

Governance and Nominating Committee Meeting Agenda

Date: Thursday, October 8, 2026
Time: 16H00 - 17H15
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Strategic Priority	Board Item	Attachment
16:00	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.05.003.X.XX)			
16:03	2. Report from the Last Meeting			
(1 min)	2.1 Approval of Previous Meeting Report - June 3, 2026			P. 3-5
(1 min)	2.2 Business Arising from Report			
(1 min)	2.3 Committee Workplan			P. 6
16:06	3. Matters for Discussion/Decision			
(5 min)	3.1 Review Governance & Nominating Committee Effectiveness Survey Results (C. Larocque)			P. 7-23
(5 min)	3.2 Review Committee Terms of Reference (C. Larocque) That the Governance & Nominating Committee recommend to the Board of Directors the Committee Terms of Reference as presented.		C	P. 24-34
(5 min)	3.3 Q1 Strategic Actions (R. Alldred-Hughes) That the Governance & Nominating Committee recommend to the Board of Directors the receipt of the Q1 2026/2027 Strategic Actions Report.	All	D	P. 35-39
(5 min)	3.4 Communication and Community Engagement Plan Review (R. Alldred-Hughes) That the Governance & Nominating Committee review and receive the Communications & Community Engagement Plan as presented.		D	P. 40-55
(5 min)	3.5 Policy Review 3.5.1 Review Senior Management Language Skills Policy (BOD.02.002) (R. Alldred-Hughes) 3.5.2 Review Developing, Reviewing, and Revising Board Policies Policy (BOD.05.001) (R. Alldred-Hughes) That the Governance & Nominating Committee recommend to the Board of Directors the approval of the following policies as presented: Senior Management Language Skills policy, and the Developing, Reviewing, and Revising Board Policies policy.	N/A	C	P. 56 P. 57 P. 58
(5 min)	3.6 Inclusion, Diversity, Equity & Anti-Racism Update (R. Alldred-Hughes) THAT the Governance & Nominating Committee approve the transition of oversight of HGMH's Inclusion, Diversity, Equity and Anti Racism Framework to the Finance, HR and Audit Committee, with formal reporting on progress against the Framework occurring at least twice annually.		C	P. 59-60
16:36	5. Date of Next Meeting			
	Thursday, November 12, 2026			
16:37	6. Adjournment			

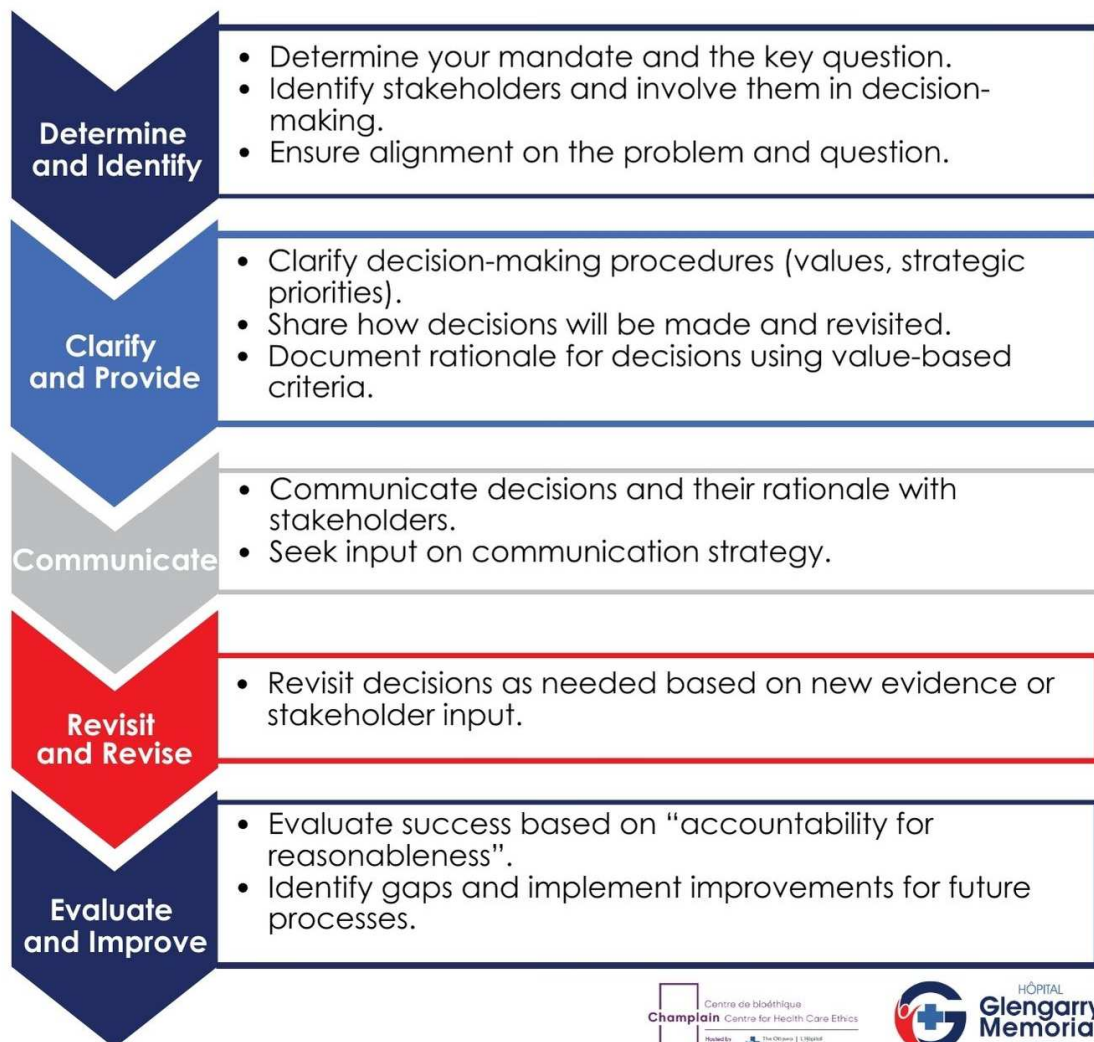
Board Item: Matters for Discussion/Decision (D) or Consent Agenda (C)

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making



A4R Action Steps



REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

June 3, 2026 at 5:30PM Boardroom/MS Teams

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

Regrets: C. Larocque, Back-Up Chair

Summary of Discussion

Approval of the Agenda

The agenda was reviewed.

Moved By: Dr. G. Raby

Seconded By: G. McDonald

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 May 13, 2026, were shared.

Moved By: Dr. S. Robertson

Seconded By: G. McDonald

THAT the meeting reports be approved as presented.

CARRIED

Business Arising from Report

There was no business arising from the report.

Committee Work Plan

The work plan was reviewed and remains on track.

Matters for Discussion/Decision

Review Board Education Plan

The education plan for 2026-2027 was reviewed.

Moved By: Dr. S. Robertson

Seconded By: Dr. G. Raby

THAT the Governance and Nominating Committee recommend to the Board of Directors the education sessions for 2026/2027 as presented.

CARRIED

The committee noted that the education sessions offered by OHA would be beneficial for both new and existing members. Rob will follow up with OHA to inquire about future training on this particular education for Board members.

There is interest from the Board in incorporating relevant ethical case studies into education sessions, allowing members to apply the ethical framework in practical scenarios. Additionally, the Board identified a need for a stronger understanding of what constitutes a health hub and

the benefits it provides to the community; it was determined this education could form part of the Board's next retreat.

Discussion also centered around the Hospital Board mandate. For example, primary care physician recruitment may not be embedded within the hospital, and the health hub operates through partnerships. While these organizations remain independent, they support hospital operations, particularly in the Emergency Department and inpatient units.

Motions for Board Approval:

- Addition of an ethics component to Board education.
- Addition of OHA hospital finances component to Board orientation material.

Review Board Orientation

The draft board orientation agenda was reviewed.

Moved By: Dr. S. Robertson

Seconded By: Dr. G. Raby

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

CARRIED

It was noted that the responsibility column requires revision to reflect the updated roles. Additionally, a handout should be developed outlining how and where to access IDEA and ethics resources, including instructions for accessing the portal, and email.

Review Committee Schedule and Membership for 2026-2027

The committee schedule and membership for 2026-2027 was reviewed.

Moved By: Dr. G. Raby

Seconded By: G. McDonald

THAT the Governance and Nominating Committee recommend to the Board of Directors the 2026-2027 committee and Board meeting schedule and the committee membership as presented.

Amendment: Add D. Elie as Foundation Representative and G. Peters as Backup Chair for Quality.

The Committee recommends bringing the proposed schedule forward to the Board of Directors for discussion, including consideration of moving Committee meetings to the second and fourth Thursday of each month, or maintaining the current schedule with June remaining as an exception. Both Version 1 and Version 2 of the schedule will be presented to the Board for decision.

CARRIED

Review Committee Work Plans

The committee work plans for 2026-2027 were reviewed.

Moved By: Dr. G. Raby

Seconded By: G. McDonald

THAT the Governance and Nominating Committee recommend to the Board of Directors the Board Committee Work Plans as presented.

The Board Retreat will include a strategic action planning session.

Policies for Review

Two policies were reviewed.

Board and Committee Expenses (BOD.04.001)

The policy was reviewed.

Moved By: Dr. S. Robertson

Seconded By: G. McDonald

THAT the Governance and Nominating Committee recommend to the Board of Directors the approval of the Board and Committee Expenses policy as amended.

Amendment: *Add publicly posted in accordance with the Broader Public Sector Accountability Act.

CARRIED

Board of Directors Orientation Program (BOD.05.015)

The policy was reviewed.

Moved By: Dr. S. Robertson

Seconded By: G. McDonald

THAT the Governance and Nominating Committee recommend to the Board of Directors the approval of the Board of Directors Orientation Program policy as presented.

