consistently across the organization.
-Builds cohesive, high-performing teams and fosters a sense of shared purpose.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
◯	◯	◯	◯	◯

Comments:

7. Achieves Results (Translates vision and strategic priorities into measurable actions and outcomes.) The CEO:

-Establishes clear organizational goals and priorities aligned with the hospital's mission and vision.
-Aligns strategies and decisions with organizational values, evidence, and best practices.
-Demonstrates decisive leadership and follow-through in implementing initiatives.
-Regularly assesses progress, measures outcomes, and makes data-informed adjustments.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

8. Develop Coalitions (Definition: Builds partnerships, networks, and collaborative relationships to achieve shared goals and enhance service delivery.) The CEO:

-Builds and maintains strong partnerships and networks with internal and external stakeholders.
-Demonstrates commitment to patient care, community needs, and service excellence.
-Leverages and shares knowledge to advance organizational and system improvement.
-Effectively navigates complex political and community environments to achieve positive outcomes.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

9. Systems Transformation (Definition: Leads change and innovation to transform health systems and organizations for the future.) The CEO:

-Demonstrates systems thinking and understands the broader healthcare environment.
-Encourages innovation and supports creative problem-solving.
-Anticipates future trends and positions the organization strategically for long-term success.
-Leads transformational change initiatives with clarity and commitment.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

10. Resource Management (Definition: Optimizes organizational resources to ensure sustainability, efficiency, and alignment with strategic priorities.) The CEO:

-Demonstrates effective stewardship of human resources, fostering engagement and retention.
-Ensures sound financial management practices that align with organizational goals.
-Oversees the efficient use and maintenance of capital and material assets.
-Utilizes information and data systems effectively for decision-making and reporting.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

11. **Overall Performance Rating**

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

HÔPITAL Glengarry Memorial HOSPITAL

2025 COS Survey by the Board of Directors

HGMH is committed to "delivering outstanding care for our communities" and "improving engagement by investing in the organizations people and empower a caring and positive culture for all". We will achieve this commitment through setting clear expectations and providing opportunities for open and honest feedback regarding individual performance.

Demonstration of HGMH Core Values
The hospital's values are our 'PACT' which is our promise to have Passion for what we do, Accountability for our role, Compassion for those we serve, and Teamwork for each other, and this at the heart of all we do, every day.

Using the ratings below, let us know how well you think the COS is demonstrating the core values of the hospital.

1. The COS demonstrates Passion for what they do.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

2. The COS demonstrates Accountability for their role.

Performance Needs Development	Performance usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

3. The COS demonstrates Compassion for those we serve.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

4. The COS demonstrates Teamwork for each other.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
◯	◯	◯	◯	◯

Comments:

LEADS in a Caring Environment Performance Evaluation Tool
For each competency area, please assess the COS using the rating scale below. Comments may be added to provide examples or context for ratings.

5. Lead Self (Demonstrates self-awareness, self-management, and integrity in leadership, fostering personal and professional growth while supporting others.) The COS:

-Demonstrates self-awareness by understanding strengths, limitations, and impact on others.
-Manages self effectively under pressure and models professionalism.
-Seeks feedback and engages in continuous personal and professional development.
-Consistently demonstrates integrity, accountability, and ethical leadership.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
◯	◯	◯	◯	◯

Comments:

6. Engage Others (Engages others by fostering the development of individuals and teams, creating healthy work environments, communicating effectively, and building commitment to shared goals.) The COS:

-Supports and mentors others to reach their full potential.
-Contributes to creating a respectful, inclusive, and collaborative organizational culture.
-Communicates clearly, transparently, and consistently across the organization.
-Builds cohesive, high-performing teams and fosters a sense of shared purpose.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
◯	◯	◯	◯	◯

Comments:

7. Achieves Results (Translates vision and strategic priorities into measurable actions and outcomes.) The COS:

-Establishes clear organizational goals and priorities aligned with the hospital's mission and vision.
-Aligns strategies and decisions with organizational values, evidence, and best practices.
-Demonstrates decisive leadership and follow-through in implementing initiatives.
-Regularly assesses progress, measures outcomes, and makes data-informed adjustments.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

8. Develop Coalitions (Definition: Builds partnerships, networks, and collaborative relationships to achieve shared goals and enhance service delivery.) The COS:

