



# **GOVERNANCE MANUAL**

for

Hawke's Bay District Health Board

**November 2019**

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November 2019

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## Introduction

All statutory Crown entities, including District Health Boards (DHBs) are expected to have a board governance manual that reflects good practice standards and the range of legislation that applies to them.

This manual has been compiled to provide HBDHB Board members with guidance and information they may require to assist them meet their governance responsibilities. DHB governance not only includes the generic processes by which organisations are directed, controlled and held to account, but has added obligations and complexities derived from the ethos of public service, health legislation and the impact DHBs have on individuals, businesses and communities in New Zealand.

This is the fifth edition of HBDHB Governance Manual and replaces the fourth edition published in 2016. This edition is significantly based on a document "Resource for Preparation of District Health Board Governance Manuals" prepared by the State Services Commission in 2010 in conjunction with the Ministry of Health. All documents in the **schedules** have been brought forward from the fourth edition and updated where appropriate.

Whilst this document contains links to relevant websites and other documents, HBDHB does not necessarily endorse any of the material in these links, nor does it guarantee that such links and documents will remain current.

Further updates and/or new editions of this manual will be produced as necessary.

## Chapter 1: Relevant legislation

Effective governance of Crown entities requires all board members to have a good understanding of the legislative environment in which they must operate.

Every District Health Board (DHB) is a Crown Agent for the purposes of the Crown Entities Act 2004 (CE Act).

DHBs are established under the New Zealand Public Health and Disability Act 2000 (NZPHD Act). Other legislation that applies to DHBs includes:

- State Sector Act 1988
- Public Finance Act 1989
- Commerce Act 1986
- Official Information Act 1982
- Privacy Act 1993
- Protected Disclosures Act 2009
- Public Records Act 2005
- Various pieces of employment legislation.

### ***New Zealand Public Health and Disability Act 2000***

The NZPHD Act is the legislation under which DHBs were created. Board members need to be familiar with all relevant sections of that Act.

A full copy of the Act can be found at [www.legislation.govt.nz](http://www.legislation.govt.nz)

In summary, the NZPHD Act establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes District Health Boards, and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations.

The NZPHD Act also sets the strategic direction and goals for health and disability services in New Zealand. These include to improve health and disability outcomes for all New Zealanders, to reduce disparities by improving the health of Māori and other population groups, to provide a community voice in personal health, public health, and disability support services and to facilitate access to, and the dissemination of information for, the delivery of health and disability services in New Zealand.

The NZPHD Act facilitates the achievement of the Government's aims by:

- establishing DHBs to take a 'population health' focus for their geographically defined populations
- requiring the development of the [New Zealand Health Strategy](#) and the [New Zealand Disability Strategy](#) and an annual report to Parliament on the progress in implementing these strategies
- encouraging co-operation and collaboration between the agencies in the sector with the aim of delivering better care and support
- strengthening local community input to decision-making about health and disability support services through electing members to DHBs.

The NZPHD Act also adopts measures that recognise and respect the principles of the Treaty of Waitangi in the health and disability support sector.

The measures are a response to the Crown's desire to have greater Maori participation in the health and disability support sector with a view to improving Maori health outcomes, and reducing health disparities between Maori and other population groups. The measures also reflect the Crown's overall partnership with Maori under the Treaty of Waitangi and its commitment to protecting Maori health.

The measures include:

- minimum Maori membership on Boards of DHBs
- provision for Maori membership of DHB committees
- training for Board members to ensure they are familiar with Treaty issues, Maori health issues, and Maori groups or organisations in the DHB
- a requirement for DHBs to establish and maintain processes to enable Maori to participate in and contribute to strategies for Maori health improvement
- a requirement that DHBs continue to foster the development of Maori health capacity for participating in the health and disability sector and for providing for their own needs
- an expectation that DHBs provide relevant information to Maori to enable effective participation

### ***The NZPHO Amendment Act 2010***

This Act amended the NZPHD Act to support desired reforms in the health sector to meet emerging challenges such as increasing demand, workforce strategies and resource constraints. Specifically the Act:

- amended planning requirements for district health boards in order to provide for a planning and accountability framework that takes account of national, regional and local requirements; and
- amended the objectives and functions of district health boards to ensure that district health boards work together for the most effective and efficient delivery of health services to meet national, regional and local needs; and
- included amendments to support the provision of shared administrative, support and procurement services across the public health system, including additional powers, such as ministerial direction, to enhance ministerial ability to require greater system collaboration and use of shared services; and
- amended regulation-making powers in the current Act relating to arbitration and mediation to enable these powers to have wider application, particularly where there are disputes between district health boards about how national, regional, and local requirements are best provided for; and
- required district health boards to operate in a financially responsible manner; and
- made structural changes to enhance quality improvement activity, including the establishment of a new Crown agent, the Health Quality and Safety Commission; and
- enabled appointment of elected district health board members to the boards of other district health boards; and
- required the Minister's approval prior to establishing any new board committees.

### ***Crown Entities Act 2004***

The CE Act provides a consistent framework for the establishment, governance and operation of Crown entities, as included in the various chapters of this guidance material. It clarifies the accountability relationships between Crown entities, their board members, responsible Ministers and the House of Representatives. The application of the CE Act to DHBs includes board

members' individual and collective duties, the role of the responsible Minister, accountability relationships, strategic planning and Statements of Intent and reporting requirements.

Some key pieces of the CE Act and its application to DHBs are listed below, and are noted in the relevant chapters of this manual.

<b>Key parts of the CE Act as it applies to DHBs</b>	
Government policy directions	DHBs <i>must give effect to</i> government policy when directed by the responsible Minister (ie, the Minister of Health) (s. 103)
Whole of government directions	DHBs must comply with a whole of government direction from the Minister of State Services and the Minister of Finance (s. 107)
Appointed board members	Appointed by the Minister of Health (s. 28)
Term of board members	Appointed members hold office for 3 years or less (s. 32)
Removal of appointed board members	May be removed by the Minister of Health at his or her discretion (s. 36)
Remuneration of board members	Determined by the Minister of Health in accordance with the <a href="#">Cabinet Fees Framework</a> <sup>1</sup> (s. 47)

Section 21 of the NZPHD Act sets out a number of provisions where the CE Act does not apply to DHBs, or to their boards, board members, committee members or employees.

DHBs also differ from other statutory Crown entities in that the majority of their board members are elected by the public, rather than appointed by a Minister.

### **State Sector Act 1988**

Under the State Sector Act (s. 6), the State Services Commissioner's mandate applies to DHBs in a number of ways, including:

- to review the machinery of government, including creating, amalgamating, or abolishing agencies, and coordinating the activities of agencies;
- to advise on management systems, structures, and organisations;
- to provide advice and guidance on matters related to the integrity and conduct of employees, including making inspections and conducting investigations; and
- to set minimum standards of integrity and conduct. The State Services Commissioner has issued a code of conduct that applies to the staff of DHBs (also, see chapter on *District Health Boards as Employers*).

### **State Sector Amendment Act 2018**

Amendments to the State Sector Act in 2018 gave the State Services Commissioner an explicit power to issue a code of conduct for Crown entity board member – s. 57(3) of the State Sector Act 1988 applies.

The development and application of this code is further discussed in Chapter 6: General Behaviours of Board members.

<sup>1</sup>[www.ssc.govt.nz/fees](http://www.ssc.govt.nz/fees)

**Public Finance Act 1989**

The CE Act specifies most of the provisions relating to a Crown entity's financial powers, accountability and reporting obligations. However, the following sections of the Public Finance Act apply to Crown entities, including DHBs:

- ss. 26Z and 29A provide for the Secretary to the Treasury to request information necessary to prepare government financial statements and reporting;
- s. 36 provides that departmental chief executives are not responsible for the outputs or financial performance of Crown entities;
- s. 45I and s. 45J provide direction on the first annual report of a newly established entity and on the final annual report for a disestablished entity, and s. 45K sets out the timing of those reports;
- s. 49 provides that the Crown is not liable to contribute towards payments of the debts and liabilities of Crown entities;
- s. 74 provides that money that has remained unclaimed in a Crown entity's account for six years is to be paid to the Treasury;
- s. 80A allows for the Minister of Finance to issue instructions. Crown entities are required to comply with those instructions, which must be consistent with generally accepted accounting principles; and
- s. 81 provides for the Governor-General to make regulations for a variety of purposes.

**Commerce Act 1986**

DHBs and their subsidiaries are interconnected bodies corporate for the purposes of the exemption from Part II of the Commerce Act under section 44(1) (b) of that Act.

The exemption facilitates co-operative and collaborative arrangements between these public health and disability organisations, by ensuring the organisations can talk to each other without fear of breaching the Commerce Act.

The exemption does not apply to unilateral dominant behaviour of the kind regulated by section 36 of the Commerce Act (DHBs are not exempt from action if they use their market power to seek to stop a provider entering a market, or to prevent competitive conduct, or to drive a provider out of a market).

**Other legislation with general application to DHBs**

A considerable body of legislation applies to **DHBs as employers**, in respect of matters such as holiday entitlements, employment relations and health and safety. Employment matters are generally handled by chief executives rather than board members but, in ensuring compliance with them, the chief executive invariably acts under delegation from the board.

The **Official Information Act 1982** (the OIA) applies to DHBs. Board minutes are among the documents that can be requested under the OIA, though provisions exist for material to be withheld under certain circumstances. The general expectation, as expressed by the Chief Ombudsman for instance, is for official information to be released (either pro-actively or in response to a request), unless there are clear grounds to withhold it under the OIA. Grounds for withholding information include:

- Where the making available of the information would be likely to prejudice the maintenance of the law or endanger the safety of any person (s 6)
- To protect the privacy of natural persons
- To protect a trade secret or any unreasonable prejudice of a persons commercial position
- To protect information which is subject to an obligation of confidence
- To avoid prejudice to measures protecting the health or safety of members of the public

- To avoid prejudice to measures that prevent or mitigate material loss to members of the public
- To maintain the effective conduct of public affairs through the free and frank expression of opinions by members or employees in the course of their duty

For further guidance, see: [www.ombudsman.parliament.nz](http://www.ombudsman.parliament.nz) The principles contained in the **Privacy Act 1993** include:

- how an organisation collects and stores personal information and what procedures are required to protect the security of that information;
- how long an organisation can keep personal information; and
- what personal information can be used for, and when it can be disclosed.

For further guidance, see: [www.privacy.org.nz](http://www.privacy.org.nz)

The **Protected Disclosures Amendment Act 2000 (as amended in 2009)** provides for the reporting of wrong-doing in workplaces (sometimes called 'whistle-blowing') to an appropriate authority, such as the Office of the Ombudsman. All DHBs must have a protected disclosures policy. Under the Act, current or former employees of an entity, contractors and board members can make a disclosure that will be 'protected' if the information they are disclosing is about serious wrongdoing in or by the organisation, and they reasonably believe that the information is true or likely to be true.

The **Public Records Act 2005** applies to information held by DHBs that is of a kind specified by regulations made under the Act. Regulation 4 of the New Zealand Public Health and Disability (Archives) Regulations 2001 also provides that the Public Records Act applies to information that has officially been made or received by a DHB in the conduct of its affairs. Accordingly, all DHBs must comply with the requirements of the Public Records Act 2005.



## Chapter 2: Objectives, functions and powers of District Health Boards

Board members must know what they and the DHB are charged with doing, and how they are empowered to carry out their functions and powers.

The role of a District Health Board (DHB) is set out in section 25 of the Crown Entities Act (CE Act) and section 26 of New Zealand Public Health and Disability Act 2000 (NZPHD Act).

Section 25 of the CE Act states that the board is the governing body of a statutory entity with the authority to exercise the powers and perform the functions of the entity. All decisions relating to the operation of the entity must be made by or under the authority of the board, in accordance with the CE Act or the NZPHD Act, as appropriate.

### The objectives of a DHB

Section 14(2) of the CE Act states that, in performing its functions, an entity must act consistently with its objectives. "Objectives" are not defined in the CE Act but include the objectives set out by s. 22 of the NZPHD Act, which are to:

- a) improve, promote, and protect the health of people and communities
- b) promote the integration of health services, especially primary and secondary health services
- c) promote effective care or support for those in need of personal health services or disability support services
- d) promote the inclusion and participation in society and independence of people with disabilities
- e) reduce health disparities by improving health outcomes for Māori and other population groups
- f) reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders
- g) exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges, the provision of, services
- h) foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services
- i) uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations
- j) exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations
- k) be a good employer in accordance with s 118 of the Crown Entities Act 2004.

The DHB must consider the specific actions to be taken to meet these objectives, while being mindful of:

- a) s. 3(2) of the NZPHD Act, which provides for objectives to be pursued to the extent that they are reasonably achievable within the funding provided;
- b) s. 3(4) which promotes the integration of services; and
- c) s. 3(5) that requires consideration of local, regional or national service configuration.

While the NZPHD Act gives the community a voice in achieving these objectives, DHBs also need to consider the overall health structure to ensure that individual items of health expenditure fit comfortably with the "big picture" of health funding.

The DHB will need to consider competing options and may, in certain circumstances, attach greater weight to certain objectives than others to attempt to achieve the purposes of the Act. In doing so, as good practice, each DHB Board should carefully record the decision-making process.

### ***Functions of a DHB***

Under section 14 of the CE Act the functions of a statutory entity are:

- the functions set out in the entity's establishing legislation (in the case of DHBs, the NZPHD Act);
- any functions that the Minister has added in accordance with the establishing legislation; and
- any functions that are incidental or related to, or consequential on, the entity's functions.