CARRIED

Matters for Information

Review Board Member Attendance

The board attendance was reviewed.

Next meeting: September 2026

S. Laframboise, Recorder

Governance and Nominating Committee Annual Work Plan 2026-2027



Deliverable	Legislation/ Accountability	MRP	Occurrence	OCT	NOV	JAN	MAR	MAY	JUN
STRUCTURE/PROCESSES									
Review Committee Effectiveness Survey Results		Chair	Annually	X					
Review/Recommend Governance Annual Committee Work Plan to BoD		Chair	Annually						X
Review/Recommend Committee Terms of Reference to BoD		Chair	Annually	X					
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 Framework		Chair	Annually			X			
Annual Board Code of Conduct & Conflict of Interest Review/Attestation	PHA; BPSAA								
DIRECTOR RECRUITMENT AND SELECTION									
Administer Board Personal Assessment Survey/Board Succession		Admin	Annually			X			
Review Board Succession Plan • Identification of number of new members required • Identification of selection criteria based on skills matrix • Review Committee Chair Selection • Review Executive Committee Positions		Chair	Annually				X		
Review Skills Matrix		CEO	Annually		X				
Complete Skills Matrix		Board	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		CEO	Every meeting			X	X	X	X
Inclusion, Diversity, Equity & Anti-Racism Update		CEO	Bi-Monthly	X		X		X	
Review Communication Plan		CEO	Annually	X					
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	Q1	Q2	Q3		Q4	
Review next fiscal years Strategic Actions		CEO	Annually				X		
POLICY REVIEW									
Senior Management Language Skills (BOD.02.002)		CEO		X					
Developing, Reviewing, and Revising Board Policies (BOD.05.001)		CEO		X					
Hospital Email Usage for Board of Directors (BOD.05.011)		CEO			X				
Delegations of Authority to the President & CEO (BOD.05.012)		CEO			X				
Inclusion, Diversity, Equity, and Anti-Racism (BOD.01.001)		CEO				X			
CEO and COS Succession Planning (BOD.02.001)		CEO				X			
Enterprise Risk Management (BOD.03.004)		CEO					X		
Honorary Membership to the Corporation (BOD.05.016)		CEO					X		
Investments (BOD.04.002)		CEO						X	
Management of Endowment Funds (BOD.04.003)		CEO						X	
Conflict of Interest (BOD.05.003)		CEO							X
Acceptance of Tender Over Board-Approved Amount (BOD.04.004)		CEO							X
French Language Services (BOD.01.002)		CEO							X

BRIEFING NOTE FOR

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

Date Prepared: September 30, 2026 Meeting Date Prepared for: October 8, 2026
Subject: Governance & Nominating Committee Effectiveness Survey Results
Prepared by: Robert Aldred-Hughes, President & CEO

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

PURPOSE

- To review the results of the Governance & Nominating Committee Meeting Effectiveness Survey completed at the end of the 2025-2026 Board Cycle and determine any actions required on the part of the Committee to sustain positive results and identify opportunities for improvement in identified areas.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- Board of Directors

SITUATION & BACKGROUND

A brief description of the background to the issue.

- The HGMH Committee Self-Assessment is one of the ways the committee can assess the degree to which its structure and processes are effective in supporting board performance.
- In the Spring of 2026, the Governance & Nominating Committee completed a self-assessment using the tool provided by the hospital.
- Based on the completed assessment process, the committee can develop a work plan to address areas for improvement or identified gaps.

OPTIONS CONSIDERED & ANALYSIS

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

- The committee self-assessment is structured to evaluate the following 5 domains:
 1. Terms of Reference and Composition
 2. Committee Management
 3. Committee Effectiveness
 4. Chair Effectiveness
 5. Overall Committee Performance
- The following tables provide the response data from all respondents to the survey:

Terms of Reference and Composition

	 Fully Satisfactory	 Could Improve	 Unknown	Total
The committee has clear and appropriate Terms of Reference.	100.00% 4	0% 0	0% 0	4
The committee has the right number of members.	100.00% 4	0% 0	0% 0	4
The committee has members with the skills and expertise that are needed by the committee.	100.00% 4	0% 0	0% 0	4

RESPONSES

There are no responses.

Committee Management

	 Fully Satisfactory	 Could Improve	 Unknown	Total
The committee meets at the appropriate time of day.	100.00% 4	0% 0	0% 0	4
I received orientation to the committee that was helpful to me as a member of the committee.	75.00% 3	25.00% 1	0% 0	4
The committee is receiving the support from hospital management that it requires.	100.00% 4	0% 0	0% 0	4
Information is received sufficiently in advance of the meeting.	100.00% 4	0% 0	0% 0	4
The committee meets the right number of times over the year.	100.00% 4	0% 0	0% 0	4

RESPONSES

The committee functions well. Developing a committee orientation program for all committees would be helpful to get committee members to participate with confidence more quickly. The orientation could train on goals and objectives of this committee, list of training material that can be done at home, concrete examples of topics that have come up in the past, etc...

Committee Effectiveness

	 Fully Satisfactory	 Could Improve	 Unknown	Total
The committee is working effectively.	100.00% 4	0% 0	0% 0	4
The committee performed its annual workplan.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by providing appropriate nominees for election to the Board of Directors.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by ensuring an appropriate orientation and education program for members.	75.00% 3	25.00% 1	0% 0	4
The committee is effectively performing by organizing, with the input of the CEO and Board Chair, the Board retreats.	75.00% 3	25.00% 1	0% 0	4
The committee is effectively performing by selecting and recommending nominees for Chair, Vice-Chair, and Treasurer of the Board.	75.00% 3	0% 0	25.00% 1	4
The committee is effectively performing by ensuring succession planning for the office of the Board.	75.00% 3	25.00% 1	0% 0	4
The committee is effectively performing by ensuring periodic review and evaluation of committee performance and Terms of Reference.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by recommending to the Board with the input of the Chair, nominees for all Board committees and Committee Chairs.	75.00% 3	0% 0	25.00% 1	4
The committee is effectively performing by establishing a program to evaluate the performance of the Board, Board Chair, Board members, and Board Committees.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by considering the results of Board evaluations in connection with renewal of terms of	100.00% 4	0% 0	0% 0	4

existing directors.				
The committee is effectively performing by reviewing and making recommendations on Board composition, size, structure, policies and procedures, by-law amendments, and attendance.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by developing a program to recruit, select, and appraise the CEO and, through annual reviews, to determine CEO compensation.	75.00% 3	25.00% 1	0% 0	4
The committee is effectively performing by ensuring succession planning is in place for the CEO and senior management.	75.00% 3	25.00% 1	0% 0	4

RESPONSES

Strategies for succession, discussion about board members strengths and weaknesses as well as appointment to the executive committee or to the actual committees should probably be discussed at the governance meetings but as far as I know, this has not happened. The survey is being approved and sent out but the results are not being discussed. I am assuming the current executive committee is filling this role.

Chair Effectiveness

	 Fully Satisfactory	 Could Improve	 Unknown	Total
The Chair is prepared for committee meetings.	100.00% 4	0% 0	0% 0	4
The Chair keeps the meetings on track.	100.00% 4	0% 0	0% 0	4
The Chair fairly reports the committee's work to the Board.	100.00% 4	0% 0	0% 0	4
The Chair encourages participation and manages discussion.	100.00% 4	0% 0	0% 0	4

RESPONSES

There are no responses.

Overall Committee Performance

	Fully Satisfactory	Could Improve	Unknown	Total
Overall, I am satisfied with my contribution to the committee.	75.00% 3	25.00% 1	0% 0	4
Overall, I am satisfied with the committee's contribution to the Board.	100.00% 4	0% 0	0% 0	4

RESPONSES

There are no responses.

Comments and Suggestions for improvement to committee processes:

RESPONSES

There are no responses.

Overview:

Overall, the survey results show that the Governance & Nominating Committee is functioning effectively, with strong satisfaction across all five domains.

This year's feedback identified opportunities to strengthen committee orientation and education, succession planning, and the discussion and use of evaluation results.

Actions for Consideration:

- Ensure committee and Board evaluation results for succession planning are formally reviewed and discussed. This would be added to the workplan in March during the review of the Board Succession Plan.

Questions for consideration:

- Based on the results of the survey, are there areas the Committee would like to explore alternate ways of accomplishing its work?
- Are there other areas the Committee would like to develop actions to support the Committees effectiveness?

IMPLEMENTATION & COMMUNICATION PLAN

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

- Results and associated actions to be shared with HGMH Board in October 2026

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- 2025-2026 Governance & Nominating Committee Effectiveness Survey Results

Q1 4 responses

Terms of Reference and Composition

	 Fully Satisfactory	 Could Improve	 Unknown	Total
The committee has clear and appropriate Terms of Reference.	100.00% 4	0% 0	0% 0	4
The committee has the right number of members.	100.00% 4	0% 0	0% 0	4
The committee has members with the skills and expertise that are needed by the committee.	100.00% 4	0% 0	0% 0	4
				12

Q2 For any answer above you marked as "could improve", please provide details below.

Answered: 0 Skipped: 4

#	RESPONSES	DATE
	There are no responses.	

Q3 4 responses

Committee Management

	 Fully Satisfactory	 Could Improve	 Unknown	Total
The committee meets at the appropriate time of day.	100.00% 4	0% 0	0% 0	4
I received orientation to the committee that was helpful to me as a member of the committee.	75.00% 3	25.00% 1	0% 0	4
The committee is receiving the support from hospital management that it requires.	100.00% 4	0% 0	0% 0	4
Information is received sufficiently in advance of the meeting.	100.00% 4	0% 0	0% 0	4
The committee meets the right number of times over the year.	100.00% 4	0% 0	0% 0	4
				20

Q4 For any answer above you marked as "could improve", please provide details below.