-Builds and maintains strong partnerships and networks with internal and external stakeholders.
-Demonstrates commitment to patient care, community needs, and service excellence.
-Leverages and shares knowledge to advance organizational and system improvement.
-Effectively navigates complex political and community environments to achieve positive outcomes.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

9. Systems Transformation (Definition: Leads change and innovation to transform health systems and organizations for the future.) The COS:

-Demonstrates systems thinking and understands the broader healthcare environment.
-Encourages innovation and supports creative problem-solving.
-Anticipates future trends and positions the organization strategically for long-term success.
-Leads transformational change initiatives with clarity and commitment.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

10. Resource Management (Definition: Optimizes organizational resources to ensure sustainability, efficiency, and alignment with strategic priorities.) The COS:

-Demonstrates effective stewardship of human resources, fostering engagement and retention.
-Ensures sound financial management practices that align with organizational goals.
-Oversees the efficient use and maintenance of capital and material assets.
-Utilizes information and data systems effectively for decision-making and reporting.

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

11. **Overall Performance Rating**

Performance Needs Development	Performance Usually Meets Expectations	Performance Consistently Meets Expectations	Performance Usually Exceeds Expectations	Performance is Excellent
○	○	○	○	○

Comments:

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee - Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: October 31, 2025 Meeting Date Prepared for: November 12, 2025

Subject: Q2 Strategic Actions Report

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- The purpose of this briefing is to provide the Board of Directors with an update on the progress of the hospital's Q2 Strategic Action Report (2025–2026). Strategic actions are derived directly from our 2023–2028 Strategic Plan and are developed through consultation with senior leadership, physician leaders, and staff committees. Each action is designed to operationalize our four strategic priorities: Quality & Safety, People & Culture, Integration & Standardization, and Future Planning, and provides tangible milestones to measure progress toward our longer-term goals.
- Monitoring and reporting progress quarterly is critical to ensuring accountability, identifying early risks, and implementing mitigation strategies where required.

RECOMMENDATION / MOTION

THAT the Governance Committee review and receive the Q2 Strategic Actions Report.

SITUATION & BACKGROUND

A brief description of the background to the issue.

• All strategic actions for Q2 were assessed against established milestones and categorized as: Complete, On Track, Not on Track (mitigation plans in place), or At Risk.

Quality & Safety:

- Actions to strengthen palliative care resources remain on track. A gap analysis of the *Best Practice Guideline: Palliative Approach to Care in the Last 12 Months of Life* was completed, with key recommendations to enhance access to cultural, spiritual, and religious supports. The *Spiritual and Cultural Care Room*—a co-designed initiative between the PFAC and IDEA Committee—was officially opened on October 8, 2025.
- Medical directives continue to be used effectively by nursing staff, improving patient flow and reducing diagnostic delays. Twenty-seven directives are currently active, and Epic workflow reviews are underway to ensure continued functionality.
- Leadership and PFAC patient rounding remain consistent, with feedback confirming that patients feel cared for and safe. Continued focus is being placed on consistent whiteboard use. PFAC members will join Senior Leadership Team rounds during Canadian Patient Safety Week (October 27–31).

People & Culture:

- Four first-year medical students from the Universities of Ottawa and Toronto completed Discovery Week placements, and a third-year medical student from Queen's University is completing a 14-week generalist placement (September 15 – December 19, 2025).
- Work on the *Psychological Safety Program* is advancing, with leadership training scheduled for the March 5, 2026 retreat. The program will be reviewed by the Joint Occupational Health and Safety Committee in November.

- The *performance evaluation redesign* is progressing—feedback surveys have been completed and results are being analyzed to shape a more meaningful, development-focused process.

Integration & Standardization:

The Epic EMR implementation through the Atlas Alliance officially launched April 2, 2025, with go-live targeted for October 24, 2026. Subject Matter Experts continue to participate in workflow design sessions. IT infrastructure improvements, including backup servers and a new uninterruptible power supply, are underway to align with Epic requirements.