Section 23 of the NZPHD Act sets out a further list of DHB-specific functions which are to:

- a) ensure the provision of services for its resident population and for other people as specified in its Crown Funding Agreement;
- b) actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities;
- c) issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b) above;
- d) establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement;
- e) continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori;
- f) provide relevant information to Māori for the purposes of paragraphs (d) and (e) above;
- g) regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services;
- h) promote the reduction of adverse social and environmental effects on the health of people and communities;
- i) monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services;
- j) participate, where appropriate, in the training of health practitioners and other workers in the health and disability sector;
- k) provide information to the Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the DHB and to the health and disability support needs of New Zealanders;
- l) provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Crown Entities Act 2004;
- m) collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes;
- n) perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of the DHB after consultation with it.

The CE Act contains several safeguards for the independence of entities in carrying out their functions and other business:

Section 113 provides that a Minister may not:

- direct a Crown entity or member, employee or office holder of a Crown entity in relation to a statutorily independent function; or
- require the performance or non-performance of a particular act or the bringing about of a particular result in respect of a particular person or persons.

Without limiting sub part 1 of Part 3 of the CE Act, the Minister of Health may give a DHB any directions [s. 32 of the CE Act] —

- a) that specify the persons who are eligible to receive services funded under the NZPHD Act; and
- b) that the Minister considers necessary or expedient in relation to any matter relating to the DHB; and
- c) that are consistent with the objectives and functions of the DHB.

No such direction may require the supply to any person of any information relating to an individual that would enable the identification of the individual.

### ***Powers of the Board***

The CE Act divides powers of entities into:

- **Statutory powers:** s. 16 provides that a statutory entity may do anything authorised by the CE Act or the entity's establishing Act. Powers may include, for example, the power to make decisions, issue a licence, or execute a search warrant.
- **Natural powers:** s. 17 provides that boards of entities have all the powers of a natural person of full age and capacity. Boards may only act for the purpose of performing the statutory functions of the entity. The CE Act contains some specific constraints on the exercise of natural powers, for example: the requirement to consult the State Services Commissioner before agreeing to the terms and conditions of employment of a DHB's chief executive, constraints on bank accounts and limits on powers to indemnify and insure. Ministers' powers of direction, where applicable, can also act as a restraint on a board's powers.

### ***Ministerial directions***

Certain provisions of the CE Act relating to government policy and government directions, apply to the giving of ministerial directions to DHBs. Under s. 103(1) of the CE Act, the Minister of Health may direct a DHB to give effect to a government policy. Section 103 is subject to s. 113 of the CE Act, under which the independence of Crown entities is safeguarded.

Under sections 32 and 33 of the NZPHD Act, the Minister of Health may give written directions to a DHB on any matter of government policy that the Minister considers necessary, and can specify the persons who are eligible to receive services funded under the NZPHD Act. In giving any such directions, the Minister must have regard to the objectives and functions of DHBs, the New Zealand Health Strategy, the New Zealand Disability Strategy and the DHB's District Strategic Plan. The Minister must also consult the DHB before issuing a direction notice.

The NZPHD Amendment Act amended s 33 of the NZPHD Act by inserting a new provision that allows the Minister to direct DHBs to:

- Implement a proposal on how administrative, support and procurement services within the health and disability system should be obtained where it is considered that the proposal cannot be reasonably implemented in another way

- Comply with stated requirements for the purpose of supporting government policy on improving the effectiveness and efficiency of the health and disability sector

Ministerial directions cannot require the supply of identifiable information about an individual.

If a direction concerns the provision of services, then it must be given in accordance with s. 33. Such a direction may not:

- specify the price of any services
- require the supply of services to named individuals or organisations, or require supply of services by named individuals or organisations (however, DHBs can be specified as the provider).

Notice of directions given under section 32 or 33 must be published in the *Gazette* and presented to the House of Representatives.

Where the Minister appoints a Crown monitor in relation to a DHB, the functions of the Crown monitor include assisting the board “in understanding the policies and wishes of the Government so that they can be appropriately reflected in board decisions” (s. 30(3)(b) NZPHD Act).

### ***The Treaty of Waitangi***

The NZPHD Act includes provisions to recognise and respect the principles of the Treaty of Waitangi in the health and disability sector.

These provisions reflect the Crown’s desire to have greater participation by Māori in the health and disability sector, with a view to improving Māori health outcomes and reducing health disparities between Māori and other population groups. The measures also reflect the Crown’s overall partnership with Māori under the Treaty of Waitangi.

Specific provisions include:

- minimum Māori membership on boards of DHBs (s.29(4));
- provision for Māori membership of DHB committees (sections 34, 35, 36);
- familiarity with Treaty issues, for Māori health issues, and for Māori groups or organisations in the DHB (Schedule 3, clause 5);
- a requirement for DHBs to establish and maintain processes to enable Māori to participate in and contribute to strategies for Māori health improvement (s23(1)(d));
- continuing to foster the development of Māori capacity to participate in the health and disability sector and for providing for their own needs (s23(1)(e)); and
- provision of relevant information to Māori to enable effective participation (s23(1)(f)).

Section 3(3) of the NZPHD Act says that nothing in the Act “entitles a person to preferential access to services on the basis of race or limits section 73 of the Human Rights Act 1993” (which relates to measures to ensure equality).

This recognises the need for service delivery that positively reduces disparities and is targeted at population related initiatives, rather than any preferential treatment sought by an individual person.

### ***Exceptions to board implementing functions and powers under legislation***

Occasionally the chief executive or other office holder in a DHB has specific statutory functions or powers under the entity’s establishing legislation. For example under s 26(3) of the NZPHD

Act, the board of a DHB is required to delegate to the chief executive the power to make decisions on management matters relating to that DHB.

In these cases, the board is not responsible for the exercise of those powers and functions. The Board and chief executive or other office holders need to be very clear about where responsibility lies in these situations.

**Governing for Quality**

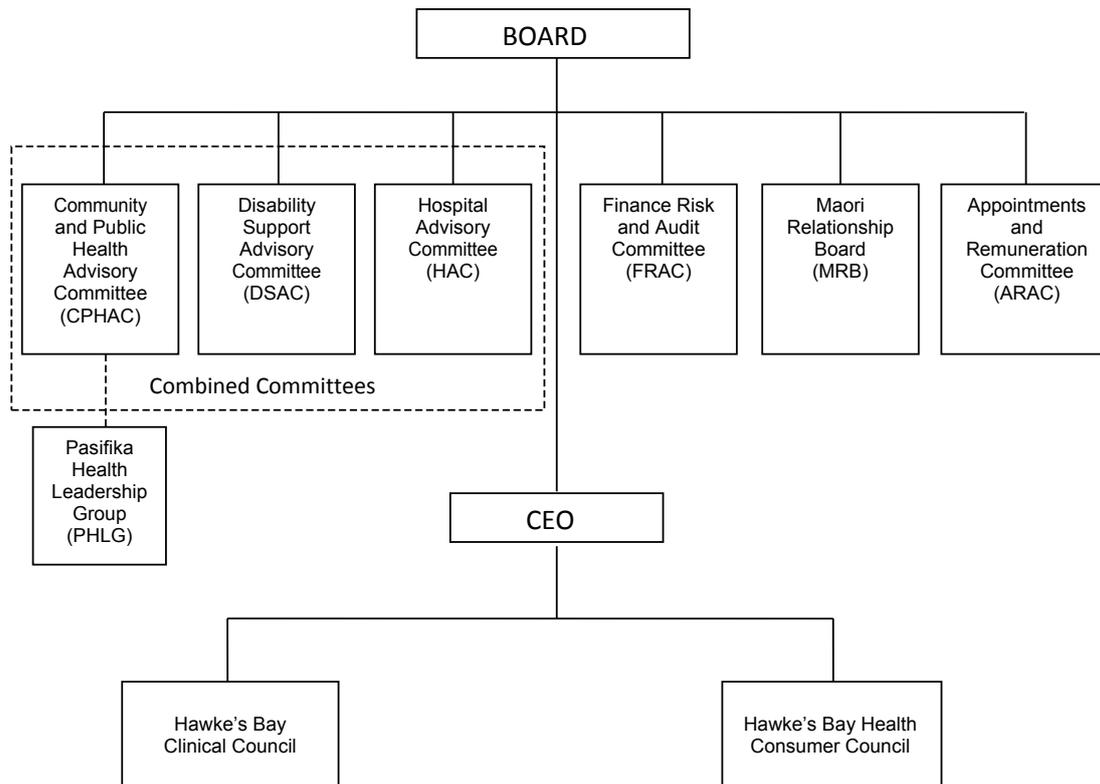
Arising from the objectives and functions above, is a very clear responsibility for DHB Boards to ensure high levels of clinical quality and patient safety in all services they provide or fund. It has been recognised internationally that effective governance and oversight by well-informed and skilled board members lies at the heart of improving quality and patient safety in health organisations.

This responsibility cannot just be delegated to medical staff and executive leadership – it is the board’s responsibility to ensure these delegations are acted on effectively. Ensuring patient care is safe and harm-free is at the core of a board’s legal and fiduciary responsibility.

The Health Quality & Safety Commission has produced a quality and safety guide for District Health Boards – ‘Governing for Quality’. This guide provides more detail on how boards may meet this responsibility. A copy of the guide is attached as Schedule 11.

**Structure**

The structure of the DHB, including the board and committees, should support the implementation of the functions and powers of the board and should be reviewed from time to time. The current governance structure of HBDHB is:





## Chapter 3: Key Relationships

One of the primary purposes of the Crown Entities Act 2004 (CE Act) is “to clarify accountability relationships between Crown entities, their board members, their responsible Ministers on behalf of the Crown, and the House of Representatives” (s. 3 CE Act) in order to assist good governance of the entity.

In simple terms this can be summarised as:

- the responsible Minister is accountable to the House of Representatives;
- the governing board of the entity (i.e. the District Health Board ) is responsible to the Minister, usually through the Chair);
- the entity’s chief executive is responsible to the board; and
- the staff of the entity are responsible to the chief executive.

District Health Board (DHB) board members need to clearly understand the different roles, responsibilities and accountabilities of each party. This will facilitate the establishment and maintenance of mutually constructive and positive working relationships.

### ***Relationship with the Minister of Health (the Minister)***

The role of the Minister is to oversee and manage the Crown’s interest in, and relationship with, the DHB, and to exercise any statutory responsibilities.

Under s. 27 of the CE Act, the Minister has powers with regard to all DHBs on matters of strategic direction, targets, funding, performance, reporting and reviews. The Minister needs to exercise these powers in a way that recognises any statutorily independent functions of DHBs.

The Minister has the power to request the following information:

- the DHB must supply to the Minister of Health any information relating to the operations and performance of the DHB that the Minister requests, under s. 133 of the CE Act; and
- the DHB must supply to the Minister of Finance any information requested by the Minister in connection with the exercise of his or her powers under Part 4 of the CE Act. Section 133 is subject to s. 134 of the CE Act, which provides for where there is a good reason to refuse to supply information requested by the Minister, for example the privacy of a person. However, the reason must outweigh the Minister’s need to have the information, for the discharge of Ministerial duties.

The Minister of Health is responsible to the House of Representatives for the performance of DHBs and is often expected to answer to the public for problems or controversies arising in connection with them. The Minister tables in the House each DHB’s statement of intent and annual report and appears before select committees where the Minister may be asked to comment on a DHB’s activities. However, the DHB itself is also accountable to the House of Representatives (s. 3 CE Act) for its own actions (see chapter *Planning and reporting*).

### ***Parliamentary select committees***

One mechanism for scrutiny of DHB operations is through select committees. The most regular contact DHBs are likely to have with select committees is for financial reviews, inquiries, and occasionally when making submissions on bills. Board members should be particularly aware of the following:

- Examination of the Estimates: The estimates are the government’s request for appropriations/authorisation for the allocation of resources, tabled on Budget day. DHBs do not attend the select committee when it examines the estimates, but the Minister and

Ministry of Health may be questioned about the intended activities and expenditure of a DHB.

- **Financial Review:** The financial review is of the DHB's performance in the previous financial year and of its current operations. The select committee will provide written questions for answer, but if the DHB is asked to appear, further questions may be asked on the day.

DHB board members and staff who appear before a select committee do so in support of ministerial accountability. Generally the Chair and the Chief Executive will represent a DHB at select committee hearings, although this is a matter for the board to decide.

DHB representatives appearing before select committees have an obligation to manage risks and spring no surprises on the Minister. This applies even when they appear on matters which do not involve ministerial accountability, such as when exercising an independent statutory responsibility or appearing in a personal capacity. Board members and employees who wish (or are invited) to make a submission to a select committee on a Bill on behalf of their DHB are expected to discuss the matter with the Minister.

Guidance on appearing before select committees needs to reflect the material contained in *Officials and Select Committee Guidelines*: [www.ssc.govt.nz](http://www.ssc.govt.nz). Within that guidance, the term 'official' includes board members and employees of DHBs.

#### ***"No Surprises" approach***

Boards are expected to engage constructively and professionally with the Minister. This is enhanced when there is a free flow of information both ways, by regular formal and informal reporting and discussion, and through an open and trusting relationship.

The enduring letter of expectations from Ministers to Crown entity boards ([www.ssc.govt.nz](http://www.ssc.govt.nz)), expects boards to adopt a "no surprises" approach with their Minister. Any protocols adopted in this respect need to recognise that what a board considers to be "business as usual" may be seen by the Minister to come within the requirement of "no surprises".