Answered: 1 Skipped: 3

#	RESPONSES	DATE
1	The committee functions well. Developing a committee orientation program for all committees would be helpful to get committee members to participate with confidence more quickly. The orientation could train on goals and objectives of this committee, list of training material that can be done at home, concrete examples of topics that have come up in the past, etc...	6/16/2026 7:51 AM

Q5 4 responses

Committee Effectiveness

	 Fully Satisfactory	 Could Improve	 Unknown	Total
The committee is working effectively.	100.00% 4	0% 0	0% 0	4
The committee performed its annual workplan.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by providing appropriate nominees for election to the Board of Directors.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by ensuring an appropriate orientation and education program for members.	75.00% 3	25.00% 1	0% 0	4
The committee is effectively performing by organizing, with the input of the CEO and Board Chair, the Board retreats.	75.00% 3	25.00% 1	0% 0	4
The committee is effectively performing by selecting and recommending nominees for Chair, Vice-Chair, and Treasurer of the Board.	75.00% 3	0% 0	25.00% 1	4
The committee is effectively performing by ensuring succession planning for the office of the Board.	75.00% 3	25.00% 1	0% 0	4
The committee is effectively performing by ensuring periodic review and evaluation of committee performance and Terms of Reference.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by recommending to the Board with the input of the Chair, nominees for all Board committees and Committee Chairs.	75.00% 3	0% 0	25.00% 1	4
The committee is effectively performing by establishing a program to evaluate the performance of the Board, Board Chair, Board members, and Board Committees.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by considering the results of Board evaluations in connection with renewal of terms of	100.00% 4	0% 0	0% 0	4
				56

existing directors.				
The committee is effectively performing by reviewing and making recommendations on Board composition, size, structure, policies and procedures, by-law amendments, and attendance.	100.00% 4	0% 0	0% 0	4
The committee is effectively performing by developing a program to recruit, select, and appraise the CEO and, through annual reviews, to determine CEO compensation.	75.00% 3	25.00% 1	0% 0	4
The committee is effectively performing by ensuring succession planning is in place for the CEO and senior management.	75.00% 3	25.00% 1	0% 0	4
				56

Q6 For any answer above you marked as "could improve", please provide details below.

Answered: 1 Skipped: 3

#	RESPONSES	DATE
1	Strategies for succession, discussion about board members strengths and weaknesses as well as appointment to the executive committee or to the actual committees should probably be discussed at the governance meetings but as far as I know, this has not happened. The survey is being approved and sent out but the results are not being discussed. I am assuming the current executive committee is filling this role.	6/16/2026 7:51 AM

Q7 4 responses

Chair Effectiveness

	 Fully Satisfactory	 Could Improve	 Unknown	Total
The Chair is prepared for committee meetings.	100.00% 4	0% 0	0% 0	4
The Chair keeps the meetings on track.	100.00% 4	0% 0	0% 0	4
The Chair fairly reports the committee's work to the Board.	100.00% 4	0% 0	0% 0	4
The Chair encourages participation and manages discussion.	100.00% 4	0% 0	0% 0	4
				16

Q8 For any answer above you marked as "could improve", please provide details below.

Answered: 0 Skipped: 4

#	RESPONSES	DATE
	There are no responses.	

Q9 4 responses

Overall Committee Performance

	Fully Satisfactory	Could Improve	Unknown	Total
Overall, I am satisfied with my contribution to the committee.	75.00% 3	25.00% 1	0% 0	4
Overall, I am satisfied with the committee's contribution to the Board.	100.00% 4	0% 0	0% 0	4
				8

Q10 For any answer above you marked as "could improve", please provide details below.

Answered: 0 Skipped: 4

#	RESPONSES	DATE
	There are no responses.	

Q11 Comments and suggestions for improvement to committee processes:

Answered: 0 Skipped: 4

#	RESPONSES	DATE
	There are no responses.	

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 30, 2026 Meeting Date Prepared for: October 8, 2026

Subject: Annual Review of Committee Terms of Reference

Prepared by: Robert Aldred-Hughes, President & CEO

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

PURPOSE

- To review the Terms of Reference as recommended by the Board Committees and make recommendation to the Board of Directors.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee recommend to the Board of Directors Committee Terms of Reference 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.

- Terms of Reference are reviewed annually by all Board Committees to ensure they remain relevant and effective in guiding the committee's activities and responsibilities.

Governance and Nominating Committee:

- The existing Governance and Nominating Committee Terms of Reference continue to accurately reflect the role, responsibilities, and membership of the Governance and Nominating Committee. They provide clear guidelines on the committee's governance and nominating functions, ensuring that all essential duties are covered.

Finance, HR, and Audit Committee:

- The Terms of Reference were reviewed by the Finance, HR, and Audit committee with a minor change to make it clear that there is no internal auditor position at the hospital.
- The title of the VP & CFO was also updated.

Quality & Patient Safety Committee:

- The existing Quality & Patient Safety Committee Terms of Reference continue to accurately reflect the role, responsibilities, and membership of the committee. There were no suggested changes from the committee.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Governance and Nominating Committee Terms of Reference
- Finance, HR and Audit Committee Terms of Reference
- Quality & Patient Safety Terms of Reference

TERMS OF REFERENCE OF THE GOVERNANCE & NOMINATING COMMITTEE

ROLE:	• To advise the Board on matters relating to the Board's governance structure and processes, evaluation of the Board's effectiveness, recruitment, education, and evaluation of Board members. • To advise the Board on the selection and recruitment, of the CEO and COS.
RESPONSIBILITIES:	a) Board Recruitment • Develop for approval by the board a description of the skills, experience and qualities including diversity of the directors and ensure French-speaking representation as per bylaw 4(3)(e); • Consider skills, experience, qualities, and diversity of current directors to determine the Board's needs; and, • Oversee the Board's recruitment and nomination process and recommend to the Board candidates for election at the Annual Meeting. b) Board Education • Ensure a comprehensive orientation session is provided to all new Board members; • Oversee Board education sessions to ensure Board members receive periodic education on governance, health care issues and the hospital operations; and, • Organize with the input of the CEO and Board Chair, the Boards retreats. c) Board Chair • Ensure succession planning for the office of Board • Oversee and complement the Board's process for selecting a Board Chair and recommend an individual for election by the Board as Chair; and, • Make recommendations to the Board for Vice Chair and Treasurer. d) Board Committees • Ensure periodic review and evaluation of committee performance and Terms of Reference and make recommendations for the Board as required; and, • Recommend to the Board, with the input of the Chair, nominees for all Board Committees and Committee Chairs. e) Evaluations • Establish and implement a program to evaluate Board performance including individual director performance, performance of the Chair, Board Committees and Committee Chairs; • Consider the results of Board evaluations in connection with renewal of the terms of existing directors; and, • Review and make recommendations to the Board on the Board composition, size, structure, board policies and procedures, by-law amendments and board attendance.

TERMS OF REFERENCE OF THE GOVERNANCE & NOMINATING COMMITTEE



	f) Executive Management Performance - Developing and appraising the CEO and COS job descriptions; - Undertaking CEO and COS recruitment processes and selection of the CEO and COS or delegating to subcommittee; - Ensuring succession planning is in place for the CEO, COS. g) Inclusion, Diversity, Equity & Anti-Racism (IDEA) - Ensure the hospital's strategic plan incorporates IDEA principles. - Review and recommend policies that promote IDEA within the organization, and holding leadership accountable for implementing and maintain these standards across the hospital. - Regular monitor progress on IDEA initiatives and key performance measures.
CHAIR:	- A member of the Committee appointed by the Board on the recommendation of the Board Chair or a committee established by the Board for that purpose. - Term of office will be for a minimum of two (2) years
MEMBERSHIP:	- Chair of the Board; - At least four Directors appointed by the Board (minimum one bilingual Director in English and French); - Chief Executive Officer as an <i>ex officio</i> member.
VACANCY:	When a vacancy occurs among the appointed members, the Chair of the board may appoint a member to fill the vacancy for the unexpired portion of the term
VOTING MEMBERS :	Only board directors appointed to this committee may vote.
FREQUENCY OF MEETINGS AND MANNER OF CALL :	At least 6 times per year, at the call of the chair
QUORUM:	51% of voting members.
RESOURCES:	- Chief Executive Officer - Guests, by invitation
REPORTS TO	Board of Directors
DATE OF LAST REVIEW	October 2025<u>2026</u>

Approved by: Corporation of l'Hôpital Glengarry Memorial Hospital

TERMS OF REFERENCE FINANCE, HUMAN RESOURCES, AND AUDIT COMMITTEE OF THE BOARD



ROLE:	• Responsible on behalf of the board of directors (the “Board”) for oversight of financial matters and the annual external audit. • To provide oversight over the planning of construction, renovation and maintenance of infrastructure and associated equipment. • Assist the Board in fulfilling its obligations relating to human resources and compensation matters.
RESPONSIBILITIES:	<i>Budget Planning and Oversight</i> • Ensure that there are processes in place for the development of an annual operating budget and capital budget. • Review and recommend to the board financial assumptions used to develop operating budget, capital budget and strategic plan. • Review and recommend to the board the annual operating plan and budget, and the capital plan and budget; • Review on a routine basis financial performance and compare actual performance against budget including year-end projections. • Review and recommend to the Board plans developed by management to address variances between budget and actual performance. • Oversee implementation of plans to address variances and report to the Board. <i>Long-Term Planning</i> • Oversee and assess achievement of the financial aspects of the strategic plan. • Review and recommend to the Board multi-year financial goals and long-term revenue and expense projections. • Review, with management, industry developments and legislative changes that may have an impact on financial resources or performance and report to the Board. <i>Asset Management</i> • Ensure there are processes in place to manage the assets of the Corporation. • Review and make recommendations on material asset acquisitions not contemplated in the annual capital plan. <i>Financial Transactions</i> • Review and make recommendations to the Board on