Future Planning:

- Stage 1.1 of the Ministry's Capital Redevelopment Planning Process was completed and approved by the Board in June 2025, outlining plans for a new patient care tower, renovations to the existing facility, and a community health hub. Advocacy continues for progression to Stage 1.2 with Ministry of Health approval.
- The HGMH Foundation has raised $1.5 million toward the CT Scanner campaign. CEO and leadership continue to engage donors and participate in fundraising events. The CT project is planned to begin in early 2026, targeting a late 2027 go-live.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

Ongoing monitoring of strategic actions ensures the hospital remains aligned with its long-term strategy and responsive to operational and environmental risks. Key Q2 impacts include:

• Enhanced Patient-Centred Care: The completion of the Spiritual and Cultural Care Room and direct feedback through rounding reflect meaningful engagement with patients and families.

• Workforce Development: Expansion of medical student placements and continued emphasis on leadership and psychological safety training reinforce HGMH's position as a teaching site and employer of choice.

• System Integration: Active engagement in the Epic EMR project and IT infrastructure readiness efforts will support regional standardization, quality, and safety.

• Future Sustainability: Progress in the capital redevelopment process and the Foundation's CT campaign strengthen HGMH's readiness for future growth and alignment with Ministry and community priorities.

CONSULTED WITH:

Indicate those bodies and individuals who have been consulted with in the development of this decision support document

- HGMH Senior Leadership Team

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Q2 Strategic Action Report

Strategic Action Report Q2

Strategic Dimension	Strategic Direction	Executive Lead	Action	Progress	Status
Quality & Safety	*Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.*	R. Romany	Implement Best Practice Guidelines to strengthen the tools and resources available to our palliative care team. This includes introducing assessment tools and reference sheets to support consistent, high-quality care across all touchpoints.	• Gap analysis of the Best Practice Guideline: Palliative Approach to Care in the Last 12 Months of Life has been completed. • A key recommendation is to ensure that nurses facilitate access to appropriate resources, spaces, and services to support the cultural, spiritual, and/or religious needs of patients and families. • The Spiritual and Cultural Care Room was officially opened on Oct 8, 2025. The creation of this room was a joint effort of the PFAC and IDEA Committee.	On track
		R. Romany	Increase the use of medical directives for nursing staff, allowing for faster initiation of diagnostic tests and treatments before physician assessment. Undertake facility enhancements to support patient care and operational efficiency.	• There are 27 medical directives currently in place. • Medical directives are being utilized by staff, particularly for initiating diagnostic tests, helping to improve patient flow and reduce delays prior to physician assessment. • The EPIC implementation process includes a review of order set workflow to ensure functionality for ordering medical directives.	On track
		R. Romany	Enhance patient involvement in care decisions by implementing Leader and Patient and Family Advisory Committee (PFAC) patient rounding to engage directly with patients and assess their level of involvement in their care before discharge.	• Patients continue to report feeling cared for, safe, and checked on during evenings and nights. • Consistent completion of patient whiteboards continues to be an area of focus. The whiteboard serves as a key communication tool to keep patients and families informed about the care plan. • PFAC members plan to join SLT for patient rounds during Canadian Patient Safety Week Oct 27-31.	On track

Fully complete | On track – no barriers for completion | Not on track – mitigation plans in place | Not on track – initiative at risk