"No surprises" means that the government expects a DHB to:

- be aware of any possible implications of its decisions and actions for wider government policy issues;
- advise the Minister of Health of issues that may be discussed in the public arena or that may require a ministerial response, preferably ahead of time or otherwise as soon as possible; and
- inform the Minister in advance of any major strategic initiative.

#### ***Relationship with the monitoring department***

The CE Act provides for Ministers to monitor Crown entity performance against the entity's strategic direction, as agreed with the Minister and set out in the Statement of Intent (SoI) and any other relevant documents; for example, a Crown Funding Agreement.

Ministers are usually supported in this engagement with Crown entities by departmental officials who in this role are known as the 'monitoring department'. While the CE Act and the NZPHD Act do not define such a role, the monitoring department (in this case, the Ministry of Health) provides the Minister with information about a DHB's performance, ensures its approach is consistent with government goals, and supports the appointment process for board members.

Guidance for departments on how to monitor an entity is available at:

<http://www.ssc.govt.nz/guidance-depts-crown-entities>

***Relationship with the chief executive and DHB staff***

All decisions relating to the operation of a DHB must be made by, or under the authority of, the board in accordance with s. 25 of the CE Act and the New Zealand Public Health and Disability Act 2000 (NZPHD Act).

The day-to-day management responsibilities within a DHB are delegated to the chief executive (section 26(3), NZPHD Act). The board and the chief executive must be clear about the boundaries between governance and management, what duties have been delegated to the chief executive and the levels of those delegations. Some detail and clarity around this is provided in the documents 'Board – CEO Linkage' in Schedule 8 and in "Board Delegations Policy" in Schedule 9.

While the relationship between the Minister and the board is usually through the chair, this is not always practical. Board members and the chief executive must be clear about who has contact with the Minister and the Minister's office. Where a Chief Executive is meeting regularly with the Minister, protocols should be put in place, including feedback to the board on all such meetings.

Other issues concerning relationships and communications between board members and staff are addressed in the "Communications Policy – Board and Board Members" attached in Schedule 9.

***Cooperative agreements with persons in the health and disability sector***

For a DHB to fulfil its obligations, it must "actively investigate, facilitate, sponsor and develop" cooperative agreements and arrangements with persons in the health and disability sector, in order to promote the inclusion of individuals and encourage independence (s. 23(1)(b), NZPHD Act).

DHBs can enter into co-operative agreements and arrangements under s. 24 of the NZPHD Act, for the purpose of:

- assisting the DHB to meet its objectives set out in s. 22 of the Act; or
- enhancing health or disability outcomes for people; or
- enhancing efficiencies in the health sector.

A DHB may not enter into such a co-operative agreement or arrangement, unless it is given consent by the Minister (s. 24(2), NZPHD Act). Any authority given by the Minister is subject to any conditions the Minister specifies.

Further approval is also needed for DHBs to hold interests in trusts and companies (s.28, NZPHD Act).

***Hawke's Bay Relationships***

In addition to the formal relationships noted above it is accepted that the HBDHB cannot achieve all its objectives on its own. Within Hawke's Bay in particular there are other key stakeholders concerned with the health and wellbeing of the population. Relationships, with these key stakeholders are developed and maintained mostly through personal contact at various levels. There are however some relationships that are more formalised. Copies of the various documents that set out the nature of these more formalised relationships are included in Schedule 1. These include:

- Hawke's Bay Health Sector Structural Relationships

- Showing the various relationships/interactions between:
  - Minister/Ministry of Health
  - HBDHB Board and CEO
  - Hawke's Bay Community/Iwi/Health Practitioner Groups
  - Te Matau a Maui Health Trust
  - Health Hawke's Bay Ltd Board and CEO.
- Hawke's Bay Health Sector Leadership Forum
  - A forum established: *To develop a common purpose and commitment to the HB health sector by HBDHB , NKII, Health Hawke's Bay Ltd, Clinical Council, Consumer Council and Pasifika Health Leadership Group.*
  - Generally meets once or twice a year
- TE PITAU Health Alliance (Hawkes Bay)
  - An Agreement between HBDHB and Health Hawkes Bay Ltd to *'improve health outcomes for our populations through transforming, developing, evolving and integrating primary and community healthcare services, consistent with commitments made in the 2018 Clinical Services Plan.*
  - Led by a Governance Group of members from HBDHB, HHB Ltd, MRB, Clinical Council & Consumer Council.
- HBDHB and Ngati Kahungunu Iwi Inc – Memorandum of Understanding
  - The purpose of the MoU is to *'establish, formalise, record and promote a collaborative working relationship that meets the parties respective goals, objectives and aspirations'*.
  - *A 'high trust relationship', which will be demonstrated by cooperation and good faith activating the principles of partnership, participation and protection.*
  - The relationship is primarily managed and maintained through respective membership of the Maori Relationship Board.
- Matariki Governance Group
  - Intersectoral leaders in Hawkes Bay have been working in partnership since 2013 to develop a Regional Development Strategy. The initial focus was on economic development and subsequently social inclusion was added.
  - The economic vision is:  
*'Every household and every whanau is actively engaged in, contributing to and benefitting from a thriving Hawkes Bay economy.*
  - The social inclusion vision is:  
*Hawkes Bay is a vibrant, cohesive, diverse and safe community, where every child is given the best start in life and everyone has opportunities that result in equity of outcomes.*
  - Matariki, Hawkes Bay Regional Development Strategy for economic and social growth, is governed by a Governance Group of local intersectoral leaders, including the HBDHB Chair.

All Board Members are expected to contribute positively to all these relationships, whether that be at a personal or individual level, or as part of a collective group.



## Chapter 4: Collective duties of the board and individual duties of board members

One of the goals of the Crown Entities Act 2004 (CE Act) is to clarify the roles of board members and responsible Ministers by setting out the accountabilities of each party; in particular, board members' duties and to whom those duties are owed.

Section 25 of the CE Act states that the board is the governing body of a statutory entity, with the authority, in the entity's name, to exercise the powers and perform the functions of the entity. It also states:

“All decisions relating to the operation of a statutory entity must be made by, or under the authority of the Board in accordance with this Act and the entity's Act.”

Collective and individual responsibility and accountability are fundamental to the integrity of the board. It is important that board members are clear about, and understand, the collective and individual duties that come with appointment to a DHB board.

Board duties are often referred to as directors' 'fiduciary duties'. The board's collective duties and members' individual duties are set out in ss. 49-57 of the CE Act. The two types of duties vary with regard to:

- whether the duties are owed by the board as a whole, or by each member individually;
- who they are owed to; and
- what the sanction is if the duty is breached.

All DHB board members are bound by collective and individual duties, whether they are appointed or elected members.

Board members' duties are constant and relevant to all actions undertaken by the board or individual members; a board and its members must always act in a manner consistent with these duties.

### **Collective Duties**

The collective duties of a DHB are the board's public duties which reflect that the board and the entity are part of the State Services. The collective duties are owed to the responsible Minister (s. 58(1), CE Act).

The collective duties of DHB boards are to:

- act consistently with their objectives, functions, statements of intent and output agreement (s. 49, CE Act);
- perform their functions efficiently and effectively, and consistently with the spirit of service to the public (s. 50, CE Act);
- operate in a financially responsible manner (s. 51, CE Act and s.41 NZPHD Act); and
- ensure that the DHB complies with sections 96 to 101 of the CE Act<sup>2</sup>.

The board of a DHB must also ensure that the DHB acts in a manner consistent with any national and regional plans (to which it is a party), its district strategic plan, annual plan, and any directions the Minister of Health may, by written notice, require the DHB to provide or arrange for the provision of any services that are specified in the notice (sections 27(1) and 33 of the

<sup>2</sup> s.28 of the NZPHD Act discuss shares in bodies corporate or interests in associations..

NZPHD Act). The board of a DHB also must act in a manner consistent with s. 103 or s. 107 of the CE Act.

### ***Individual duties of board members***

Individual board member duties are a mix of common law duties and duties similar to the ones in the Companies Act 1993 (common law is law that is derived from judges' decisions). The individual duties in the CE Act are owed to the entity and the Responsible Minister (s. 59). Board members' individual duties under the CE Act are to:

- comply with the CE Act and the NZPHD Act (s. 53)
- act with honesty and integrity (s. 54)
- act in good faith and not at the expense of the entity's interests (s. 55)
- act with reasonable care, diligence and skill (s. 56)
- not disclose information, except in specified circumstances (s. 57).

### ***Health & Safety***

One specific duty of note, is the duty of board members to exercise due diligence on health and safety. This duty has been highlighted through the Health and Safety at Work Act 2015. Board member responsibilities relating to this duty are now set out in the Health & Safety Policy (attached in Schedule 9).

To assist members with this due diligence, each member will undertake the role of Board Health & Safety Champion, on a rotational basis. This role is also described in Schedule 9.

### ***Breach of duty***

If a DHB member does not act with good faith, or with reasonable care, the DHB may bring action against that member for breach of an individual duty (s. 59(3) of the CE Act).

Every member of the DHB board or of any committee of the board is indemnified by the DHB for<sup>3</sup>:

- costs and damages for any civil liability arising from any action brought by a third party in respect of any act or omission done or omitted in his or her capacity as a member, if he or she acted in good faith and with reasonable care, in pursuance of the functions of the organisation; and
- costs arising from any successfully defended criminal proceeding in relation to any such act or omission.

A member of a DHB board committee established or appointed under Part 3 of the NZPHD Act is not liable for any act or omission done or omitted in his or her capacity as a member, if he or she acted in good faith, and with reasonable care, in pursuance of the functions of the committee.

The Minister of Health may take action if the collective or individual duties of a DHB board have been breached. If the board does not comply with any one of its collective duties, all or any of the board members may be removed from the board. However, a board member cannot be removed if the member did not know, and could not reasonably be expected to know that the duty was being or was to be breached, or if the board member took all reasonable steps in the circumstances to prevent the duty being breached.

<sup>3</sup> Sections 120 to 126 of the CE Act, on protections from liability, do not apply to a 'publicly-owned health and disability organisation,' members of the board or a committee of the board of a DHB

A board member is not liable for breach of a collective duty, other than to be removed from office (s. 58, CE Act).

The chapter *Board Appointments and Reappointments* addresses the different processes for removal from office of appointed and elected DHB board members. In addition, the Minister of Health can remove the whole board and replace it with a Commissioner.



## Chapter 5: Role of the Chair

An effective chair is vital to the good governance and performance of an entity. DHB chairs are appointed from various backgrounds and they need to understand the requirements of the role. The role has many similarities to that of a private sector board chair, but with some different elements which come from legislation or practice.

A DHB chair's role includes:

- Providing effective leadership and direction to the board and the DHB, consistent with the Minister's expectations.
- Ensuring effective accountability and governance of the DHB, consistent with the requirements of relevant legislation including the Crown Entities Act 2004 (CE Act), (see also, the chapter *Relevant legislation*).
- Developing and maintaining sound relationships with Ministers and their advisors, including:
  - leading any formal discussions with Ministers, particularly on budget and planning cycles, including the Statement of Intent and letter of expectations (see chapter *Planning and reporting*);
  - signing-off formal governance documents (Statement of Intent, Annual Report), generally in conjunction with the deputy chair;
  - acting as spokesperson for the board, in ensuring the Minister and other key stakeholders are aware of the board's views and activities, and that Ministers' views are communicated to the board; and
  - ensuring that the Minister is kept informed under the 'no surprises' obligations (see chapter *Key relationships*).
- Acting as the leader of the DHB, including presenting its objectives and strategies externally, and representing the DHB to Government and stakeholders, including attending select committees.
- Chairing board meetings including: setting the annual board agenda (see chapter *Board meeting procedures*); setting meeting agendas; ensuring there is sufficient time to cover issues; ensuring the board receives the information it needs - before the meeting in board papers and in presentations at the meeting; considering which matters should be dealt with in the 'public included' and 'public excluded' portions of DHB board meetings, encouraging contributions from all board members; assisting discussions towards the emergence of a consensus view; and summing up so that everyone understands what has been agreed.
- Providing motivation, guidance and support to other board members to ensure they contribute effectively to the governance of the DHB.
- Taking the lead, often in conjunction with the Ministry of Health, in providing comprehensive tailored induction for new board members (see chapter *Board appointments and reappointments*).
- Ensuring that the development needs of individual board members are identified and addressed.
- Where necessary, dealing with underperformance by board members.
- Ensuring that an annual performance evaluation is conducted of the board as a whole, as well as of the chair and individual members individually (see chapter *Board and member performance evaluation*).
- Participating in the recruitment process for appointed board members. This is likely to include: maintaining a view on the desired composition of the board; considering member and chair succession planning; supporting the Minister and Ministry of Health in appointing

- and reappointing board members (see chapter *Board Appointments and Reappointments*).
- Providing guidance and support to the chief executive to ensure the DHB is managed effectively. This includes establishing and maintaining an effective working relationship, while also taking an independent view to challenge and test management thinking (see chapter *Key Relationships*).
  - Overseeing the employment of the chief executive, including succession planning and organising induction for a new chief executive.
  - Representing the board in formal assessments of the chief executive's performance, and in the required discussions with the State Services Commission in respect to chief executive terms and conditions at time of appointment and performance reviews (see chapter *District Health Boards as employers*).
  - Ensuring that conflict of interest policies, including disclosure provisions, are in place, that members' conflicts of interest (including those of the chair) are dealt with properly, and that, where appropriate, dispensation is given to act despite being interested.
  - If the chair of a DHB board is not present or is unwilling to preside at a meeting of the board, the deputy chair of the board presides, if he or she is present and willing to do so. If neither of them is present and willing to preside at a meeting of the board, the members present must elect a member who is present to preside at the meeting.