TERMS OF REFERENCE FINANCE, HUMAN RESOURCES, AND AUDIT COMMITTEE OF THE BOARD



	banking arrangements. - Review and make recommendations to the Board on lines of credit and long-term debt. <i>Donations and Bequests</i> Advise the Board on major gifts that involve donor recognition agreements and related policies. <i>Investments</i> - Review and recommend to the Board the Corporation's investment policy. - Oversee investment performance for compliance with the investment policy. <i>Internal Controls, Risk Management, and Oversight of Internal Audit</i> - Oversee, review, and make recommendations to the Board on management's risk management processes. - Review and make recommendations on the adequacy of financial resources. - Review and make recommendations on insurance coverage. - Obtain reasonable assurance from management that the Corporation's financial accounting systems and financial reporting systems, including fraud prevention and risk management, are appropriately designed and that internal controls are operating effectively. - Identify unusual risks and oversee management's plan to address unusual or unanticipated risks and make recommendations to the Board. - Review and make recommendations on the quality and integrity of management's internal controls, including scope of work of the internal auditor and overseeing management's response and resulting action plans to address issues or deficiencies identified by internal auditor <u>any internal audit as required</u>. <i>External Audit</i> - Recommend to the Board the external auditor for appointment or re-appointment by the members at the annual members' meeting. - Annually review and make recommendations to the Board on the external auditor's remuneration. - Meet with the external auditor to review the proposed scope of audit.
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TERMS OF REFERENCE FINANCE, HUMAN RESOURCES, AND AUDIT COMMITTEE OF THE BOARD



- Review, approve, and authorize management to execute the external auditor's engagement letter.
- Oversee performance of the external audit as required, including ensuring the external auditor is receiving the assistance of management.
- Review audited financial statements and the external auditor's report and make recommendations to the Board.
- Meet with the external auditor and receive and review recommendations with respect to management, accounting systems, and internal control issues.
- At least annually, the elected director committee members shall meet with the external auditor without management present.
- Review non-audit services provided by the external auditor and other factors that might compromise the external auditor's independence and make recommendations to ensure independence.
- Review management's response to internal control recommendations of the external auditor and oversee implementation of internal control recommendations.

Human Resources

- Review, together with the chief executive officer and chief of staff, existing staff and physician management resources and plans, including recruitment and learning programs.
- Participate in the creation of the Corporation's strategic plan and provide input from a human resources perspective.
- Review on an annual basis the Corporation's human resources plan to ensure alignment with the strategic plan for the organization.
- Receive and review on a periodic basis a report on the human resources' performance indicators.

Building and Property

- Make recommendations to the board for the purchase of equipment, property, renovations to existing building or construction of new buildings.
- Make such recommendations in conjunction with the annual capital budget with exceptions for emergency purchases.

Compliance with Applicable Law

- Oversee compliance with accounting and financial, legal, public disclosure, and regulatory requirements.
- Approve material changes to accounting principles and practices as suggested by management with the

TERMS OF REFERENCE FINANCE, HUMAN RESOURCES, AND AUDIT COMMITTEE OF THE BOARD



	concurrence of the external auditor. Other • Perform such other duties as may be requested by the Board from time to time.
CHAIR:	• Treasurer of the Board
MEMBERSHIP:	• The Treasurer • The Board Chair, or their designate • The Chief Executive Officer, ex officio • The VP of <u>Support Corporate</u> Services and Chief Financial Officer, ex officio • A minimum of three elected Directors of the Board (minimum one bilingual Director in English and French) • Invited guests may attend committee meetings at the invitation of the Chair • In accordance with the Ontario <i>Not-for-Profit Corporation Act</i>, 2010, the committee shall be comprised exclusively of directors of the Corporation, and the majority of committee members must not be officers or employees of the Corporation or any of its affiliates¹
MEETING PARTICIPATION	• Notice of the time and place of committee meetings shall be given to the external auditor.² The external auditor shall be entitled to attend committee meetings and to be heard, and shall attend every committee meeting if requested to do so by a committee member.³ • The Vice President of Support Services and Chief Financial Officer of the Corporation, <i>ex officio</i>, shall be invited to attend and participate in these meetings as a guest, but shall not have a vote. • The Chief Human Resources Officer, <i>ex officio</i>, shall be invited to attend and participate in these meetings as a guest, but shall not have a vote.
VACANCY:	• When a vacancy occurs among the appointed members, the Chair of the board may appoint a member to fill the vacancy for the unexpired portion of the term.

¹ ONCA, s. 80(1), provides that a corporation may have an audit committee comprising one or more directors and the majority of the committee must not be officers or employees of the corporation or of any of its affiliates.

² ONCA, s. 80(2) provides that the corporation shall give the auditor notice of the time and place of any meeting of the audit committee. The auditor is entitled to attend the meeting at the expense of the corporation and be heard, and shall attend every meeting of the committee if requested to do so by one of its members.

³ ONCA, s. 80(2).

TERMS OF REFERENCE FINANCE, HUMAN RESOURCES, AND AUDIT COMMITTEE OF THE BOARD



VOTING MEMBERS :	Only board directors appointed to this committee may vote.
FREQUENCY OF MEETINGS AND MANNER OF CALL:	At least six (6) times annually, at the call of the committee chair. Meetings may also be held at the call of the external auditor or a committee member.⁴
QUORUM:	51% of voting members.
RESOURCES:	VP of Support Services and Chief Financial Officer
REPORTS TO	Board of Directors
DATE OF LAST REVIEW	September 2025<u>September 2026</u>

⁴ ONCA, s. 80(3) provides that the auditor or a member of the audit committee may call a meeting of the committee.

TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD



ROLE:	- The Quality and Patient Safety Committee operates under the authority of the Board and is the Quality Committee for the purposes of the Excellent Care for All Act, 2010 (the “Act”). The Quality and Patient Safety Committees role is to: - Assist the Board in the performance of the Board's governance role for the quality of patient care and services; and - Perform the functions of the Quality Committee under the Act. - Guide the strategic priority of Quality & Safety.
RESPONSIBILITIES:	The Quality Committee, in accordance with the responsibilities in the Act, shall: <i>Quality Oversight and Quality Improvement</i> - 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 including: - Performance indicators used to measure quality of care and services and patient safety; - Reports received from the Medical Advisory Committee identifying and making recommendations regarding systemic or recurring quality of care issues; - Publicly reported patient safety indicators; - Critical incident and sentinel event reports; - Patient Satisfaction Survey Results; - Complaints, source of complaints, and interventions; - Quality Indicator Dashboard. - Consider and make recommendations to the board regarding quality improvement initiatives and policies; - Ensure that best practices information supported by available scientific evidence is translated into materials that are distributed to employees, members of the professional staff and persons who provide services within the hospital, and subsequently monitor the use of these materials by such persons; - Oversee preparation of the hospital’s annual quality improvement plan; and - Perform such other responsibilities as may be provided under regulations under the Act. <i>Critical Incidents and Sentinel Events</i> “Critical incident” means any unintended event that occurs when a patient receives treatment in the hospital: - That results in death, or serious disability, injury or harm to the patient; and - Does not result primarily from the patient’s underlying medical condition or known risk inherent in providing treatment. In accordance with Regulation 965 under the Public Hospitals Act, receive from the Chief Executive Officer, at least twice a year, aggregate critical

TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD



incident data related to critical incidents occurring at the hospital since the previous aggregate data was provided to the quality committee. Annually review and report to the board on the hospital's system for ensuring that, at an appropriate time following disclosure of a critical incident, there be disclosure as required by Regulation 965 under the Public Hospitals Act of systemic steps, if any, the hospital is taking or has taken to avoid or reduce the risk of further similar critical incidents.

The quality committee shall review reports of sentinel events and oversee any plans developed to address, prevent or remediate such events.

Compliance

- Monitor the hospital's compliance with legal requirements and applicable policies of funding and regulatory authorities related to quality of patient care and services.

Financial Matters

- As and when requested by the board, provide advice to the board on the implications of budget proposals on the quality of care and services.

Hospital Services Accountability Agreement and Hospital Annual Planning Submission (HAPS)

- As and when requested by the board, provide advice to the board on the quality and safety implications of the hospital annual planning submission and quality indicators proposed to be included in the hospital's service accountability agreement or in any other funding agreement.

Risk Management

Review and make recommendations with respect to:

- The hospital's standards on emergency preparedness;
- Policies for risk management related to quality of patient care and safety; and
- Areas of unusual risk and the hospital's plans to protect against, prepare for, and/or prevent such risks and services.

Accreditation

- Oversee the hospital's plan to prepare for accreditation.
- Review accreditation reports and any plans that need to be implemented to improve performance and correct deficiencies.

Professional Staff Process

- Annually review with the chief of staff/chair of the medical advisory committee the appointment and re-appointment processes for the professional staff, including:
 - Criteria for appointment;
 - Application and re-application forms;
 - Application and re-application processes; and
 - Processes for periodic reviews.

TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD



	- Ensure coordination and alignment with the Corporation's medical advisory committee for physician human resource planning. Policy Implementation - Oversee implementation of policies, processes and programs to ensure quality objectives are met and maintained. Other - Perform such other duties as may be assigned by the board from time to time.
CHAIR:	- A member of the Committee appointed by the Board on the recommendation of the Board Chair or a committee established by the Board for that purpose. - Term of office will be for a minimum of two (2) years.
MEMBERSHIP:	- The Chief of Staff - The Chief Executive Officer - The Chief Nursing Executive - One (1) health professional other than a nurse or doctor - Five (5) voting board members (minimum one bilingual Director in English and French), and - Such other persons as appointed by the hospital's board.
VACANCY:	When a vacancy occurs among the appointed members, the Chair of the board may appoint a member to fill the vacancy for the unexpired portion of the term.
VOTING MEMBERS:	Only Board Directors appointed to this committee may vote.
FREQUENCY OF MEETINGS AND MANNER OF CALL	At least six (6) times annually, at the call of the committee chair.
QUORUM:	51% of voting members.
RESOURCES:	VP of Clinical Services, Quality & Chief Nursing Executive
REPORTS TO	Board of Directors
DATE OF LAST REVIEW	September 20252026

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 30, 2026 Meeting Date Prepared for: October 8, 2026
 Subject: Q1 Strategic Actions Report – 2026/2027
 Prepared by: Robert Aldred-Hughes, President & CEO

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

PURPOSE

The purpose of this briefing is to provide the Governance Committee with an update on progress against HGMH's Strategic Action Report for Q1 2026/2027.