Updated October 24, 2025

People & Culture	*Improve engagement by investing in the organizations people and empower a caring and positive culture for all.*	Dr. L. MacKinnon	Initiate a Medical Student and Resident Program to provide hands-on learning experiences within our medical community. By collaborating with the Rural Ontario Medical Program (ROMP) and other academic partners, we will support initiatives such as Discovery Week for medical students and structured resident placements	• In the spring, we successfully welcomed four first-year medical students—two from the University of Ottawa and two from the University of Toronto. • We are actively collaborating with ERMEP and ROMP to create our medical student and resident program. • Additionally, we will be hosting a third-year medical student from Queen's University for a 14-week generalist placement, scheduled from September 15 to December 19, 2025.	On track
		K. MacGillivray	As part of our ongoing commitment to health and safety, we are enhancing leadership training with a dedicated focus on psychological safety in addition to management responsibilities.	• The development of the psychological safety program is underway. • Training for the leadership team will be held at our annual Leadership retreat on March 5, 2026. We have reached out to a trainer and are exploring other training materials. • Will be bringing the Program for review to the Joint Occupational Health and Safety Committee in November.	On Track
		K. MacGillivray	Redesign our performance evaluation process to create a more meaningful, transparent, and development-focused experience for our employees.	• Feedback survey on the current performance appraisal process has been sent to the leadership team with a deadline of September 12. • Results have been received and currently reviewing the feedback and analyzing options.	On Track
Integration & Standardization	*Deliver standardized quality care in a cost-effective way through collaboration & integration opportunities.*	R. Romany	Continue the transition to a new Electronic Medical Record (EMR) system by joining the Atlas Alliance and implementing the EPIC EMR platform in the Fall of 2026.	• The implementation project officially launched on April 2, 2005. Go-live date is targeted for October 24, 2026. • Subject matter experts (SMEs) continue to participate in various workgroups reviewing clinical and operational workflows.	On Track
		L. Ramsay	Invest in critical upgrades to our information technology infrastructure. This year, we are enhancing system reliability and security by purchasing backup servers and an uninterruptible power supply (UPS) for our server environment.	• Looking at our current set-up and ensuring that it is lines with the requirements for our EPIC implementation.	On Track

Fully complete | On track – no barriers for completion | Not on track – mitigation plans in place | Not on track – initiative at risk

Updated October 24, 2025

Future Planning	*Invest in the sustainability of our equipment & infrastructure to support safe, quality care.*	R. Alldred-Hughes	Submit pre-capital submission to support the future redevelopment and revitalization of the hospital	• Board and Hospital Leadership completed Stage 1.1 of the Ministry Capital Redevelopment Planning Process, and received Board approval for submission in June 2025. The plan contains a new patient care tower, renovation of existing site, and a community health hub. • Hospital will continue to advocate for the proposal to move to stage 1.2 with Ministry of Health approval.	Complete
		R. Alldred-Hughes	Actively work with and support the HGMH Foundation in their efforts to fund our ability to bring CT to HGMH.	• Foundation has launched the their capital campaign, and continuous fundraising efforts. CEO has been meeting with donors as needed, providing hospital tours and context for our ask. In addition, the HGMH leadership team has been supporting fundraising events through volunteerism and attendance. • Foundation has raised $1.5M toward the CT Scanner at this time. Based on these results, plan to start the CT project early 2026 for a late 2027 go live.	On Track

Fully complete | On track – no barriers for completion | Not on track – mitigation plans in place | Not on track – initiative at risk

Updated October 24, 2025

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: October 31, 2025 Meeting Date Prepared for: November 21, 2025

Subject: Patient & Family Engagement Policy

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

The purpose of this briefing is to present the new *Patient and Family Engagement Policy* for review. The policy formalizes the Board's commitment to embedding a people-centred care approach throughout the organization and within its governance practices.

RECOMMENDATION / MOTION

That the Governance & Nominating Committee recommend to the Board of Directors the approval of the *Patient and Family Engagement Policy* as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

The *Patient and Family Engagement Policy* was developed to align with Accreditation Canada's People-Centred Care Standards and HGMH's commitment to advancing inclusion, diversity, equity, anti-racism, and partnership in care delivery and governance.

This policy reflects the Board's responsibility to ensure that patient and family voices are meaningfully integrated into decision-making and that care and governance processes reflect what matters most to the people served by the hospital. It establishes a clear link between the Board's oversight role, the work of the Patient and Family Advisory Committee (PFAC), and hospital operations.

Key policy features include:

- A commitment to embedding people-centred care in governance and decision-making.
- Support for an inclusive and representative Patient and Family Advisory Committee.
- A structured process for two-way communication between PFAC and the Board.
- Emphasis on safety, respect, transparency, and accountability in all engagement activities.

The policy will be reviewed by senior leadership and PFAC, and reflects HGMH's broader vision of "Providing your care, your way."

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

Option 1: Approve the Patient and Family Engagement Policy (Recommended)

Approval would establish a clear governance framework that integrates patient and family perspectives into Board

deliberations and hospital operations. It would strengthen alignment with Accreditation Canada standards and demonstrate HGMH's commitment to partnership, transparency, and accountability.