## Chapter 6: General behaviours of board members

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Best practice corporate governance boards exhibit certain behaviours in order to undertake their board role effectively and in accordance with the highest ethical and professional standards, notwithstanding any legal requirements that are placed upon the board. While such behaviours may form the basis of a separate board code of practice/code of conduct, we recommend they also are part of the governance manual.

The list below is not exhaustive nor in order of importance, but it should assist the board to specify appropriate behaviours.

- **Responsibility to the entity.** Members need to recognise and always act consistently with their responsibilities to the DHB and to Ministers. Members owe a duty to the organisation as a whole and are not to act purely in the interest of a specific group. They should attend induction training and board members' professional education to familiarise and update themselves with their governance responsibilities.
- **Strategic perspective.** Members need to be able to think conceptually and see the 'big picture'. They should focus as much as possible on the strategic goals and overall progress in achieving those rather than on operational detail.
- **Integrity.** Members must demonstrate the highest ethical standards and integrity in their personal and professional dealings. They should also challenge and report unethical behaviour by other board members.
- **Intellectual capacity.** Members require the intellectual capacity to understand the issues put before them and make sound decisions on the entity's plans, priorities and performance.
- **Independent judgement.** Members need to bring to the board objectivity and independent judgement based on sound thought and knowledge. They need to make up their own mind rather than follow the consensus.
- **Courage.** Members must be prepared to ask the tough questions and be willing to risk rapport with fellow board members in order to take a reasoned, independent position.
- **Respect.** Members should engage constructively with fellow board members, entity management and others, in a way that respects and gives a fair hearing to their opinions. In order to foster teamwork and engender trust, members should be willing to reconsider or change their positions after hearing the reasoned viewpoints of others.
- **Collective responsibility.** Members must be willing to act on, and remain collectively accountable for, all decisions even if individual members disagree with them. Board members must be committed to speaking with one voice once decisions are taken on a DHB's strategy and direction.
- **Participation.** Members are expected to be fully prepared, punctual and regularly attend for the full extent of board meetings. Members are expected to enhance the quality of deliberations by actively asking questions and offering comments that add value to the discussion.
- **Informed views.** Members are expected to be informed and knowledgeable about the DHB's business and the matters before the board. They should have read the board papers before meetings and keep themselves informed about the environment in which the DHB operates.
- **Understanding.** Members are expected to recognise the need for service delivery to positively reduce disparities between various population groups. Members are expected to understand Māori health and Treaty of Waitangi issues (Schedule 3, clause 5 to the New Zealand Public Health and Disability Act 2000). This includes establishing and maintaining processes to enable Māori to participate in and contribute to strategies for Māori health improvement and to foster Māori capability.

- **Financial literacy.** Boards monitor financial performance and thus all members must be financially literate. They should not rely on other members who have financial qualifications, but should undertake training to improve their own financial skills where necessary.
- **Sector knowledge.** Members need to make themselves familiar with the activities of the entity and sector. This is likely to include attending induction sessions and ongoing background study.

### **Code of Conduct**

As indicated in Chapter 1, amendments to the State Sector Act in 2018 gave the State Services Commissioner an explicit power to issue a code of conduct for Crown entity board members

The intent of this Code is to support and provide greater clarity for member's collective and individual duties as set out in the Crown Entities Act 2004. Given the high profile and important roles members undertake, such a code will assist public transparency, accountability and confidence in the State services. Government and the public have high expectations that everyone in the State services, board members and employees, demonstrate high standards of integrity and conduct. The first draft of this code was sent out for feedback in October 2019, so there is still much to do before it may be applied.

A specific "HBDHB Board Code of Conduct and Ethics was agreed in 2014 and continues to apply to all board members. This Code (in Schedule 4) sets out key principles that govern the conduct of Board members, both individually and collectively. This Code does however need to be reviewed and updated, but such a review may need to be deferred to ensure it aligns with the proposed new Code from the State Services Commissioner (current draft also attached in Schedule 4)

## Chapter 7: Members' interests and conflicts: identification, disclosure and management

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The New Zealand health and disability sector is an inherently close community where relevant knowledge is in high demand from public and private entities. Conflicts of interest are an inevitable result.

To address conflicts of interest in the health and disability sector, the Ministry of Health has published "Conflicts of Interests Guidelines for District Health Boards". These guidelines are aimed specifically at District Health Board (DHB) members. They are a resource to help board members maintain public confidence and integrity in the health sector, in those circumstances where conflicts of interest may exist and need to be managed appropriately. The guidelines discuss members' interests and conflicts and how to manage these under the provisions set out in the New Zealand Public Health and Disability Act 2000. A copy of these guidelines are included in this manual at Schedule 3. The resource can be found in the Publications section of the Ministry of Health's website at: <https://www.health.govt.nz/publications>

A Conflicts of Interests Practice Guide put out by the Institute of Directors is also included at Schedule 3.

To assist with the guideline requirements for documentation, disclosure, regular review and management of member's interests and potential conflicts, a specific form has been developed. An example of this form is attached in Schedule 8. Members will be requested from time to time to complete relevant documentation. All interests declared will be entered into the HBDHB Interests Register which will be tabled at Board meetings and members will be invited to advise of any amendments.

A sample of the interests register is attached in Schedule 7.

The process for disclosing a potential conflict of interest or an interest in a transaction and the resultant procedure to be followed, is set out in HBDHB Standing Orders at clause 2.11. A copy of Standing Orders is attached in Schedule 5.

The HBDHB Company Secretary will be the nominated central contact person for administering interest matters, with the interests register being maintained by the Board Administrator.



## Chapter 8: Disclosure of information

In the course of their work, board members will often have access to information that is commercially sensitive or valuable, or that could be personally sensitive for others. For District Health Boards (DHBs) to be trusted, this information needs to be handled with the highest standards of care and integrity and in a manner consistent with the relevant legislation.

### Principles

Under s. 57 of the Crown Entities Act 2004 (CE Act), board members must not disclose to any person, or make use of or act on information they receive as a member, and to which they would not otherwise have had access, unless:

- it is in the performance of the DHB's functions;
- it is required or permitted by law; for instance, where disclosure is made in accordance with the Official Information Act 1982 (OIA);
- it is complying with the requirement for the member to disclose his or her interests;
- the member has been authorised by the board or by the Minister of Health to disclose the information; or
- the disclosure, use or act in question will not prejudice the DHB or will be unlikely to do so.

However, under s. 57(2) of the CE Act, a member may disclose, make use of, or act on such information, provided that:

- the member is first authorised to do so by the board; and
- the disclosure, use, or act in question will not, or will be unlikely to, prejudice the DHB.

### ***NZPHD Act 2000***

Clause 32 to Schedule 3 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) contains a specific provision regarding the right of a DHB board, by resolution, to exclude the public from the whole or any part of any meeting of the board if the public conduct of the whole or the relevant part of the meeting would be likely to result in:

- the disclosure of information for which good reason for withholding would exist under ss. 6, 7, or 9 (except s. 9(2)(g)(i)) of the OIA; and/or
- disclosure of information, the public disclosure of which would:
  - i) be contrary to the provisions of a specified enactment; or
  - ii) constitute contempt of court or of the House of Representatives.

### ***Official Information Act 1982***

Conclusive reasons for withholding official information under s. 6 of the OIA include:

- prejudice the security or defence of NZ
- maintenance of law and order
- endanger the safety of any person
- damage seriously the economy of NZ

Other reasons for withholding official information under s. 9 of the OIA include:

- protect the privacy of natural persons

- protect information where the making available of the information would disclose a trade secret, unreasonably prejudice the commercial position of a person
- protect information which is subject to an obligation of confidence
- avoid prejudice to measures protecting the health or safety of members of the public
- void prejudice to the substantial economic interests of NZ
- avoid prejudice to measures that prevent material loss to members of the public
- maintain a constitutional convention
- maintain the effective conduct of public affairs through:
  - the free and frank expression of opinions
  - the protection of ministers, board members, officers and employees from improper pressure or harassment
- maintain legal professional privilege
- carry out negotiations and/or commercial activities without prejudice or disadvantage
- prevent the disclosure or use of official information for improper gain or advantage

When considering obligations to provide information to parties, the privacy of individuals must be respected and the Privacy Act 1993 and the Health Information Privacy Code 1994 complied with. (Refer [www.privacy.org.nz](http://www.privacy.org.nz))

## Chapter 9: Gifts and Hospitality

The way in which a board handles gifts and hospitality offered to its members has serious implications for the trust placed in the governance of the entity concerned. When a board member is offered gifts or hospitality, careful judgement is needed in light of the roles and responsibilities of District Health Boards (DHBs). The perception of influence being sought can be as important as the reality.

Like all Crown entities, DHBs have different constituencies and influences. A single prescriptive policy on gifts for board members is impracticable. Gifts or hospitality may be offered for various reasons including as a token of appreciation, as part of a ceremonial occasion, or as an attempt to exercise influence. While the best way of avoiding any perception of influence would be to refuse all offers of gifts and hospitality, this is unworkable in practice. However, there are a set of principles that can inform members' decisions about gifts and hospitality, and to promote transparency and consistency of approach.

### Principles

- Board members should not compromise their integrity by placing themselves under any obligation to a third party. They must always be aware of the public perception that can result from their accepting gifts or hospitality.
- Members must never solicit favours for themselves or others.
- Gifts should be declined unless they are of nominal value, so their acceptance can be judged against internal or other relevant policies.
- Timing and frequency are relevant. Offers of gifts or hospitality, even if of limited monetary value, may be of concern if offered repeatedly and/or at times when they could be seen to influence or reinforce a particular decision or action.
- The commercial influence, actual or perceived, that a gift or benefit may represent is important.
- Hospitality offered may provide opportunities for members to develop productive relationships but their presence at such occasions is potentially open to criticism.

### Practice

The exercise of common sense will usually determine whether an offer of hospitality or a gift should be accepted. Useful tests could be to consider how Parliament, the media, competing suppliers and the wider public might interpret its acceptance; the reasons that may be behind the offer, and how the member would justify accepting what has been offered.

Board members should carefully consider timing and frequency. For instance, extra vigilance is needed in considering a gift offered at a time when an entity is negotiating for purchases or services. Board members should satisfy themselves that any hospitality offered is not too frequent or elaborate given the nature of the relationship, nor is it part of a pattern of invitations which could be considered excessive.

Board policy on the offering or accepting of gifts, hospitality or other benefits, includes:

- board members must not solicit gifts and benefits from, or on behalf of, anyone under any circumstances.
- board members must not accept gifts and benefits from anyone, or on behalf of anyone, who could benefit from influencing them or the DHB.
- open and transparent practices in relation to gifts and benefits are in place, to enhance trust in the State services, and reduce any misplaced speculation.

- a principles based approach to each situation rather than the dollar value of gifts or hospitality will determine what is appropriate for board members to accept, and the practice to be followed regarding the use of benefits in kind (eg, air points).
- unless they are 'consumable' at the time (eg, meals, invitation to events), gifts should be regarded as the property of the DHB.
- context be taken into account when considering hospitality offered by stakeholders, to balance the opportunities that may be provided against the potential for criticism. For instance, does the timing coincide with a particular board decision that affects the donor; how relevant is the event or function to the DHB's role; will the board's interests genuinely be advanced by having a member present; should the DHB itself meet the costs of attendance, to avoid any perceptions of influence?
- close scrutiny be made of offers such as invitations to attend conferences in New Zealand or overseas that may include travel, accommodation, meals, a speaking fee, and/or inclusion of a member's partner. It is essential to consider whether there would be real value to the DHB from attendance and, if so, who is best placed to represent it.
- all boards which are considering offering gifts or hospitality should think very carefully about both the cost and the public and political perception of doing so. Policies need to specify the purposes for which, and occasions on which, it is acceptable to offer gifts, and the nature and value of gifts that are appropriate to particular occasions.

### **Koha**

DHBs should be clear about their approach to the question of koha, to avoid misunderstandings. Koha is a gift, token or contribution given on appropriate occasions, such as a visit by board members in conjunction with a consultation hui. It is not a transaction in the usual sense: for example, there often is no written acknowledgement of receipt.

The OAG's good practice guide on sensitive expenditure ([www.oag.govt.nz](http://www.oag.govt.nz)) includes an expectation that entities will ensure that:

- their policy on koha includes the means of determining the amount of any koha;
- a koha reflects the occasion;
- koha is not confused with any other payments that a DHB makes to an organisation; and
- koha is approved in advance, at an appropriate level of authority.

These principles need to be applied to koha received as well as given.

### **Disclosure**

The DHB has in place procedures that enable the chair to disclose and seek advice on gifts and hospitality that are offered. Members should seek advice from the chair or other appropriate source if they are at all uncertain about the appropriate action to take. All such disclosures will be made by use of the appropriate form attached in Schedule 8.

Disclosing gifts and hospitality as soon as practicable after they are accepted and maintaining a register of them, represents an effective and transparent way for boards to demonstrate integrity in practice, both as a model of accepted behaviour within the DHB concerned and in respect of their stakeholders. A sample of the register maintained by HBDHB is attached in Schedule 7.

## Chapter 10: Board Meeting Procedures

Boards need a clear understanding of any legal provisions regarding their meeting procedures, and to organise their business in a way that meets statutory obligations and the expectations of their stakeholders, while maximising the use of members' time and skills.