Strategic actions are developed annually to advance HGMH's 2023–2028 Strategic Plan and provide measurable actions under our four strategic priorities: Quality & Safety, People & Culture, Integration & Standardization, and Future Planning.

Quarterly reporting provides the Board with oversight of progress, identifies emerging risks or barriers, and supports accountability for implementation.

RECOMMENDATION / MOTION

THAT the Governance & Nominating Committee recommend to the Board of Directors the receipt of the Q1 2026/2027 Strategic Action Report.

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 Q1 Strategic Action Report represents the first formal progress update against the 2026/2027 annual priorities established to advance HGMH's 2023–2028 Strategic Plan.
- Overall, implementation is progressing as planned. All strategic actions have advanced during the first quarter, with no actions currently identified as at risk or requiring a formal mitigation plan.
- The first quarter has largely focused on establishing the foundations required for implementation throughout the remainder of the year. Several initiatives have moved from planning into active implementation, while others have established the teams, partnerships, education and operational structures required to support further progress.
- Q2 will represent an important period of execution for the organization. In particular, preparations for the October 24, 2026 Epic go live will require significant organizational attention alongside continued advancement of the CT project and other strategic commitments.
- Management will continue to monitor progress, organizational capacity and emerging risks throughout the year and will bring forward any material issues that may affect achievement of the Strategic Action Plan.

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.

- The 2026/2027 Strategic Action Plan includes several significant initiatives being advanced concurrently with day to day hospital operations. While individual actions are progressing, the cumulative demands on leadership and staff capacity will require continued attention as implementation activity increases through the year.
- The most significant near term organizational impact will be the Epic go live in October. Training, scheduling, backfill and operational readiness will place additional demands on teams and may temporarily affect the pace of other strategic work.
- Several actions also depend on factors outside of HGMH's direct control, including external approvals and partnership activities. The CT project in particular will continue to require coordination with other partners as it moves from planning toward implementation.
- Management will balance these competing priorities through the year and adjust sequencing where necessary to protect operational capacity while continuing to advance the commitments established in the Strategic Action Plan. Material changes to timelines, scope or risk will be identified through subsequent quarterly reporting.

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

- Q1 Strategic Action Report

2026-2027 Strategic Action Report Q1

Strategic Dimension	Strategic Direction	Executive Lead	Action	Progress		Status / %
Quality & Safety	<i>Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.</i>	Robert Alldred-Hughes	Advance CT implementation by completing detailed planning for infrastructure, equipment procurement, clinical model design, staffing strategy, and operational integration to support service launch readiness.	Q1	RFP and space design process has been completed for both the CT Equipment and Turnkey Construction. Submission made to MOH Capital Branch to support approval to proceed.	10%
				Q2		
				Q3		
				Q4		
		Rachel Romany	Implement the RNAO Best Practice Guideline for wound care to strengthen evidence-based assessment, prevention, and management practices across the organization.	Q1	Established a dedicated wound care team led by the IPAC Nurse with RPN support. Team members have applied to complete a five-month wound care course starting in August to build expertise and support implementation of the RNAO Best Practice Guideline.	25%
				Q2		
				Q3		
				Q4		
		Robert Alldred-Hughes	Collaborate with PFAC to co-design and implement a priority improvement initiative that enhances the patient and family experience.	Q1	PFAC meeting has occurred to determine which initiative they would like to advance this year. Focus has been determined to support the development of a patient advisor framework and role description.	25%
				Q2		
				Q3		
				Q4		
People & Culture	<i>Improve engagement by investing in the organizations people and empower a caring and positive culture for all.</i>	Kayla MacGillivray	Advance implementation of an organization-wide Learning Management System to standardize training delivery, monitor mandatory education compliance, and enhance workforce development.	Q1	Vendors were met with and the project team selected Dual Code, an Ottawa-based organization. The project was kicked off in June.	70%
				Q2	The platform has a soft go-live on August 10, 2026 as we continue to populate the education programs.	

				Q3		
				Q4		
		Rachel Romany	Advance comprehensive NVCI training across patient-facing teams to enhance de-escalation capability and reduce workplace violence risk.	Q1	An internal NVCI instructor has been certified, with staff training beginning July 23. Phase 1 includes ED, Diagnostic Imaging, and Registration staff, followed by inpatient and Allied Health teams. NVCI training will be added to new staff orientation in January 2027.	25%
				Q2		
				Q3		
				Q4		
		Kayla MacGillivray	Execute priority IDEA initiatives, including gender identity education, integration of patient voice in committee governance, cultural safety learning experiences, and implementation of an anti-racism lens in organizational policy review.	Q1	Gender-identity training was launched on the intranet. A corporate IDEA policy has been developed and is currently going through the approval processes.	30%
				Q2		
				Q3		
				Q4		
		Kayla MacGillivray	Advance implementation of the psychological safety strategy by delivering targeted training and reinforcing leadership accountability.	Q1	Commitment from Senior Leadership was signed. The Program was shared with all staff. Guarding Minds at Work survey was launched.	20%
				Q2		
				Q3		
				Q4		
Integration & Standardization	Deliver standardized quality care in a cost-effective way through collaboration & integration opportunities.	Rachel Romany	Achieve successful Epic EMR go-live by executing required clinical, operational, and technical readiness activities across the organization.	Q1	Achieved 56% end-user training registration against the initial 50% target. Current focus is coordinating staff schedules and backfill, with a goal of reaching 100% registration by August 21 to support Epic readiness with a go-live date of October 24, 2026.	25%
				Q2		
				Q3		
				Q4		
		Robert Alldred-Hughes	Advance Endoscopy Program expansion through targeted business development, partnership engagement, and operational capacity planning.	Q1	Opportunity is progressing well. The surgeons are supportive of the opportunity to increase endoscopy. Working through billing support, and requisition	25%

Future Planning	Invest in the sustainability of our equipment & infrastructure to support safe, quality care.				development. Referring physicians supportive of new referral pattern.	
				Q2		
				Q3		
				Q4		
		Linda Ramsay	Implement an Infrastructure Renewal Strategy to ensure infrastructure investments are sequenced, risk-informed, and aligned with the hospital's long-term redevelopment direction.	Q1	Infrastructure Renewal Strategy Executive Summary and a Facilities Operations and Maintenance Operational Plan have been drafted.	25 %
				Q2		
				Q3		
				Q4		
		Linda Ramsay	Develop and implement an Environmental Stewardship Plan to guide energy efficiency, waste reduction, and sustainable operations.	Q1	First meeting of the committee was held in July. Terms of reference were drafted and reviewed by the committee members.	25 %
				Q2		
				Q3		
				Q4		

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors

☒ Board Committee – Governance

☐ Senior Leadership Team

☐ Other (please specify):

Date Prepared: September 18, 2026

Meeting Date Prepared for: October 8, 2026

Subject: Communications and Community Engagement Plan

Prepared by: Robert Aldred-Hughes, President & CEO

☐ DECISION SOUGHT*

☒ FOR DISCUSSION/INPUT

☐ FOR INFORMATION ONLY

PURPOSE

- To review the hospital Communications and Community Engagement Plan to ensure the plan aligns with organizational goals and communication needs and meets accreditation standards.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee review and receive the Communications and Community Engagement Plan 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.

- Effective communication is essential to maintaining transparency both internally and externally to also help build and retain community trust.
- The hospital developed a communication plan in 2022. The plan has since evolved into the Communications and Community Engagement Plan, reflecting the hospital's broader approach to both communication and stakeholder engagement.
- The plan serves as the framework for internal and external communications and guides how the hospital communicates and engages with staff, physicians, patients, families, community partners, stakeholders and the public.
- The plan is reviewed annually to ensure continued alignment with applicable legislative requirements, including the French Language Services Act and Accessibility for Ontarians with Disabilities Act, as well as the hospital's strategic priorities, key initiatives, accreditation requirements and evolving communication needs.
- Upon review of the Communications and Community Engagement Plan, Management is not recommending any major changes at this time. Town Hall sessions were updated to be quarterly to allow for more conversation with staff and physicians on key initiatives throughout the year.
- Management completed its annual review of the Communications and Community Engagement Plan. No substantive changes are recommended at this time. Minor administrative and editorial updates have been incorporated to ensure the plan remains accurate and current. The plan is presented to the Governance and Nominating Committee for review and feedback.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Communications and Community Engagement Plan

Communications & Community Engagement Plan



HÔPITAL
**Glengarry
Memorial**
HOSPITAL



Effective: Oct 2022	Last review/revision: Oct 2026	Next Review: Oct 2027
Owner: Communications Officer		Signing Authority: Senior Leadership
PLN-001-0-26		

Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

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Background

Established in 1965, Hôpital Glengarry Memorial Hospital has been a cornerstone of healthcare in Alexandria, Ontario. It provides acute care, 24-hour emergency services, outpatient services, and rehabilitation to over 41,000 residents annually. Our team of over ~~180~~ 220 staff members, 50 Medical Staff members, and 100 volunteers are dedicated to delivering high-quality health care to our Eastern Ontario community.

Our Mission

Delivering outstanding care for our communities.