Option 2: Defer Approval for Further Revision

Deferring approval would delay the hospital's ability to demonstrate compliance with Accreditation standards and the Governance policy review cycle. Feedback has already been incorporated from all relevant stakeholders, and no significant concerns remain.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

Approval of this policy has a positive impact on governance and organizational culture. It formalizes structures and principles already in practice, ensuring consistent engagement and representation at both the operational and governance levels. It reinforces the link between patient experience, quality, and safety outcomes and provides clear accountability for how patient and family feedback informs decision-making.

There are minimal risks associated with adopting the policy. Ongoing monitoring will be achieved through PFAC reports to the Quality Committee, the Board of Directors, and periodic policy review every three years. The policy positions HGMH to meet or exceed Accreditation Canada's expectations regarding people-centred care and governance awareness.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Draft Policy of Patient & Family Engagement

Document Name:	Patient and Family Engagement	
Document Number:	BOD.0X.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board of Directors is committed to embedding a people-centred care approach throughout the organization and its governance activities. This policy outlines the Board's role in fostering a culture and practice of inclusion, diversity, equity, anti-racism, safety, and partnership, where patients and families are active participants and co-producers of their health and care experience.

The Board recognizes that engaging patients and families as partners:

- Enhances the patient and family experience of care.
- Leads to improved health outcomes for individuals and communities.
- Strengthens trust, accountability, and transparency within the organization.
- Ensures care is designed and delivered around the comprehensive needs of people.

The Board will model, champion, and support a people-centred approach in governance and decision-making. This commitment is grounded in the hospital's Patients' Rights and Responsibilities, which affirm that every patient has the right to be treated with dignity, compassion, and respect, and the responsibility to participate actively in their care and decision-making.

Guiding Principles

- Inclusion, Diversity, Equity, and Anti-Racism (IDEA): Engagement will reflect the diverse backgrounds, cultures, languages, and experiences of the communities we serve.
- Safety and Respect: Patients and families will feel safe, valued, and supported to share their perspectives.
- Partnership: Patients and families are recognized as collaborators and decision-makers, not passive recipients of care.
- Transparency: Information and decisions will be shared openly to support trust and informed participation.
- Accountability: The Board is responsible for ensuring that engagement meaningfully influences hospital priorities and outcomes.

PROCEDURE:

1. Board of Directors Responsibilities

The Board of Directors will:

a) Embed People-Centred Care in Governance:
   - Ensure that Board members receive education and training on people-centred care principles.
   - Demonstrate commitment by incorporating patient and family perspectives into governance activities and decisions.
   - Support a hospital-wide culture that values patient and family engagement as essential to quality and safety.

b) Supporting and Partnering with the Patient and Family Advisory Committee (PFAC):
   - Maintain a Patient and Family Advisory Committee (PFAC) to serve as the formal mechanism for patient and family engagement at the governance and organizational levels.
   - Ensure PFAC membership reflects the diversity of the hospital's patient population and community.
   - Establish two-way communication between the PFAC and the Board to ensure feedback, priorities, and actions are shared in both directions.
   - Regularly review recommendations and feedback from the PFAC and ensure appropriate follow-up or action.

2. Organizational Commitment to People-Centre Care

The Hospital will:

a) Ensure Inclusiveness:
   - Incorporate cultural, linguistic, accessibility, and psychosocial factors into care planning and service delivery.
   - Address barriers related to the social determinants of health that affect care access, quality, and outcomes.
   - Promote equitable participation of diverse patient and family voices in planning, evaluation, and governance.

b) Provide Support:
   - Offer family, spiritual, and staff supports across the continuum of care.
   - Support patients and families through care transitions to maintain safety and continuity.
   - Equip patients and families to contribute meaningfully to discussions and decisions that impact service delivery.

c) Maintain a Patient-Centred Focus:
   - Respect and integrate patient and family preferences, needs, values, and lived experiences into all aspects of care, planning, and evaluation.
   - Consider what patients define as good outcomes when evaluating care quality and success.
   - Ensure that care, policy, and program design reflect what matters most to patients and families.

d) Foster Partnership and Shared Decision-Making:
   - Promote collaborative decision-making by ensuring patients and families are well informed about care choices, risks, benefits, and alternatives.

- Encourage patients to take active ownership in their treatment, recovery, and self-care, with the hospital providing tools and education to support engagement.
- Engage patients and families as co-designers of programs, policies, and initiatives that shape service delivery.