The procedures for District Health Board (DHB) meetings are contained in Schedule 3 to the New Zealand Public Health and Disability Act 2000 (NZPHD Act). Key provisions include:

- all meetings of DHBs must be publicly notified during a specified time period (clause 16), but no meeting of a board is invalid because it was not publicly notified (clause 17);
- meeting agendas and papers must be available for inspection by any member of the public at least two working days before every meeting (clause 19), and board minutes must be available for public inspection except for those meetings or parts of meetings from which members of the public were excluded (clause 21);
- no business of a DHB board can be transacted, nor any power or discretion exercised at any board meeting unless the quorum of members is present (clause 25 (1)). The quorum is defined in clause 25(2), and the consideration of declared interests and board vacancies in establishing a quorum are contained in clause 26; and  
(NOTE: With 11 members, the quorum for a DHB Board meeting is 6)
- DHB board meetings are open to the public (clauses 31 and 34), though the board has the right to exclude the public in certain circumstances (clauses 32 and 33).

Schedule 4 to the NZPHD Act contains the equivalent provisions that apply to meetings of DHBs' community and public health advisory committees, disability support advisory committees, and hospital advisory committees.

### ***Standing Orders***

HBDHB has adopted "Standing Orders" to provide more detailed guidance on procedures and processes associated with meetings. These Standing Orders apply to the proceedings of all HBDHB board and committee meetings, including public excluded sessions, and it is required that all members of the board and committees shall abide by them.

A copy of these Standing Orders are attached as Schedule 5.

### ***Board Workplan***

To ensure that all regular and major strategic issues are addressed in a timely way, the board will develop and maintain an annual workplan. This workplan will be included in the agenda papers for all board meetings, and discussed and/or updated at each meeting as appropriate. A sample of the Governance Workplan is attached in Schedule 7.

### ***Crown monitors***

Under s. 30 of the NZPHD Act, the Minister of Health may appoint one or more Crown monitors to any DHB board, to assist in improving the performance of that DHB. If such a Crown monitor has been appointed, the board must:

- permit each Crown monitor appointed by the Minister in relation to the DHB to attend any meeting of the board; and
- provide the Crown monitor with copies of all notices, documents, and other information that is provided to board members.

The functions of a Crown monitor are to:

- observe the decision-making processes, and the decisions of the board;
- assist the board in understanding the policies and wishes of the Government so that they can be appropriately reflected in board decisions; and
- advise the Minister on any matters relating to the DHB, the board, or its performance.

A Crown monitor may provide to the Minister any information that the Crown monitor obtains in the course of carrying out their functions as noted above.

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## Chapter 11: Board Committees

Board committees can enhance the effectiveness and efficiency of boards, by allowing closer scrutiny and more efficient decision-making in different areas of board responsibility. When boards establish committees, careful consideration is required of the powers, duties, reporting procedures, membership and duration that apply to the committees.

### **Legislative basis**

Every District Health Board (DHB) must establish three Advisory Committees under ss 34-36 of the NZPHD Act. These are Community and Public Health (CPHAC), Disability Support (DSAC), and Hospital Advisory Committees (HAC). Schedule 4 to the NZPHD Act contains provisions concerning the functions, membership, meeting procedures, voting, public access and disclosure of members interests relating to these committees, with ss 34-36 containing specific provision for Maori membership of these committees.

Under clause 38 of Schedule 3 to the NZPHD Act, the board of a DHB may also establish one or more committees for particular purposes, and appoint to such committees members of the board and/or other persons. As a result of the enactment of a recent amendment, the NZPHD Act now requires the approval of the Minister of Health before establishing a new committee of the board.

The board has the power to dismiss any committee member and to dissolve any committee. If a member is dismissed, the board must provide that person with a written statement of the reasons for their dismissal, as soon as reasonably practicable.

If a person who is not a member of the DHB board is appointed to a board committee, that person must disclose to the board any conflict of interest he or she has with the DHB at that time, or that is likely to arise in the future (Schedule 4, clause 6(3)(a)(b), NZPHD Act). However, if a DHB board member is appointed to a board committee, they do not have to disclose their already known conflicts.

### **Key considerations**

Good practice for DHB board committees includes provisions such as:

- Committees should only exist where there is clear reason for them, and they assist the governance of the DHB
- Discretionary committees should be subject to regular review as to whether they should continue
- There should be explicit reporting requirements back to the Board, which will allow other members to question committee members and assess the effectiveness of the committee
- An audit committee, providing oversight of the Board's financial and risk management, is widely recommended in the public sector
- An audit committee should generally include some independent (non-board) members, members with financial expertise, and a committee chair who is not the board chair.
- One operational matter that is often delegated to a remuneration committee is the review of the Chief Executive's performance.

### **HBDHB Committees**

HBDHB currently has provision for six board committees:

- Community and Public Health Advisory Committee (CPHAC)
- Disability Support Advisory Committee (DSAC)
- Hospital Advisory Committee (HAC)
- Finance, Risk and Audit Committee (FRAC)

- Maori Relationship Board (MRB)
- Appointments and Remuneration Advisory Committee (ARAC)

The Board has also approved the establishment of a Sub Committee of CPHAC being Pacific Health Leadership Group. Current terms of reference (TOR) for each of the above committees and subcommittee are attached in Schedule 2.

Note: From 2013 CPHAC, DSAC and HAC ceased to have regular individual committee meetings, with stakeholder input now being provided by the Clinical and Consumer Councils.

### ***Hawke's Bay Clinical Council***

HBDHB in collaboration with Health Hawke's Bay Ltd (PHO) has the Hawke's Bay Clinical Council as part of its governance structure. The Clinical Council is the principal clinical governance, leadership and advisory group for the Hawkes Bay health system

Its functions include:

- Provide clinical advice and assurance to the Hawkes bay health system management and governance
- Work in partnership with the HB Health Consumer Council to ensure Hawkes Bay health services are organised around the needs of people
- Provide oversight of clinical quality and patient safety
- Provide clinical leadership to the Hawkes Bay health system workforce

Given the nature of the issues to be discussed, the engagement process and status of the members and the requirement for the Council to report to the Board (and the PHO) through the Chief Executive, the Clinical Council is technically a management committee (rather than a board committee) with a governance function.

The TOR of the Clinical Council is attached in Schedule 2.

### ***Hawke's Bay Health Consumer Council***

HBDHB, in collaboration with Health Hawke's Bay Ltd (PHO) has also established the Hawke's Bay Health Consumer Council. The Consumer Council essentially mirrors the Clinical Council in its structure and status, with a clear purpose:

- "The Hawke's Bay Health Consumer Council (Council) works collaboratively with the Hawke's Bay District Health Board (HBDHB) and Health Hawke's Bay Ltd governance and management teams, and the Hawke's Bay Clinical Council to develop effective partnerships in the design and function of an effective health system in Hawkes Bay that meets the needs of the people.
- Through true partnership, the Council provides a strong and viable voice for the community and consumers, on health service planning and delivery. The Council seeks to enhance consumer experience and service integration across the sector, promote equity and ensure that services are organised around the needs of people.

The TOR of the Consumer Council is also attached in Schedule 2.

***Guidance on audit committees***

For guidance on DHB audit committees see the *Audit Risk and Finance Handbook for District Health Boards*, issued by the Ministry of Health: (Refer Schedule 10)

[www.moh.govt.nz](http://www.moh.govt.nz)

In addition, for guidance on audit committees in the New Zealand public sector, see the good practice guide issued by the Office of the Auditor-General:

[www.oag.govt.nz](http://www.oag.govt.nz)



## Chapter 12: Delegations

All decisions about the operation of a District Health Board (DHB) must be made by, or under the authority of, the board in accordance with the New Zealand Public Health and Disability Act 2000 (NZPHD Act). Where a board's powers and functions have been delegated, good governance and statute mean that the board remains legally responsible for the exercise of those functions and powers exercised under the delegation.

Each DHB is required to have a policy for the exercise of its powers of delegation: the formulation, amendment or replacement of such policies must be approved by the Minister of Health (the Minister), who can specify any conditions. The board's delegations policy must be made publicly available, (Schedule 3, clauses 39 and 40, NZPHD Act). The policy is a statement of how the board intends to exercise its powers of delegation (including financial matters, statutory and regulatory powers) and the reasons for doing so. The actual delegation will be made by letter from the board to the person concerned. The current HBDHB "Delegation of Board Authority Policy" is attached in Schedule 9.

### Effect of Delegation

The board remains responsible for the actions of its delegates in exercising the board's powers. Boards, therefore, need to be satisfied that delegates will use powers appropriately and not expose the board to risk. All requirements applying to a board in relation to a power will apply equally to the delegate.

### Conditions attached to delegations

There are a number of procedural checks and balances on delegating. These are designed to ensure the board always remains in control of and responsible for the exercise of functions and powers by delegates. Sections 73 to 76 of the Crown Entity Act 2004 (CE Act), which set out the provisions relating to delegations, do not apply to DHBs (see s. 21 of the NZPHD Act). However, clauses 39 and 40 of Schedule 3 to the NZPHD Act contain the relevant provisions relating to delegations in respect of DHBs. These include:

- the delegation of a DHB board's function, duty or power is revocable at will;
- a delegate may not delegate the function, duty or power without the written consent of the board or unless it is done in accordance with the provisions of the delegation;
- the board cannot delegate a function or power unless it has authorised the delegation by resolution and written notice to the delegate;
- delegation of a function, duty or power does not prevent the board or the DHB concerned from performing that function or duty, or exercising that power;
- clause 39(8) of Schedule 3 to the NZPHD Act contains provisions concerning the exercise of delegated functions, powers or duties when the delegate may have conflicts of interest with the DHB. A delegate who is interested in a transaction of the DHB concerned may not perform any function, power or duty under the delegation if it relates to the transaction concerned, unless the board of the DHB has given its prior written consent (clause 40); and
- a person acting under a delegation should be able to produce evidence of their authority to exercise functions and powers when asked to do so.



## Chapter 13: District Health Boards as employers

District Health Boards (DHBs) have obligations as employers; these are set out in the Crown Entities Act 2004 (CE Act) and other legislation, and in government statements.

### ***Chief executive employment***

The employment of a DHB's chief executive is a key responsibility of a board.

Under s. 26 of the New Zealand Public Health & Disability Act 2000 (NZPHD Act), the board of a DHB must delegate to their chief executive the power to make decisions on management matters relating to the DHB. Any such delegation may be made on such terms and conditions as the board thinks fit.

Chief Executives of DHBs have independent responsibility for all matters relating to individual employees (such as appointment, promotion and cessation of employment) without any interference from the board, its committees or from board members (Schedule 3, clause 44(4), NZPHD Act).

The board should ensure that a robust process is followed in preparing the position description, seeking suitable candidates and selecting the chief executive. The terms and conditions for chief executives of DHBs are determined by agreement between the board and the appointee. In accordance with clause 44(1) of Schedule 3 to the NZPHD Act, these terms and conditions and any amendments to them (which includes remuneration reviews), must not be finalised without first obtaining the consent of the Fees & Remuneration team at the State Services Commission

The State Services Commission has model agreements which contain the standard terms and conditions for chief executives of Crown entities, including DHBs. Use of these model agreements is not mandatory but it is recommended, at least as a starting point, because they incorporate good legal practice, manage risk, and are likely to make the consultation process smoother. The model agreements can be tailored to the requirements of the particular DHB. They are available at [www.ssc.govt.nz](http://www.ssc.govt.nz).

### ***Chief Executive Performance Management***

Good practice in relation to chief executive performance management would include:

- the board defining the performance expectations of the chief executive, and the criteria against which performance will be measured;
- ongoing and constructive discussions between chair and chief executive;
- addressing problems early, for instance by the chair communicating and discussing non-performance concerns; and
- a formal performance evaluation process, managed by the board chair.

### **Employer responsibilities**

#### **Good employer**

Under s. 118 of the CE Act, a DHB is required to operate a personnel policy that complies with the principles of being a good employer. These principles include provisions requiring:

- good and safe working conditions;
- an equal opportunities programme;
- impartial selection of suitably qualified people for appointment; and
- recognition of the aims and aspirations and employment requirements of Māori and ethnic or minority groups and the employment requirements of women and people with disabilities.

The Equal Employment Opportunities Commissioner at the Human Rights Commission has responsibility for issuing good employer and EEO guidance to Crown entities. That advice can be found at: [www.neon.org.nz/crownentitiesadvice/](http://www.neon.org.nz/crownentitiesadvice/).

#### **Standards of integrity and conduct**

*Standards of Integrity and Conduct* is the code of conduct issued by the State Services Commissioner under s. 57 of the State Sector Act 1988. The code applies to all staff (but not board members) of statutory Crown entities including DHBs, and to board members and staff of some subsidiaries of Crown entities. It must be reflected in each DHB's internal policies. The Code can be found at: [www.ssc.govt.nz/code](http://www.ssc.govt.nz/code), together with additional guidance on its interpretation and application.

#### **Pay and employment conditions – government expectations**

The government's expectations for pay and employment conditions in the State sector extend to all public service employees (not just those covered by collective agreements) and to all Crown entities, including DHBs. DHBs are required to take a number of factors into account in setting pay and employment conditions, including:

- fiscal sustainability and value for money;
- contributing to the achievement of the DHB's strategic business outcomes;
- avoiding risk of flow-on implications to other parts of the State sector;
- fairness to employees and taxpayers; and
- enhancing productivity and fostering continuous improvement.

The expectations are set out in: [www.ssc.govt.nz](http://www.ssc.govt.nz).

The Minister of Health will require DHB boards to have regard to these expectations when establishing pay and employment conditions.

Chief executives of DHBs may enter into collective agreements on behalf of the board with any or all of the board's employees, provided the Director-General of Health has first been consulted about the terms and conditions of such an agreement. (Schedule 4, clause 44(4), NZPHD Act).