Our Vision

Providing your care, your way with seamless integration, innovation, and equitable access for our communities.

Our Values

Our 'PACT' is our promise to have Passion, Accountability, Compassion & Teamwork at the heart of all we do, everyday.

Executive Summary

Effective communication is the process of sharing ideas and information in such a way that the content is received and understood in the way it was intended through a variety of channels to ensure understanding, collaboration, and trust among internal and external audiences. This includes day-to-day operational updates, announcements, crisis communication, health education, and promotional content.

HGMH's Communications & Community Engagement Plan is intended to guide the organization in communicating with its various stakeholders and ensure that the right people have the right information when they need it. This work requires that we provide information by the most appropriate method(s) to maximize clarity, conciseness, understanding, and transparency. All communication that is public facing will be available in both official languages (English and French) to align with the hospital's designation as a French Language Service hospital (as per the French Language Services policy BOD.01.002).

Community engagement refers to the process of building strong, reciprocal relationships with patients, families, and groups in the broader community. It involves listening, learning, and collaborating with stakeholders. The goal is to foster trust, reflect community voices, and ensure services and communications are culturally safe, inclusive, and responsive to community needs.

Communications

Stakeholders

The stakeholders listed below reflect the individuals, groups, and organizations with whom HGMH maintains strategic, operational, regulatory, and community relationships. Distribution ensures transparency, accountability, and engagement with those who have a vested interest in the hospital's performance and achievements.

Key themes that could be communicated are:

- **Strategic Direction & Accountability:** Annual Report; progress on Strategic Plan; governance and policy updates; hospital performance metrics
- **Clinical Excellence & Patient Care:** Accreditation readiness; patient safety initiatives; quality improvement updates; new/expanded services; recruitment successes
- **Workforce Engagement & Recognition:** recognition of staff, physicians and volunteers; milestones & retirements; professional development and training; IDEA initiatives
- **Community Impact & Partnerships:** partnerships within the community
- **Advocacy & Government Relations:** capital project needs; hospital funding priorities; alignment with municipal/federal priorities; small hospital advocacy
- **Education & Training Opportunities:** Student placement opportunities; partnerships with nursing/allied health institutions
- **Philanthropy & Fundraising:** Foundation campaign updates; impact of donations; capital equipment needs
- **Public Awareness & Media Relations:** Hospital news & service updates; health promotion & prevention campaigns; Care Champion stories; system updates of public interest

Stakeholder Group	Stakeholders	Key Themes for Communications & Engagement
Internal Governance & Leadership	• HGMH Board of Directors • HGMH Senior Leadership Team • HGMH Management Team • HGMH Medical Advisory Committee (MAC) • Department Chiefs	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Advocacy & Government Relations • Philanthropy & Fundraising
Hospital Staff, Physicians, and Volunteers	• All HGMH staff (via internal email and intranet) • Credentialed physicians and allied health professionals • Volunteer Auxiliary	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Education & Training Opportunities
Community Partners & Political Stakeholders	• Township of North Glengarry (Mayor, Council, CAO) • Township of South Glengarry (Mayor, Council, CAO)	• Community Impact & Partnerships • Advocacy & Government Relations

	• United Counties of Stormont, Dundas, and Glengarry (Council, CAO) • Local First Nations leadership - Mohawk Council of Akwesasne • MPP Prescott, Russell, & Glengarry • MPP Cornwall, Stormont, Dundas, and South Glengarry • MP Cornwall, Stormont, Dundas, Glengarry	
Healthcare and System Partners	• Ontario Health East Region • Ministry of Health - Ontario • Eastern Ontario Health Unit • Great River Ontario Health Team (OHT) partners • Regional hospitals and healthcare alliances (e.g., Atlas Alliance members) • Champlain Alliance of Small Hospitals	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Advocacy & Government Relations
Educational & Training Partners	• Nursing and allied health educational institutions partnered with HGMH • Medical residency and student placement programs	• Education & Training Opportunities
Fundraising & Philanthropic Partners	• HGMH Foundation Board of Directors & Staff	• Strategic Direction & Accountability • Philanthropy & Fundraising
Public & Media	• Local and regional media outlets • Posting on the HGMH public website and social media channels • Community members via newsletters and public engagement events	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Philanthropy & Fundraising • Advocacy & Government Relations • Public Awareness & Media Relations

This stakeholder distribution list will be reviewed annually by the Governance Committee to ensure accuracy, completeness, and alignment with Accreditation Canada requirements.

Planning Communication

With each communication, the following questions should be considered:

- Why is this important to communicate? (**What is the purpose?**)
- With whom do we want to communicate? (**Who are the stakeholders?**)
- What do we want to communicate? (**What is the message?**)
- How do we want to communicate it and through which medium? (**What communication tools are to be used?**)
- What is the timeline of communications / presentations? (**Define when and who plans, prepares, and presents**)
- What needs to be developed? (**Develop material, ads, news articles, etc.**)

The answers to these questions will establish the Communications Action Plan (51-A-293) to communicate successfully with the intended audience. This action plan will focus on the messaging, making it possible to target the stakeholders accurately, providing structure to define who HGMH needs to reach and the medium. This process will make communication more efficient, effective, and long lasting. More importantly, flexibility is key in planning and being prepared to adapt messaging to ensure success.

Guiding Principles

The hospital's approach to communication and engagement is grounded in several core principles:

- **Transparency:** Communicate timely, accurate, and honest information.
- **Accessibility:** Ensure all communication meets accessibility standards and is available in both English and French, in accordance with the hospital's designation under the French Language Services Act (FLSA).
- **Cultural Sensitivity and Inclusion:** Reflect and respect the diversity of the communities we serve.
- **Engagement:** Foster meaningful, two-way communication with staff, patients, families, and community members.
- **Alignment:** Support the hospital's strategic goals, values, and vision.

Goals and Objectives

The overarching goal is to enhance hospital experiences and community trust through clear, consistent, and culturally respectful communication.

Objectives:

- Maintain public trust through proactive messaging.
- Keep staff informed and engaged.
- Promote hospital programs and achievements.
- Respond quickly and effectively in crisis or urgent situations.
- Foster meaningful staff participation in internal initiatives.
- Improve patient and family experiences by promoting two-way dialogue.
- Strengthen community partnerships through inclusive outreach and collaboration.

Key Messages

HGMH aligns its key messages with the four strategic priorities from its strategic plan:

- **Quality and Safety**
 - Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.
- **People and Culture**
 - Improve engagement by investing in the organization's people and empower a caring and positive culture for all.
- **Integration and Standardization**
 - Deliver standardized quality care in a cost-effective way through collaboration & integration opportunities.
- **Future Planning**
 - Invest in the sustainability of our equipment & infrastructure to support safe, quality care.

Communication Tools

HGMH uses several methods to communicate, including:

- Patient and Family Advisory Committee meetings
- Website - www.hgmh.on.ca
- Social Media ([Facebook](#), [Instagram](#), [LinkedIn](#), [YouTube](#))
- Advertising (media releases, news stories, other publications)
- Community engagement / events
- Staff Forums
- Glentranet (Hospital Intranet)
- Town Hall Meetings
- Internal communications:
 - Bi-Weekly Blitz newsletter
 - Weekly Clinical Update newsletter
 - ~~Monthly~~ Quarterly Physician newsletter

Corporate Publications

Annual Report

Following the Annual General Meeting, the hospital's annual report / update to the community is released electronically on the website and communicated via social media. The Annual Report includes a high-level overview of the hospital's achievements, financial performance, strategic initiatives, and community impact over the past year. Hard copies are available upon request.

Strategic Plan

The Hospital's Strategic Plan serves as a guiding framework for a five-year period, outlining the hospital's long-term vision, mission and values as well as the strategic priorities, and commitments to patients, families, staff, and the community. It reflects input from stakeholders across the organization and community and is aligned with regional and provincial healthcare strategies.

The Strategic Plan is published on the hospital's website and shared with staff, physicians, partners, and the broader community through multiple communications channels including newsletters, media releases, and social media. Updates on progress toward Strategic Plan goals are integrated into the Annual Report and Annual Operating Plan. This ensures transparency and accountability, while keeping stakeholders informed of achievements and ongoing priorities.

Hard copies of the Strategic Plan are available upon request to ensure accessibility for all members of the community.

Annual Operating Plan

The Annual Operating Plan is released in May and outlines the hospital's strategic goals and operational priorities for the coming year. It serves as a roadmap for service delivery, quality improvement, and resource allocation, and it supports alignment with regional and provincial healthcare directives.

Patient Handbook

Our Patient Handbook is published annually at no cost to HGMH due to the sponsors who advertise in the publication. Hard copies are available for pick-up in high traffic areas (lobbies and waiting rooms), and electronically on the hospital's website. All admitted patients receive a copy of the Patient Handbook on admission as it outlines important information about patients' rights and responsibilities, hospital policies, services available, and what to expect during their stay.

Program / Service Brochures and Posters

HGMH develops various brochures and posters on an as needed basis to promote programs, services, or provide patient and family education.

Digital Media

Corporate Website

HGMH's website is used to outline programs and service offerings, sharing news updates, and to provide the community with feedback opportunities. The website is maintained by the Communications Officer and continues to evolve with new and improved content as needed.

Newsletters

Internal newsletters are produced and distributed to staff by email and on the intranet to ensure current information is disseminated on a regular basis. The Weekly Clinical Update includes up-to-the-minute information from the clinical managers, highlighting reminders about workflow changes, policy updates, upcoming education opportunities, etc. The Bi-Weekly Blitz is a general newsletter for all staff, which provides updates on internal wellness activities, community events, news from various departments, etc. The monthly physician newsletter is geared towards physicians and includes physician meeting dates, important departmental information, highlights around workflow changes, and policy updates.