REFERENCES:

1. University of Ottawa Heart Institute Patient and Family Engagement Framework
2. St. Joseph's Healthcare Hamilton
3. HGMH Patient Rights and Responsibilities

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee - Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: October 31, 2025 Meeting Date Prepared for: November 12, 2025

Subject: Accreditation Standard Feature

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- As part of the hospital's efforts to embrace the new continuous model for Accreditation and embed it into our daily work, committees will feature 1-2 criteria from an Accreditation standard that applies to their committee's work at each meeting
- These features will provide an opportunity for the committee to discuss the standard and how HGMH achieves compliance, identifies opportunities for improvement, while ensuring the committee is well-equipped to make informed decisions and recommendations related to quality

STANDARD / CRITERIA FEATURED

Include the standard name, number(s), statement(s), guideline text, and other information if applicable

4.2 The governing body evaluates its effectiveness.

4.2.1 The governing body regularly evaluates its effectiveness, to make improvements as needed.

Priority: **High Priority** | Quality Dimension: **Efficiency**

Guidelines
The governing body conducts regular (e.g., annual) evaluations of its effectiveness and that of its committees. The governing body may use Health Standards Organization's Governance Functioning Tool, along with other tools, to evaluate its effectiveness.

Evaluations may include formal or informal self-evaluations and/or external evaluations of:

- The role, structure, and composition of the governing body and its committees, and how they contribute to the overall effectiveness of the governing body.
- The overall working culture of the governing body and its committees (e.g., reviewing membership turnover, members' satisfaction with feeling heard and the use of their time and skills, members' confidence in presenting perspectives that are contrary to the majority to ensure open and honest discussions)
- The activities and procedures of the governing body and its committees (e.g., reviewing the governing body's use of valid, reliable, and relevant evidence to make decisions; reviewing its renewal and succession planning procedures to ensure the sustainability of the governing body)
- The performance of the governing body and its committees (e.g., reviewing outcomes of its activities and decisions)
- The mechanisms used by the governing body to promote an organizational culture of people-centred care and engage with clients and families in governance activities.

The governing body's evaluation practices should foster transparency. This may be done by using defined standards for evaluation that are shared with stakeholders, and by seeking feedback from governing body members and the executive leader. The governing body's evaluation practices may also include a review of research and leading practices in governance to compare its performance against a benchmark.

The governing body members discuss the evaluation results and use the results to make improvements.

In some jurisdictions, government may be accountable for evaluating the governing body's performance. In this case, the governing body works with government to inform and contribute to the process and participates to the fullest extent possible.

DISCUSSION QUESTIONS

Choose 1-2 questions from the list below to guide discussion at your meeting, or create your own question(s)

- What does this standard mean to you / why is it important for this team?
- What does the hospital already do to meet this standard?
- What new things can the hospital implement to meet this standard?
- How does this team contribute to meeting this standard?
- What opportunities are there for this team to do things differently?
- How would you respond to a surveyor asking you a question about this standard?
- How can we best support staff awareness of the hospital's approach to this standard so they are prepared to answer surveyor questions?
- What evidence (i.e.: documentation) can support the hospital's compliance with this standard?

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: October 28, 2025 Meeting Date Prepared for: November 12, 2025

Subject: Review Strategic Plan and Refresh

Prepared by: Robert Alldred-Hughes, President & Chief Executive Officer

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

The purpose of this briefing note is to provide the committee with an annual update on the hospital's Strategic Plan (2023–2028) and to outline the process for future reviews and potential refreshes.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

The hospital's current Strategic Plan was launched in 2023 and provides the framework to guide priorities, decision-making, and resource allocation through to 2028. The plan was developed following extensive consultation with staff, physicians, partners, patients, and the community.

As part of the Board's governance responsibilities, an annual review of the Strategic Plan is required to monitor progress and ensure continued alignment with organizational priorities and the external healthcare environment. A strategic plan refresh is typically considered mid-cycle or when there are significant shifts in priorities, system-level changes, or emerging needs that warrant an update.

Current Status

The Strategic Plan remains relevant and continues to guide hospital operations and strategic decision-making. As the plan is still in the early stages of its five-year cycle, a refresh is **not required at this time**.