#### ***Employment code of good faith***

The Employment Relations Act 2000 contains a code of good faith for the public health sector (s. 100D(1) and Schedule 1B), which applies to DHBs. The code applies subject to other provisions of that Act and any other enactment that does not limit the duty of good faith in relation to the health sector. Further, the code of good faith for collective bargaining and the code of employment practice also applies in relation to the health sector (s. 100D(5), Employment Relations Act 2000).

## Chapter 14: Subsidiaries

A DHB may establish one or more subsidiaries, either partly or fully owned, to carry out its functions and contribute towards the achievement of its objectives. The parent entity remains accountable for activities and performance of a subsidiary, which are reported in the parent entity's results. Accordingly the board should ensure that it follows governance good practice in establishing any subsidiary, and in monitoring and reporting on its activities.

### **Legislative basis**

#### **Types of subsidiaries**

"Crown entity subsidiaries" are companies that are controlled by one or more Crown entities (sections 7 and 8, Crown Entities Act 2004 (CE Act)). Each such subsidiary is a Crown entity in itself. The Companies Act 1993 applies to such subsidiaries, and their board members are directors under that Act.

The test for control is that expressed in ss. 5 to 8 of the Companies Act 1993. Essentially this is control of the composition of the board, or greater than 50% of either the shareholding, right to dividends, or voting rights. The definition of a Crown entity subsidiary in s. 7 of the CE Act also includes multi-parent subsidiaries i.e. where several DHBs, each with less than a controlling interest, have come together to establish a company.

Some bodies established by Crown entities do not come within the definition of "Crown entity subsidiary" in s. 8 of the CE Act. These are bodies that are not companies (e.g. trusts, incorporated societies or other non-company bodies), or that are associate companies (i.e. where the test for control is not met).

#### **Which Crown entities may establish subsidiaries?**

All Crown entities (other than corporations sole) are authorised to acquire and establish Crown entity subsidiaries.

Under s. 28 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) no DHB may, except with the consent of the Minister of Health (the Minister) or in accordance with regulations made under this Act:

- a) hold any shares or interests in a body corporate or in a partnership, joint venture, or other association of persons; or
- b) settle, be or appoint a trustee of, a trust.

The Minister's consent may be given subject to any conditions the Minister specifies. Any such conditions must be consistent with s. 97 of the CE Act.

#### **Rules that apply to subsidiaries**

The provisions of the Companies Act 1993 apply to Crown entity subsidiaries (except as provided in s. 102 of the CE Act). As subsidiaries are Crown entities themselves, the following applies to them:

- the provisions of the CE Act;
- other legislation that is applicable to Crown entities generally or DHBs in particular; or
- the other relevant chapters of this guidance.

The Minister's relationship is with the parent entity rather than directly with a subsidiary. Responsible Ministers generally have no power to give policy, whole of government or other directions to Crown entity subsidiaries. Accordingly, ss. 97 and 98 of the CE Act set out the obligations the parent has to ensure that the subsidiary acts in accordance with the parent's functions and objectives, and observes the same statutory limitations as are applied to the parent. Sections 52 and 93 of the CE Act specify that one of the collective duties of the board of a DHB is to ensure that it complies with ss. 96 to 101 (relating to the formation and shareholding of subsidiaries).

For multi-parent subsidiaries, the responsible Minister of the parent DHB must agree how the restrictions and obligations on subsidiaries in the CE Act apply to the subsidiary (s. 99).

### ***Key considerations***

The parent DHB is accountable for a subsidiary's activities, including ensuring it complies with legislative restrictions. Among other things, the board will want to put in place procedures for ensuring:

- best practice in the identification and appointment of directors for the subsidiary, including setting appointment terms and fees (see also the chapter Remuneration and expenses for board members, in regard to fees for directors of subsidiaries);
- appropriate business planning and monitoring procedures, including that public accountability documents such as statements of intent and annual reports for the DHB adequately include information on the activities of the subsidiary;
- an internal control environment is in place so that the subsidiary complies with statutory obligations and is well managed; and
- reporting to the board of the DHB/s concerned on the activities and the performance of the subsidiary, including any exceptions that are highlighted by the internal control environment.

## Chapter 15: Planning and Reporting

Key board responsibilities include strategic planning, monitoring and reporting publicly on the expected and actual performance of their District Health Board (DHB); this enables Parliament and the public to hold Crown entities accountable.

Section 42 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) confirms the requirement for all DHBs to prepare statements of intent, annual financial statements and annual reports in accordance with Part 4 of the Crown Entities Act 2004 (CE Act) and any regulations made under s. 92(1) of the NZPHD Act. The expectation that boards are fully engaged in these areas is reflected by the requirement that these two accountability documents are signed by members of the board.

In 2008, the Auditor-General issued a discussion paper on the quality of performance reporting, in which he observed that “as well as their external accountability purpose, performance reports should reflect good management practice. Such practices involve clearly articulating strategy, linking strategy to operational and other business plans, monitoring the delivery of operational and business plans, and evaluating strategy effects and results”<sup>4</sup>.

The DHB’s Operational Policy Framework further specifies the financial requirements for DHBs. An annually updated version of the DHB’s Operational Policy Framework can be found through the following website: [www.nsfh.health.govt.nz/](http://www.nsfh.health.govt.nz/).

Section 38 (1) of the NZPHO Act–

- Requires the Minister to direct every DHB to prepare a plan for each financial year beginning on or after 1 July 2011; and
- Enables the Minister direct a DHB to prepare or contribute to 1 or more other plans.

Every plan directed to be prepared or contributed to under section 38(1) must meet the criteria set out in section 38 (2). Those criteria include the requirement that the plan address –

- Local, regional, and national needs for health services; and
- How health services can be properly coordinated to meet those needs; and
- The optimum arrangement for the most effective and efficient delivery of health services.

Further requirements relating to the plan are set out in subsections (3) to (8). Of note, subsection (5) requires that a DHB that is a party to the plan must give effect to it.

Section 39 provides a process that the Minister may use to resolve disputes over the contents of a plan that the Minister has directed a DHB to prepare or contribute to under section 38.

### Statements of Intent

The purpose of a Statement of Intent (SOI) is to promote the public accountability of a Crown entity (s. 138, CE Act) by:

- enabling the Crown to participate in the process of setting the entity's medium-term intentions and undertakings;
- setting out for the House of Representatives those intentions and undertakings; and
- providing a base against which the actual performance can later be assessed.

The Minister may participate in determining the content of the SOI, by agreeing with the DHB on any additional information to be incorporated; specifying the form in which any information

<sup>4</sup> *The Auditor-General’s observations on the quality of performance reporting*, Office of the Auditor-General, June 2008.

must be presented; commenting on a draft SOI; and directing amendment in relation to some of its content (s. 145, CE Act).

An SOI flows out of a DHB's strategic planning process, and through it the board expresses its strategic thinking and future intentions. The SOI articulates the impacts, outcomes, or objectives that the DHB seeks to achieve or contribute to. It includes qualitative and quantitative (financial and non-financial) measures and standards against which future performance will be assessed. The SOI is prepared under the leadership of the board, signed off by the board, and tabled by the Minister in Parliament.

The SOI will reflect engagement with the Minister and Ministry of Health through the planning process, and should incorporate Government's health sector and all-of-government priorities.

### **Crown Funding Agreements (Output Agreements)**

The Minister may require a DHB to have a Crown Funding Agreement (CFA) for goods or services the DHB intends to supply that are paid for by the Crown. The CFA is agreed annually between the DHB and the Minister. It is an "output agreement" for the purposes of Part 4 of the CE Act, and s. 170(2) to (5) of the CE Act applies to the CFA (s. 10(2A), NZPHD Act).

Where there is a CFA, a separate output agreement is not necessary for that DHB and cannot be required under s. 170(1) of the CE Act (s. 10(6), NZPHD Act).

The purpose of a CFA/Output Agreement is to assist the Minister and the DHB to clarify, align and manage their respective expectations and responsibilities for the funding and production of outputs, including the standards, terms and conditions under which the DHB will deliver and be paid for the outputs.

An output agreement need not be legally enforceable as an agreement (s.170(4), CE Act), but it does create legally-enforceable duties on the Board members to ensure that the DHB acts consistently with its objectives, functions, current SOI, and the current output agreement (ss. 49 and 92, CE Act).

Output agreements may also include accountability arrangements such as reporting requirements and how the relationships between the Minister, the DHB and the Ministry of Health will be managed.

### **Annual Report**

DHBs report on their performance to the Minister and Parliament through their annual reports (ss. 150 – 157, CE Act). The annual report must provide information that enables an informed assessment to be made of the DHB's operations and performance for that financial year, including an assessment against the intentions, measures, and standards set out in the SOI. Through this document, the board informs stakeholders on how it is leading the performance of the DHB, and how it is using public resources. The CE Act sets out specific information that must be included, for instance the annual financial statements for the DHB, a statement of service performance, any direction given to the DHB by a Minister in writing, and the total value of the remuneration paid to each board member during the financial year (sections 151 and 152, CE Act).

Every annual report of a DHB also must contain:

- a report on the extent to which it has met its other objectives under s. 22, NZPHD Act;
- a report on the performance of the hospital and related services the DHB owns;

- the names of any bodies corporate, partnerships, joint ventures or other associations, or trusts with which the DHB is involved, and a list of all shares and interests the DHB holds in such bodies; and
- a statement of how the DHB has given and intends to give effect to its functions specified in s. 23(1)(b) – (e) of the NZPHD Act.

The board will lead development of the annual report, including engagement as necessary with the Minister.

The Auditor-General is the DHBs' auditor, but will generally appoint another auditor to act on his or her behalf. The auditor is required to audit the annual financial statements, statement of service performance, the annual report, and any other required or agreed information.

The annual report must be in writing, be dated, and be signed on behalf of the DHB board by two board members. A DHB must provide its annual report to the Minister of Health within 15 working days of receipt of the audit report; it is recommended that a near final draft also be provided to the Ministry of Health, to enable the Minister to be briefed on key issues.

For assistance in developing an annual report, please refer to *Preparing the Annual Report 2008: Guidance and Requirements for Crown Entities* [www.ssc.govt.nz](http://www.ssc.govt.nz). The Minister presents the annual report to Parliament according to the timetable set out in this guidance.

#### **Enduring letter of expectations**

An enduring letter of expectations to Crown entities is issued periodically, with the most recent on 26 July 2012: see [www.ssc.govt.nz](http://www.ssc.govt.nz). It sets out the ongoing expectations that the Minister of Finance and the Minister of State Services have of all statutory Crown entities, including DHBs. These expectations include effective self monitoring by boards, increasing transparency of performance and "Better Public Services" delivery. . An enduring letter remains 'in force' until it is replaced.

#### **Annual letter of expectations**

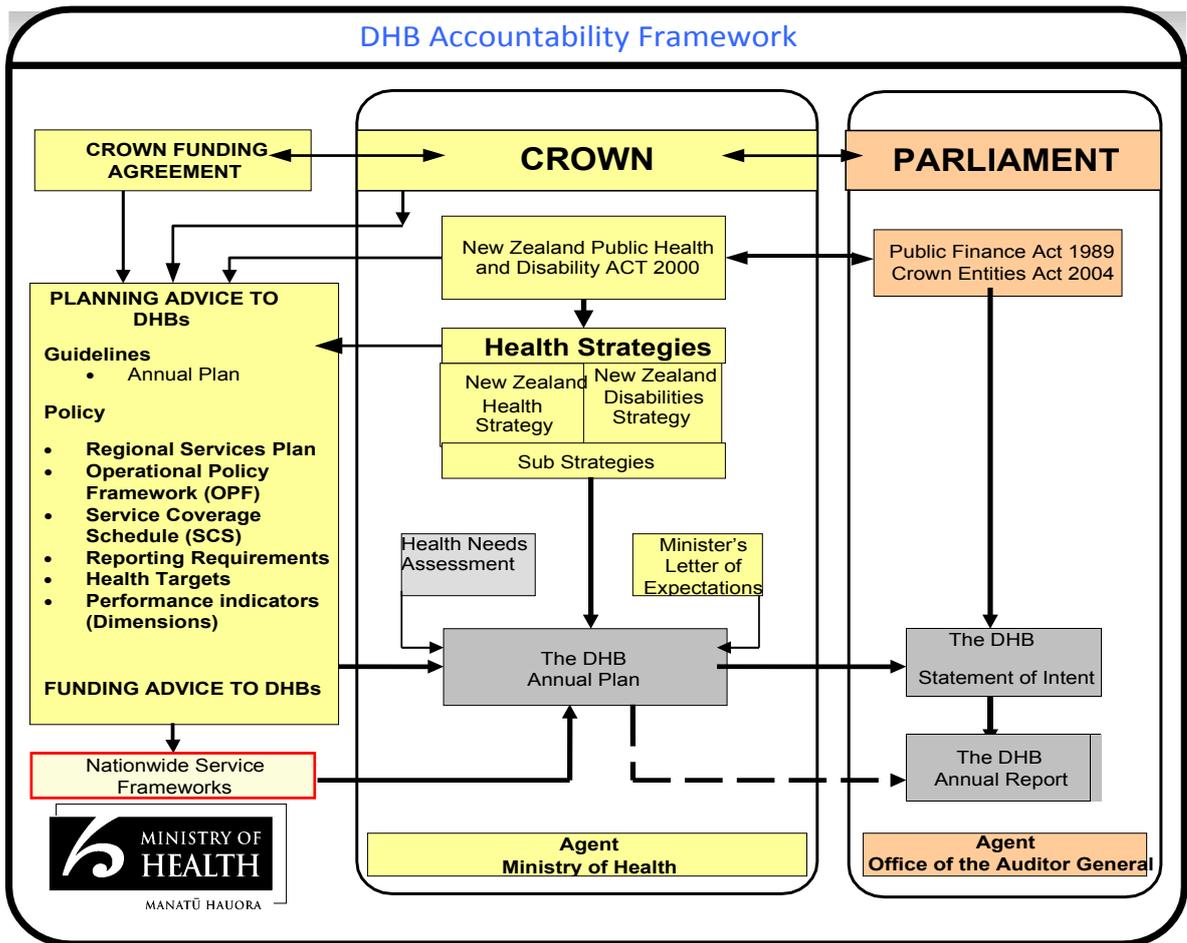
Ministers "participate in the process of setting and monitoring the entity's strategic direction and targets" (s. 27(1)(f), CE Act). Ministerial expectations for DHBs' strategic direction and their specific priorities for the planning period may be reflected in a letter of expectation from the Minister to the DHB. It may also cover expectations of a DHB's governance and performance and of the monitoring information to be provided. The letter will usually be sent to the chair before the board starts its annual planning.