Glentranet (intranet site)

The Glentranet site is the go-to place for staff and physicians to find information including memos, reports, hospital committee information, policies and forms, etc., as well as newsletters.

Social Media

Rapid information delivery on a 24/7 news cycle has moved us beyond traditional media to a vastly expanding social media reality. Guided by an internal social media policy, HGMH creates and maintains our presence on Facebook, LinkedIn, and YouTube. Pages are regularly updated with timely content, photographs, and videos related to hospital activities, services, disruptions, provincially recognized health topics, and wellness content.

Visual media has proven an excellent support to ensure the broadest possible reach to our stakeholders, including photographs, infographics, and videos.

Media Relations

We recognize that timely and accurate media attention can support recruitment and retention, employee and community engagement, and fundraising and funding.

HGMH aims to communicate with media in a proactive rather than a reactive manner via designated spokespersons as per the Communications & Hospital Spokesperson policy (BOD.05.018). Planned media briefings occur during times of significant announcements to ensure local media has timely and accurate information available to report to the community.

CEO Communications

CEO communications with stakeholders is an important component to the HGMH communications plan which is designed to provide opportunities to increase stakeholder engagement.

Communication initiatives will allow for both two-way and one-way communication, centered around an approach to ensure CEO communications are *accessible, timely, relevant, and meaningful*. The following communication strategies will be used:

Communication Tactic	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Twice-Quarterly Annual Virtual Town Hall - (and as needed)	✓		✓	✓			✓			✓		
CEO Vlog (video blog)		✓			✓			✓			✓	
Round Table with Rob	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Regular Rounding on Units	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bi-Weekly Blitz CEO Corner		✓		✓		✓		✓		✓		✓
Bi-Weekly Blitz Board of Directors Updates	✓		✓		✓		✓		✓		✓	
Annual Community Engagement Session							✓					
Twice Annual Meeting with Political Leaders	✓						✓					
SLT Patient Rounding	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Annual Report			✓									
Annual Operating Plan		✓										

Public Disclosure

Purpose

HGMH is committed to maintaining transparency, accountability, and trust through proactive public disclosure of information that is of interest and relevance to our patients, families, staff, partners, and community. Public disclosure is a cornerstone of good governance and demonstrates the hospital's commitment to engaging stakeholders in meaningful ways.

Scope of Disclosure

Public disclosure includes, but is not limited to, the following areas:

- **Quality and Safety Indicators:** Regular posting of quality improvement metrics and patient safety indicators in alignment with provincial reporting requirements.
- **Financial Information:** Annual audited financial statements and operating plan updates, made available to the public following approval by the Board of Directors.
- **Executive Compensation:** Disclosure of executive compensation in compliance with the Public Sector Salary Disclosure Act.
- **Board Governance:** Posting of Board meeting highlights, annual reports, bylaws, and strategic priorities.



- Accreditation and Compliance: Publicly sharing results of Accreditation Canada surveys and compliance with relevant healthcare legislation and standards.
- Policies of Public Interest: Ensuring public access to key hospital policies, such as accessibility, privacy, and French Language Services policies.

Channels of Disclosure

Public disclosure will be carried out through the following methods:

- Corporate website (www.hgmh.on.ca) as the primary platform for publicly available documents and updates.
- Annual Report and Annual Operating Plan, distributed electronically and in print upon request.
- Media releases and social media updates for timely, high-profile announcements.
- Community engagement sessions, which provide opportunities for open dialogue and questions regarding disclosed information.

Guiding Principles

- Transparency: Disclose timely, accurate, and honest information to stakeholders.
- Accessibility: Ensure all disclosure materials are available in both English and French and meet Accessibility for Ontarians with Disabilities Act (AODA) standards.
- Clarity: Use plain language to ensure information is understandable to a broad audience.
- Accountability: Align disclosures with legislation, accreditation requirements, and best practices in healthcare governance.
- Engagement: Provide opportunities for community members, patients, and families to participate in governance-related discussions.

Communication in Non-Official or Minority Languages

HGMH recognizes that the community may speak languages beyond English and French. To ensure clear and accurate communications with patients, a professional interpretation services provider which offers interpretation services in all languages including American Sign Language (ASL). This service is offered in accordance with the hospital's Interpretation Service Request policy (COR.03.001.X.XX).

Crisis Communication Protocol

Purpose

To ensure that during any crisis, HGMH provides timely, accurate, clear, and bilingual information to all audiences, using coordinated communication strategies that maintain trust and reduce misinformation.

Definition of a Crisis

A crisis, for the purposes of this plan, is any event or situation that significantly disrupts the hospital's normal operations, poses a risk to safety, or threatens the hospital's reputation. Crises can originate internally or externally and may include:

- Large-scale medical emergencies, such as mass casualty incidents or disease outbreaks.
- Facility issues, including fires, floods, or power outages.
- Medical errors or adverse events that draw public or media attention.
- Security threats, including active shooter situations or bomb threats.
- Cybersecurity breaches or loss of critical patient data.
- Labour actions or significant staff shortages.
- Natural disasters impacting hospital operations.

Objectives

- Maintain consistent, transparent communication during a crisis.
- Provide timely updates to internal and external audiences.
- Ensure communications are accessible, culturally sensitive, and bilingual.
- Fulfill requirements regarding system capacity, backup methods, reunification communications, community preparedness education, partner coordination, staff notification, and language accessibility.

Activation

The crisis communication protocol is initiated when a situation arises that has potential to significantly impact patient safety, staff operations, public perception, or media attention, and where rapid communication is necessary.

Roles in Communication

- **CEO:** Primary spokesperson (or delegate) for official public statements as per the Communications & Hospital Spokesperson policy ([BOD.05.018.X.XX](#)).
- **Communications Officer:** Coordinates all communication activities, drafts and distributes updates, manages website, media relations and social media as per the Social Media policy ([COR.08.005.X.XX](#)).
- **Managers:** Share approved messages with teams and gather feedback/questions for follow-up.
- **Administration On-Call:** Acts as the 24-hour contact point for the organization, ensuring stakeholder inquiries during emergencies are addressed or escalated to the appropriate lead as per the Administration On-Call policy ([COR.01.005.X.XX](#)).

Key Communication Actions

1. **Initial Holding Statement:** Release a brief, factual, and empathetic message acknowledging the situation and advising when further updates will follow.
2. **Audience Identification:** Determine priority audiences (staff, patients/families, media, community partners, public).



3. **Channel Selection:** Choose the most effective mix of channels (email, intranet, website banner, social media, media release).
4. **Update Frequency:** Commit to regular updates, even if the information is unchanged, to reinforce transparency.
5. **Message Consistency:** Ensure all public-facing channels deliver the same core messages.
6. **Compliance with Legislation and Standards:** All communications will comply with applicable laws, regulations, and quality standards, including:
 - a) **Accessibility Requirements:** Ensure content is accessible in accordance with the Accessibility for Ontarians with Disabilities Act (AODA) and other relevant accessibility standards.
 - b) **Privacy laws:** Protect personal and health information in compliance with applicable privacy legislation.
 - c) **French Language Services Requirements:** Provide communications in both English and French, meeting obligations under the French Language Services Act (FLSA).
7. **Monitoring:** Track social media, media coverage, and public feedback to identify and correct misinformation quickly.

Media Management

During a crisis, all media inquiries will be directed to the Communications Officer, who will then report to the President & CEO as per the Communications & Hospital Spokesperson policy (BOD.05.018). This ensures that the hospital speaks with one consistent voice and prevents misinformation from circulating. Press conferences will be held at designated safe locations, and media representatives will be informed of regular update times to avoid constant interruptions to hospital operations.

Social media will be monitored continuously for inaccurate or harmful information, and corrective statements will be issued promptly when needed, always in both English and French.

Staff and Physician Communication

In a crisis, HGMH will ensure that all staff and physicians, including those who are off duty, are kept informed as per the Automated Fanout Communication System policy ([COR.02.019.X.XX](#)).

- **Automated Alerts:** The system will send notifications via phone, text, and email to all staff in the database.
- **Message Content:** Updates will be concise, factual, and will specify whether staff are required to report to work, remain on standby, or take other action.
- **Two-Way Capability:** Where possible, the system will allow staff to confirm receipt or provide status updates back to the hospital.
- **Redundancy:** If the automated system fails, alternate channels such as phone trees, secure messaging apps, or public radio announcements will be used.

System Overload & Backup Communication

HGMH recognizes that communication systems may become overloaded during high-profile crises. To ensure continuity of communication, the hospital will:



- **Ensure Website Readiness:** The hospital's website will be prepared to handle increased traffic, with critical updates presented in simplified formats (minimal graphics/color) to reduce load time.
- **Provide FAQ Management:** A dedicated crisis FAQ page will be maintained to answer common questions and reduce phone/email inquiries.
- **Have a Website Downtime Plan:** If the website is unavailable, updates will be shared through:
 - Social media (Facebook, Instagram, LinkedIn)
 - Media briefings and releases
 - Recorded information on a dedicated public information phone line
- **Use Internal Communication Backup:** If internal email is unavailable, use the intranet (if functioning), secure messaging apps, or pre-printed memos for distribution in key staff areas.

Reunification Communication

HGMH will incorporate communication into its reunification strategy for families during emergencies or disasters. While the operational plan for reunification is covered in the Job Action Sheets under Family Information, the communications component will ensure:

- **Clear Instructions:** Families and friends seeking loved ones receive clear, bilingual directions on how to access reunification support.
- **Designated Updates:** A specific communication channel (e.g., website page, hotline, media briefings) will be used to share information on reunification procedures.
- **Partnership Messaging:** If reunification is coordinated with external organizations (e.g., local health partners, community agencies, emergency services), messaging will be consistent across all parties.
- **Privacy and Sensitivity:** Communications will protect personal health information while ensuring families receive the support and guidance they need.