A summary table outlining progress on each strategic priority area is attached to this briefing note for the Board's review. The table highlights accomplishments to date, ongoing initiatives, and areas of focus for the coming year.

Next Steps

- Continue implementation of the 2023–2028 Strategic Plan with regular progress monitoring through quarterly Strategic Action reports.
- Plan for refresh in 2027 for implementation in 2028.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Strategic Plan Progress Table

Strategic Priorities		Actions
Quality & Safety Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.	• Advance Person & Family Centred Care, ensuring the patient voice is embedded throughout hospital programs and services. • Provide culturally safe care for those who access our services and support health equity for racialized and marginalized people. • Support safe care by assessing and addressing risk throughout the organization. • Progress the implementation of the Best Practice Spotlight • Organization commitments with an interprofessional approach.	• Recruited new PFAC members • Implemented having PFAC members sit on internal hospital committees • PFAC developed/implemented two initiatives: o Partnership with library o Completed training on ECP • Implemented Inclusion, Diversity, Equity, and Anti-Racism framework • Increased the use of medical directives for nursing staff, allowing for faster initiation of diagnostic tests and treatments before physician assessment. Undertake facility enhancements to support patient care and operational efficiency. • Developed a business case for Surgical Services at HGMH to support care close to home and wait time reduction in the region. • Implemented BPGs: o Alternate Approaches to the Use of Restraints o Delirium, dementia & Depression in Older Adults o Care Transitions o Person & Family Centred Care o End-of-Life Care o Oral Health o Palliative Care • Implemented the Essential Care Partner program • Implemented the HELP program • Implemented purposeful hourly rounding • Implemented Senior Leadership Team Patient Rounding
People & Culture	• Recruitment & Retention	• Developed a creative recruitment brand that markets the hospital to prospective talent in meaningful ways

	• Diversity, Equity, Inclusion & Reconciliation • Safety & Wellness • Professional Leadership Development • Rewards & Recognition	• Redeveloped the onboarding process for new hires • Initiated a Medical Student and Resident Program to provide hands-on learning experiences within our medical community. By collaborating with the Rural Ontario Medical Program (ROMP) and other academic partners, we will support initiatives such as Discovery Week for medical students and structured resident placements • Redesigned our performance evaluation process to create a more meaningful, transparent, and development-focused experience for our employees. • Developed an HR strategic plan • Created of IDEA committee to guide the framework • Enhanced leadership training with a dedicated focus on psychological safety in addition to management responsibilities. • Implemented leadership forums at the Leadership meetings • Implemented Management Bites sessions for management • Developed and implemented a standardized retirement and recognition program that celebrates staff members who are retiring from the hospital
Integration & Standardization	• Engage in opportunities within the Great River Ontario Health Team that focus on system integration & collaboration which enhance the patient, family, and provider experience. • Support patients and families through transitions in care with modernization,	• Collaborated with GR OHT to develop a plan and proposal that would see Enhanced Remote Care Monitoring by OH at Home integrated into our discharge process. • Explored viability of a Health Hub to support Primary Care, Emergency Department diversion, and sustainable physician recruitment and retention. • Working on the transition to a new Electronic Medical Record (EMR) system by joining the Atlas Alliance and implementing the EPIC EMR platform in the Fall of 2026. • Invested in critical upgrades to our information technology infrastructure. This year, we are enhancing system

	communication, and collaboration. • Develop and sustain programs and services that meet the needs of the communities we serve by exploring optimal resource utilization and virtual care opportunities.	reliability and security by purchasing backup servers and an uninterruptible power supply (UPS) for our server environment. • Implemented a care model to support reduced wait times and enhance physician initial assessment times in the ED during peak periods
Future Planning	• Drive financial stabilization to address gaps in funding and identify new funding opportunities which support innovative care delivery models. • Leverage and enhance equipment & technology for our patients to receive care close to home with support and collaboration from our partners. • Engage in infrastructure renewal & capital redevelopment planning processes.	• Continue advocacy that supports appropriate operational funding, and implementing efficiencies that reduce operating cost. • Working with MOH and Foundation to bring CT to HGMH • Submitted the pre-capital submission to support the future redevelopment and revitalization of the hospital