#### **Health Sector Framework**

Collectively all the above planning and reporting documents and processes make up a Health Sector Framework, largely enabled by the recent legislative changes (and the pending regulatory changes that will flow from this). The government has introduced these changes to support a more unified public health and disability sector and to provide a legislation environment more conducive to a high performing system. In order to maximise the value of local input and decision making of these issues, it is important that Board members understand the objectives, structures, strategies and processes within the new framework.

#### **DHB Accountability Framework**

A diagrammatic view of the DHB Accountability Framework.



**Annual DHB Planning Package**

The Ministry of Health (MoH) produces a DHB Planning package by December annually for the following financial year. The Package is designed to assist the DHB sector to meet its legislative obligations to produce annual plans, regional services plans, and statements of intent, and meet accountability requirements. The development of the Planning Package is completed in consultation with the health sector and central Government agencies and the process normally begins in August.

Typically there are two components to the DHB Planning Package and these are:

1. Planning Guidelines that provide guidance for the DHBs to develop their annual planning documents
2. Updates to the Crown Funding Agreement schedules, including reporting requirements for the coming year

A DHB Funding package, issues separately to the Planning package, is timetabled for release before Christmas each year and includes the expected appropriation funding including the forecast inter-district flow payments.

### Planning Guidelines

Planning Guidelines issued by the MoH, include structural, organisational and process planning guidance, along with information about the Ministerial priorities for the coming year and the expectations arising from these priorities on the DHB sector. Guidelines are prepared for the following documents:

- *Regional Services Plan* – a plan prepared under s. 38 of the NZPHD Act 2000 by a group of two or more DHBs and relates to services provided for a region by those DHBs. The RSP contains both strategic and implementation components and must be updated annually.
- *Statement of Intent (SOI)* – An SOI prepared under s. 139 of the CE Act 2004, with a four year outlook. This is tabled in parliament at least once every three years
- *Annual Plan* – All DHBs must produce an Annual Plan under s. 38 of the NZPHD Act 2000 that sets out the DHBs planned performance for the financial year providing accountability directly to the Minister of Health.
- *Statement of Performance Expectations (SPE)* – prepared under s.149C of the CE Amendment Act 2013 includes forecast financial statements and is tabled in Parliament annually
- *Public Health Unit Annual Plan* - A stand-alone document developed by Public Health Units to ensure they deliver services that are aligned with Government, MoH and DHB priorities

NOTE: The Planning Guidelines for the DHB Annual Plan encourages the development of a singular but modular document incorporating the SOI and SPE. This modular structure enables the SOI (when relevant) and SPE components to be extracted if necessary and tabled in Parliament.



## Chapter 16: Board & Member Performance Evaluation

Evaluating the performance of the board and of board members allows a board, led by the chair, to take stock and reflect on both these aspects of performance. The knowledge gained from the review is a means to continually improve the effectiveness of the leadership and governance of the entity.

The board should assess its own performance in relation to the board's key responsibilities, which include:

- managing the relationship with the Minister and meeting the Minister's expectations;
- strategic planning;
- discharging the board's legal and ethical obligations;
- monitoring entity performance;
- monitoring and reviewing the performance of the chief executive; and
- managing relationships with stakeholders.

The benefits of evaluating individual board member performance include:

- providing feedback to individual board members, so their contribution to the board's work can be maximised;
- the ability to put in place mentoring, development or training for individual board members or the board as a whole;
- reinforcing the accountability of the chair for the effective performance of the board; and
- assisting the Minister of Health with succession planning, appointment and reappointment processes.

Principles of good practice in evaluating board performance are that:

- It should be undertaken regularly, preferably each year
- A formal method provides an objective framework for evaluation
- Board member peer review is consistent with the self appraisal principle whereby professionals monitor their own performance
- Confidentiality should be observed to allow for the free expression of views.

The chair is expected to offer appropriate feedback to the board and to individual members, and to provide assurance to the Ministry of Health that a process for performance evaluation is in place and that it is undertaken. A detailed outline of requirements is set out in the Operational Policy Framework for DHBs: [www.nsfh.health.govt.nz](http://www.nsfh.health.govt.nz).

In December 2012, the HBDHB Board engaged the services of the Institute of Directors, and using the IOD "Better Boards" appraisal system, carried out a review of the Board, Chair and individual member's performance. An action plan was developed from feedback to this process, and a decision was made to conduct the 'whole of Board' part of the process again, every three years, twelve months after each election. Subsequent appraisals have been undertaken in 2015, 2017, and again in 2018 as part of a Central Region collective/comparative review of Board's performance. The next appraisal will be due in November/December 2020.



## Chapter 17: Board Appointments & Reappointments

Board appointment and reappointment decisions have considerable impact on performance. Every vacancy for an appointed member on a District Health Board (DHB) creates an opportunity to reassess the future needs of the DHB, and the skills and experience that will best complement the talents of the other board members. Where possible boards, through the chair, should be involved in these processes: this could be through the Ministry of Health or direct to the Minister of Health (the Minister).

### ***DHB board membership***

The board of each DHB consists of:

- seven members elected in accordance with Schedule 2 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act); and
- up to four members appointed by the Minister under s. 28(1)(a) of the Crown Entities Act 2004 (CE Act) which states that a responsible Minister may only appoint a person who, in the Minister's opinion, has the appropriate knowledge, skills, and experience to assist the DHB to achieve its objectives and perform its functions.

If, at an election of members of a board of a DHB, fewer than seven members are elected, the Minister may, in accordance with the procedure in s. 28 of the CE Act, appoint persons who were eligible to stand in that election to fill the vacant elected member positions. Those who are so appointed hold office in all respects as if they had been elected under the NZPHD Act.

Where a vacancy occurs in an elective position on a board, the Minister may, in accordance with the procedure in s. 28 of the CE Act, appoint a person for the remainder of the term of office of the person who vacated office.

In making appointments to a DHB board, the Minister must endeavour to ensure that:

- Māori membership of the board is proportional to the number of Māori in the DHB's resident population; and
- in any event, there are at least two Māori members of the board.

### ***Chair and deputy chair appointments***

The Minister must, by notice in the *Gazette*, appoint one member of the DHB board as chair of the board, and another as deputy chair. This notice may be the same as the notice appointing the member. It must state the period for which the member is appointed chair or deputy chair, and the date on which he or she comes into that office.

A member appointed chair or deputy chair, and whose appointment as such has expired:

- continues in that office until his or her successor is appointed; and
- is eligible for reappointment to that office so long as he or she continues to be a member of the board.

Chairs and deputy chairs retain all their responsibilities as a board member as well as any additional responsibilities deriving from their chair or deputy chair role.

### ***Role of Chair in appointment processes***

The Minister or Ministry of Health should generally engage with the Board chair throughout the process of appointing a DHB board member. The chair should be able to:

- reflect his/her knowledge of the workings of the board and its less formal interactions and relationships, as part of identifying the skills needed of an appointee;
- provide feedback on the board's annual evaluation as to the future needs of the entity (refer chapter *Board and member performance evaluation*);
- assist with updating position descriptions; and
- suggest nominees for consideration.

Where possible, board chairs should also be part of the selection and interview panel for appointed board members. This would not be appropriate where the chair is being assessed for reappointment or replacement.

#### **Desirable Attributes in Appointed Board Members**

The skills and attributes most relevant to a specific vacancy that is filled by ministerial appointment rather than election are determined by analysing the current composition of the board in question. This analysis also involves the board's chairperson, and considers the board's needs and the particular challenges faced by the DHB in terms of performance, health outcomes and collaboration. Other factors may also be considered (eg, if the board is planning a major capital development).

Board appointees must have backgrounds that demonstrate strong personal integrity to enable them to meet their obligations in terms of personal behaviour and ensuring the propriety of the DHB's actions (set out in sections 53-57 and 59 of the CE Act).

Generic skills for a board member will usually include:

- a wide perspective on, and awareness of, social, health and strategic issues
- integrity and a strong sense of ethics
- financial literacy and critical appraisal skills
- strong reasoning skills and an ability to actively engage with others in making decisions
- knowledge of a board member's responsibilities, including an ability to distinguish governance from management, understanding of collective responsibility and an appreciation of the Crown as owner
- good written and oral communication skills
- an ability to contribute constructively and knowledgeably to board discussions and debates.

These qualities will usually be demonstrated through some or all of the following:

- governance experience in significant organisations with either a commercial, public service or community focus
- experience at chief executive or senior management level in organisations that have commercial or public service attributes
- holding senior positions in relevant professional areas including, but not limited to, health, social services, finance, law, and social policy
- relevant governance or management experience in community or professional organisations.

In addition to the above qualities, members are often appointed for their unique abilities, such as expertise in an area of specialisation or representation.

**Conflicts of interest**

Before a chair, deputy chair or member is appointed or elected, they must declare their conflicts of interest. Members to be appointed declare their interests to the Minister of Health before their appointment (s. 31(1)(c), CE Act). Candidates for elected member positions give a statement to the electoral officer, who then discloses any conflicts of interest to the public (Schedule 2, clause 6, NZPHD Act). Further information on conflicts of interest can be found in Chapter 7: *Members' interests and conflicts: identification, disclosure and management*, and in the separate publication *Conflicts of Interest Guidelines for District Health Boards*.

**Terms of office for DHB board members****Appointed members**

Under s. 32 of the CE Act, the term of office for appointed members of DHB boards is up to three years. Appointed members of the board of a DHB are eligible for reappointment unless they have held office for six consecutive years, in which case they must not be reappointed immediately unless the Minister consents in writing to them being re-appointed immediately and holding office consecutively for longer than six years but not exceeding nine years (Schedule 3, clause 2(1)(b), NZPHD Act refers). A person may hold office as an appointed member of the board of one or more DHBs.

Appointed members come into office on the date specified for that purpose in the notice appointing the member or, if no date is specified in the notice, from the date on which the notice is published in the *Gazette*.

**Elected members**

Elected members of DHB boards come into office on the 58th day after polling day. An elected member of the board of a DHB who has not ceased to hold that office earlier and is not re-elected in the next triennial board election, ceases to hold that office when the members elected in that election come into office. An elected member of a DHB board is not to hold office as an elected or appointed member of the board of any other DHB.

**Board members on more than one State sector Board**

Generally, a DHB board member may be a member on more than one State sector board at any one time, as long as there is no legislation or other rule preventing this, there are no unmanageable conflicts arising from the situation and the board member has the time available to properly undertake the positions.

**Reappointment principles**

The Minister decides, in light of a DHB's strategic direction and other considerations, whether an appointed member should be reappointed when his or her term expires. Incumbent board members have no automatic right of reappointment and need to be aware that the requirements for appointment under the CE Act will apply. For example:

- s. 29: Criteria for appointment or recommendations by the responsible Minister;
- s. 30: Qualifications of members; and
- s. 31: Requirements before appointment, which includes disclosure of interests.

Incumbent board members will be required to provide an updated curriculum vitae to the Minister or Ministry of Health and may be required to attend an interview. Incumbent board members who are reappointed will receive a notice of appointment and an appointment letter, which may convey the Minister's expectations of that board member.

**Board member induction and training**

Ministers, boards and monitoring departments all have responsibilities in relation to induction of new board members. The NZPHD Act (Schedule 3, clause 5) requires a board with elected or appointed members to fund and ensure the undertaking of training approved by the Minister. Training may include subjects such as board membership duties and obligations, Treaty of Waitangi issues, or Māori groups or organisations in the district of the DHB concerned.

The board must keep an up-to-date record of the following matters:

- the name of each member of the board and the date on which they most recently came into office as a member of the board;
- any familiarity each member of the board has at that date with the obligations and duties of a member of a board, Māori health issues, Treaty of Waitangi issues, and Māori groups or organisations in the district of the DHB concerned;
- the nature of the training (if any) the board is required to fund and, to the extent practicable, have any of its members undertake and complete; and
- the date that training was completed or, if it is still in progress, the date on which it started and the date by which it is expected to have been completed or, if it has not yet started, the date on which it is expected to start.

HBDHB maintains a register of such induction and training activities, an sample of which is attached in Schedule 7.

Boards are required to provide a copy of this record to the Minister if requested to do so.

**Removal from office**

The Minister may remove an appointed member of a DHB board from that office in accordance with s. 36 of the CE Act (ie, at the Minister's discretion).