Contact List for Key Emergency Communication Partners

To ensure seamless coordination during crises, the Communications Officer will maintain and annually update the Emergency Partner Contact List (51-F-62). This list will be accessible in the EOC bins, and will include:

- **Emergency Medical Services (EMS):** Direct communications line and public information officer contact.
- **Fire Services:** Dispatch and designated communication liaison.
- **Police Services:** Community safety and public affairs contact.
- **Regional Health Authorities & Ontario Health East:** Emergency coordination contact.
- **Local Government (Mayor's Office, Council):** Official spokesperson and media relations contact.
- **Neighboring Hospitals & Health Partners:** Communications leads for mutual support.
- **Community Support Agencies:** Partners in reunification, shelter, and mental health support.

The contact list will include 24/7 phone numbers, email addresses, and alternate methods (e.g., encrypted messaging platforms) to ensure redundancy.



Transition and Recovery Communication

As services transition back to normal after the crisis, the EOC will conduct a full debrief within two weeks. This review will assess what communications strategies worked well, what challenges arose, and what improvements can be made. The findings will be documented, and the Communications and Community Engagement Plan will be updated accordingly.

Community Engagement and Consultation Strategies

Engagement is embedded in every day interactions with staff, patients, and the broader community. Internally, the hospital promotes engagement through staff recognition events, employee feedback surveys, town halls, committee participation, and small group sessions (Round Table with Rob). These channels allow staff to voice ideas, raise concerns, and contribute to shaping the work environment.

Patient and family engagement is facilitated through the Patient and Family Advisory Committee, bilingual satisfaction surveys, patient rounding, and the use of accessible education and orientation materials. The hospital is committed to involving patients and families in the design and evaluation of care processes to enhance experience and outcomes.

Consultation is an integral component of community engagement at HGMH. The hospital actively seeks input from community members, local organizations, healthcare partners, and municipal representatives to guide planning, programs, and decision-making. Consultation may occur through surveys, focus groups, or public meetings, and ensures that the voices and perspectives of those we serve are reflected in hospital priorities and strategic initiatives. This collaborative approach supports transparency, strengthens trust, and ensures services remain responsive to community needs.

Annual Community Engagement Sessions take place to promote two-way dialogue with the communities we serve. These sessions create space for open discussion and feedback.

Evaluation of Communications and Community Engagement

We acknowledge that it is extremely difficult to measure the impact of communications activities on stakeholders' perceptions, attitudes, and behaviours, and even more difficult to measure the impact of communications on HGMH's strategic goals. HGMH can look to other, more subtle, indirect ways of measuring the success of its communications efforts, including:

- Number and tone of media articles, editorials, and letters to the editor
- Feedback through the website, phone calls, and at meetings / presentations
- Employee feedback and employee surveys
- Input from our Patient & Family Advisory Committee
- Website visitors and monitoring hits on the pages that people visit
- Feedback from all stakeholders as part of regular meetings with these groups.

Strategies and tactics will be modified over time in response to these results and as new challenges and opportunities arise.



Roles and Responsibilities

The Communications Officer leads the implementation of this plan, supported by the Senior Leadership Team. Department managers are responsible for cascading messages and encouraging team feedback, while all staff are encouraged to participate in engagement initiatives and provide input. The plan is reviewed annually in collaboration with key committees, including the IDEAA Committee and the Patient and Family Advisory Committee, to ensure alignment with the hospital's strategic direction and community needs.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.05.018.X.XX	Communications & Hospital Spokesperson
COR.03.003.X.XX	Accessibility Multiple Formats
COR.08.005.X.XX	Social Media
BOD.01.002.X.XX	French Language Services
COR.02.019.X.XX	Automated Fanout Communications System

ASSOCIATED FORMS:

Form Number	Form Name
51-A-293-XX	Communications Action Plan
51-F-62	Emergency and Disaster Response Contacts

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 30, 2026
 Meeting Date Prepared for: October 8, 2026

Subject: Policy Reviews

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

The purpose of this briefing note is to provide an overview of the two policies up for review and highlight any material changes to each policy.

RECOMMENDATION / MOTION

That the Governance Committee recommend to the Board of Directors the approval of the following policies as presented: Senior Management Language Skills Policy, and the Developing, Reviewing, and Revising Board Policies policy.

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.

Summary of amendments:

Senior Management Language Skills Policy

- No amendments recommended

Developing, Reviewing, and Revising Board Policies

- No amendments recommended

IMPLEMENTATION & COMMUNICATION PLAN

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

- Obtain Board Approval – October 22, 2026
- Update Board Policy Online
- Include any applicable updates in Board Orientation Material

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Senior Management Language Skills Policy
- Developing, Reviewing, and Revising Board Policies Policy

Document Name:	Senior Management Language Skills		
Document Number:	BOD.02.002.0. 23 <u>26</u>		
Review Period:	☒ 3 years ☐ 1 year	Manual: Governance Policy Manual	
Classification:	Board of Directors	Section:	Leadership
Owner:	President & CEO	Signing Authority:	Board of Directors

POLICY STATEMENT:

The Hospital will ensure that at least one (1) of the members of the senior management team has a “superior” level of linguistic proficiency in French and English.

PROCEDURE:

1. In the event the Chief Executive Officer (C.E.O) is deemed to have limited French linguistic skills, the Board delegates the C.E.O. the responsibility to ensure one of the other senior positions is filled with a candidate with “superior” bilingual (French and English) language skills.

Effective: May 2002	Last review: Sep-2023 <u>Oct 2026</u>	Next review: Sep-2026 <u>Oct 2029</u>
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Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

Document Name:	Developing, Reviewing and Revising Board Policies		
Document Number:	BOD.05.001.0. 23 <u>26</u>		
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:

All Board policies are developed, approved, and reviewed through the process outlined in this document.

PROCEDURE:

Policy Development

1. New Board Policies shall be developed by the most appropriate Board Committee to address an identified need (e.g., change to applicable law, standardization, direction, etc.) and approved by the Board.

Policy Review

2. Board policies shall be reviewed one year after implementation and at least every three years thereafter. It is the responsibility of the President & Chief Executive Officer to ensure that Board policies are reviewed in a timely manner. Board policies requiring review shall be brought forward to the Governance Committee with recommendation to the Board. Board policies shall be reviewed for relevance, and to ensure compliance with applicable laws, the Corporation's Articles and By-laws, and governance best practice. Board Committee Terms of Reference must be approved annually by the Board.

Governance Review

3. The Board shall undertake a comprehensive review of its governance policies, practices, and structures every five years, or more frequently, if considered appropriate by the Board to ensure that they are contemporary and consistent with the needs of the Corporation.

Effective: May 2016	Last review: Sep-2023 <u>Oct 2026</u>	Next review: Sep-2026 <u>Oct 2029</u>
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Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 30, 2026 Meeting Date Prepared for: October 8, 2026
 Subject: IDEA – Transition to Governance Oversight
 Prepared by: Robert Aldred-Hughes, President & CEO

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

PURPOSE

The purpose of this briefing note is to provide an update on HGMH's IDEA Framework and recommend an ongoing approach to Board oversight.

Over the past several years, HGMH has moved from establishing its IDEA commitments and foundational activities to embedding IDEA within the organization's policies, practices, patient care and governance. Management is recommending that oversight of the IDEA Framework now become part of the Board of Directors' regular governance responsibilities, with formal reporting to the Board at least twice annually.

RECOMMENDATION / MOTION

THAT the Governance & Nominating Committee approve the transition of oversight of HGMH's Inclusion, Diversity, Equity and Anti Racism Framework to the Finance, HR and Audit Committee, with formal reporting on progress against the Framework occurring at least twice annually.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- Finance, Human Resources and Audit

SITUATION & BACKGROUND

A brief description of the background to the issue.

- In Fall 2023, the Board of Directors approved a recommendation that the Governance Committee take a proactive role in leading, coordinating and monitoring IDEA related activities at HGMH. This included oversight of Accreditation Canada requirements and supporting a culture of inclusion, diversity, equity and anti racism throughout the organization.
- Since that time, considerable work has been completed to establish the foundations for this work. HGMH developed its IDEA Framework in 2024 to provide greater structure and focus to the organization's efforts and has continued to advance actions under the Framework.
- The Board has also become increasingly involved in this work. Board members have participated in IDEA and Indigenous Cultural Safety education, supported IDEA related hospital and community activities, introduced voluntary equity based demographic information into the Board recruitment process, and overseen the development and adoption of HGMH's Land Acknowledgment.
- At the organizational level, IDEA considerations are increasingly being incorporated into regular operations. This includes patient experience monitoring, staff education, policy review, psychological safety, employment equity work and development of an IDEA lens for organizational decision making.

- Should the Governance Committee agree with the recommendation, a decision as to whether the oversight responsibilities will be overseen by the Finance, Human Resources, and Audit Committee or the Governance Committee of the Board of Directors. Please consider this question in advance of the meeting.

OPTIONS CONSIDERED & ANALYSIS

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

- As this work has matured, there is an opportunity to transition IDEA from a developing initiative overseen primarily through the Governance Committee to an established area of Board oversight.
- This approach is consistent with Accreditation Canada's governance standards, which establish specific responsibilities for the governing body related to systemic racism, Indigenous specific systemic racism, cultural safety and humility, organizational policies, education and monitoring of organizational action plans.
- Management recommends that the Board receive an update on the IDEA Framework at least twice annually. Reporting would provide the Board with an opportunity to:
 - ✓ Review progress against the IDEA Framework and associated action plans
 - ✓ Monitor key measures and organizational activities
 - ✓ Consider patient, staff and community perspectives where available
 - ✓ Ensure continued alignment with Accreditation Canada governance requirements
 - ✓ Identify opportunities for continued Board education and governance action
- ✓ This would embed IDEA within the Board's regular oversight responsibilities while allowing management and the IDEA Committee to continue leading the operational work associated with the Framework.