Under the NZPHD Act (Schedule 3, clause 8(1)) the Minister may remove an elected member of a board from that office by notice in the *Gazette* stating the date on which the removal takes effect, but only:

- if the Minister has first consulted the member, and the board, about the removal; and
- for a reason stated in clause 9 to Schedule 3 of the NZPHD Act. These include:
  - the Minister is satisfied that the member failed to declare an interest in circumstances where clause 6 of Schedule 2, or clause 36, required the member to do so; or
  - the Minister is satisfied that the integrity of the board, or of the DHB to which the board relates, has been seriously compromised because the member has neglected his or her duties as a member of the board, or has failed to perform his or her duties under the Act; or
  - the member has been absent from four consecutive board meetings without permission from the board or the Minister; or
  - the member has breached any of the obligations and duties of a board member, and s. 58(2) or s. 59(2) of the CE Act applies.

A chair or deputy chair may be removed from that office by the Minister by notice in the *Gazette* stating the date on which the removal takes effect, but only if the Minister has first consulted the person concerned and the board, about the removal. A chair or deputy chair removed from that

office continues to be a member of the board unless removed from that office as well, under s. 36 of the CE Act or clause 8(1) to Schedule 3 of the NZPHD Act, as the case may be.

The Minister has the power to replace a whole board with a Commissioner under s. 31 of the NZPHD Act.

Board members are not employees, and no compensation is made in the event of their removal from a board.

### ***Cessation of office***

Board members may resign their position at any time (s. 44, CE Act). Resignations must be made by written notice to the Minister with a copy given to the DHB. The notice must state the date on which the resignation takes effect.

The chair or deputy chair of a DHB board may resign from that office by written notice to the Minister and board stating the date on which the resignation takes effect. A chair or deputy chair who resigns from that office continues to be a member of the board unless he or she also resigns from that office (Schedule 3, clause 11, NZPHD Act).

A chair or deputy chair of a DHB board ceases to hold that office if he or she ceases to be a member of the board. A deputy chair ceases to hold that office if he or she is appointed chair of the board.

Board members are not employees, and no compensation is made in the event of their resignation from a board or non-reappointment.

### ***Board Members Standing for Parliament***

General expectations from Ministers in previous governments include:

- Board members will avoid potential, perceived or actual conflicts of interest, including conflicts that may arise from their candidacy for election to Parliament.
- In general, Ministers expect board members who have declared their intent to stand as candidates, to stand down from their board positions with effect from Nomination day, or such earlier date as may be determined.
- For clarity, 'stand down' means that the board member does not exercise the duties of office for the specified period of time, and receives no remuneration for that period.
- In general, most board members are expected to resign their positions upon being elected to Parliament.
- Elected members of statutory Crown entities may retain their board positions while concurrently serving as members of Parliament (s. 30(3) CE Act)
- If a board member stands down from his or her position, but is unsuccessful in being elected to parliament, he or she is not prevented, post-election, from resuming duties relating to the position. (any post-election potential conflicts of interest will need to be managed)
- Any queries on this may be directed to the State Services Commission Election team at [election@ssc.govt.nz](mailto:election@ssc.govt.nz)



## Chapter 18: Remuneration and expenses for board members

Setting fee levels that are sufficient to attract and retain talented board members is an important element of effective governance. Members do not set their own fees, remuneration and allowances but it is important for boards to understand how they are set and how to engage with the relevant fee-setting authority when fees are reviewed.

Sections 47 and 48 of the Crown Entities Act 2004 (CE Act) provide the mechanism for setting the remuneration and expenses for board members of District Health Boards (DHBs), ie by the Minister of Health (the Minister) under the Cabinet Fees Framework (the Fees Framework), which applies to DHB board members, and is administered by the State Services Commission.

The Fees Framework is set out in a Cabinet Office circular. Boards using it need to be sure they are working from the latest version, as it is reviewed periodically. The current version is located at: [www.ssc.govt.nz/fees](http://www.ssc.govt.nz/fees).

When a DHB board establishes a committee or a subsidiary, the board itself becomes the fee-setting authority and should then follow the provisions in the Framework.

In general:

- board chairs are paid more than other members due to their larger role;
- deputy chairs are paid an additional amount on top of their member fee;
- members who receive an annual fee for board membership do not generally receive additional payment under the CE Act unless they are a member of a board's committee. The Fees Framework provides additional payments for DHB board members who sit on one of the DHB's three statutory committees (up to \$2500 pa for a committee member and \$3250 pa for a committee chair); and
- members of DHB committees who are not already on the DHB board may be paid a fee. The Auditor-General suggests the fee should be at a level that reflects the time it takes to properly carry out their duties.
- Over the years, it has become practice to pay all DHB Committee members, the fees set out in the Fees Framework relating to DHB statutory committees.

Fees under the Fees Framework are set on a fair but conservative basis to reflect a discount for the element of public service involved. The Fees Framework includes provision for fees to be reviewed periodically, which does not necessarily lead to an increase. This review is normally undertaken by the Ministry of Health on behalf of the Minister.

Under the Fees Framework, members should not receive payment as consultants from a DHB to which they are appointed. If, however, the Minister agrees that there are overriding reasons for board members to carry out consulting assignments, any proposal to do so needs to be submitted to Cabinet for consideration.

### **Administrative matters**

Board members who travel to meetings or on other board business that requires them to be away from their normal places of residence are entitled to reimbursement of actual and reasonable travelling, meal and accommodation expenses. Boards should have in place appropriate policies and procedures for submitting and approving board member expenses. This should cover matters such as class of travel, entertainment expenditure and use of credit cards. The Office of the Auditor-General has issued guidance on drawing up suitable policies and procedures, which boards should find useful: [www.oag.govt.nz/2007/sensitive-expenditure/](http://www.oag.govt.nz/2007/sensitive-expenditure/)

The total value of remuneration paid to each board member is disclosed in the annual report of the DHB concerned (s. 152, CE Act).

Taxation matters and their impact on the way the DHB pays fees and allowances depend on the personal circumstances of the member concerned. Board members and entity management can clarify their taxation status by reference to professional advice or the Inland Revenue Department.

Board members need to take a personal decision on whether they should take out any kind of insurance protection pertaining to sickness, etc.

Board members are not entitled to any compensation or other payment or benefit relating to loss of office (s. 43, CE Act).

Full details on the claiming and payment of Board Members remuneration, fees and expenses are set out in Schedule 6 of this manual.

The Board has also adopted a wider policy on:

“Payment of Fees and Expenses – HBDHB Committees, Advisory Groups, Stakeholder Groups and Project Teams.”

A copy of this policy is attached in Schedule 9.

## Chapter 19: Liability and protection from legal claims or proceedings

To assist in attracting the best quality candidates to serve on boards and to ensure that boards act without fear or favour, the New Zealand Public Health and Disability Act 2000 (NZPHD Act) contains a regime for exclusion from liability and indemnities. The Crown Entities Act (CE Act) provisions on liability and protection from legal claims or proceedings do not apply to District Health Board (DHB) members. Instead, s. 90 of the NZPHD Act states that members of DHB boards or committees are not liable:

- 1 for any liability, act or omission of the organisation;
- 2 to the organisation for any act or omission done or omitted in their capacity as a member, if they acted in good faith and with reasonable care in pursuance of the functions of the organisation.

All boards are expected to govern well and to the best of their abilities. However, even the most careful and law-abiding board can find itself involved in legal claims and proceedings. All board members need to be aware that failing to comply with their duties may lead to personal liability, civil proceedings or criminal prosecution. Individual board members can also be held liable for actions of the board as a collective.

Although Crown entities are legally separate from the Crown, in some cases a court may decide that the Crown is liable for the entity. This will depend largely on its statutory functions and the extent of control exercised over the entity by Ministers and other central Government agencies. Every board should spend time discussing these matters as they relate to themselves and their employees, preferably with the assistance of a trained specialist, perhaps the entity's legal advisor.

### Indemnities

An indemnity is an agreement by one person to pay another person any sums owed to a third party. "Indemnification" means that the entity relies on its own resources to pay the legal costs of board members and any other persons for claims that result from board/entity actions, unless the board has decided to take out indemnity insurance.

The CE Act (s. 21) provides that members of an entity are immune from civil liability, unless they have breached an individual duty set out in the Act.

Every member of a DHB board or committee is indemnified by the DHB, in terms of s. 90 of the NZPHD Act:

- for costs and damages for any civil liability arising from any action brought by a third party in respect of any act or omission in his or her capacity as a member, if he or she acted in good faith and with reasonable care, in pursuance of the functions of the organisation; and
- for costs arising from any successfully defended criminal proceeding in relation to any act or omission.

Board members should be aware of the extent of any indemnity.

## **Insurance**

Insurance provides financial protection for board members and others who are covered, in the event that they are sued in conjunction with the performance of their duties as they relate to the DHB. The NZPHD Act, however, does not contain powers for DHBs to purchase insurance for board members. To the extent that DHB board members consider it necessary in light of s. 90 of that Act, they should make their own arrangements for professional indemnity insurance to cover their work as a member of the board.

As insurance is not provided, the board must ensure that the individual member is made aware that he or she is not covered, as well as of any relevant statutory protection from liability, so the member can consider whether to make their own provision for such insurance.

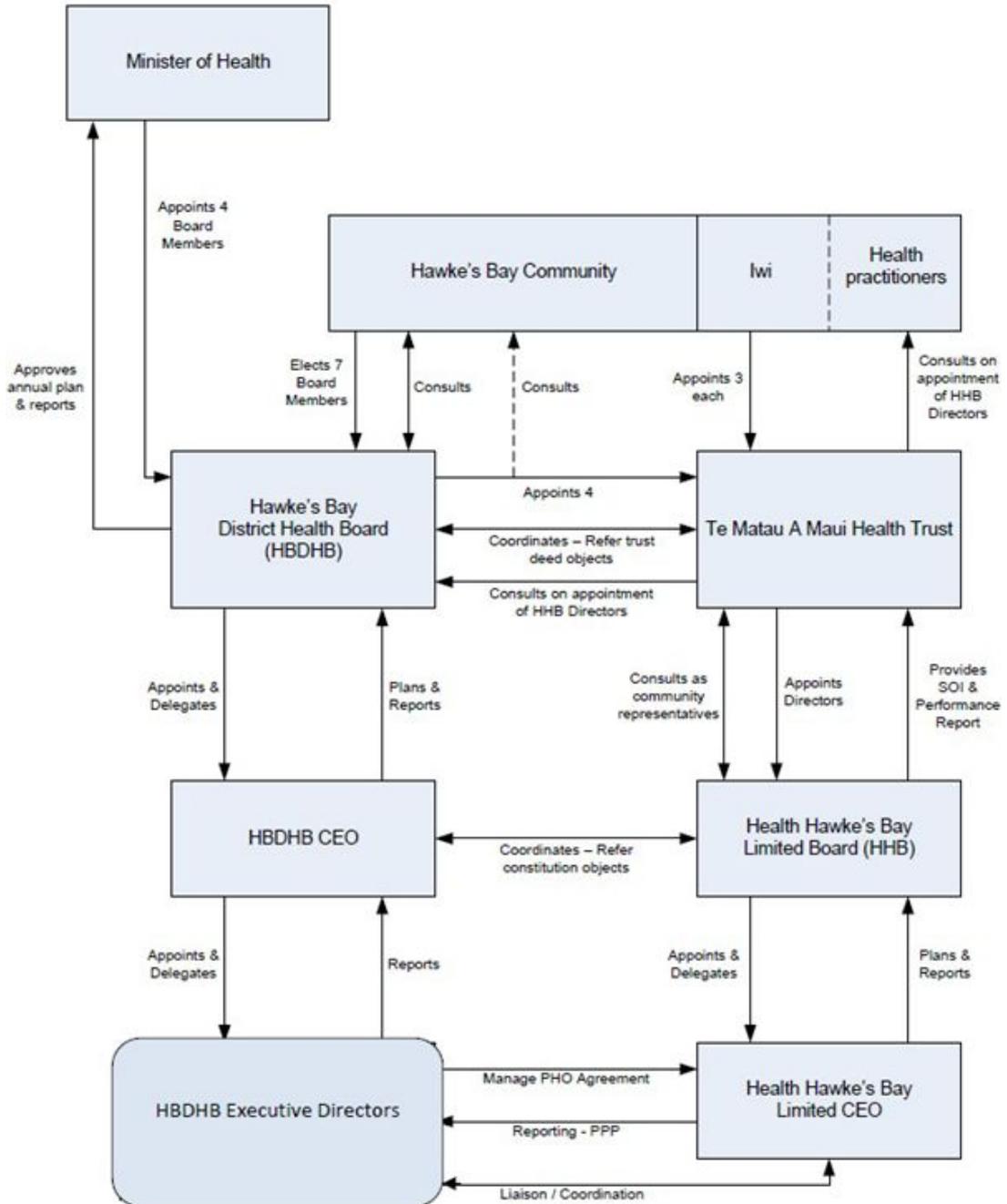
# SCHEDULES



## **Schedule 1: Hawke's Bay Relationships**

- [Health Sector Structural Relationships](#)
- [Health Sector Leadership Forum – Terms of Reference](#)
- [Te Pitau Health Alliance Governance Group Agreement](#)
- [HBDHB and Ngati Kahungunu Iwi Incorporated – Memorandum of Understanding](#)
- [Matariki Leadership Group – Terms of Reference](#)

## Hawke's Bay Health Sector Structural Relationships





**TERMS OF REFERENCE**

**Hawke's Bay Health Sector Leadership Forum**

**August 2015**

<b>Purpose</b>	To develop and consolidate a common purpose across the leadership group of the health sector to which we are all committed and working actively towards.
<b>Objectives</b>	<ol style="list-style-type: none"> <li>1. To propose a shared vision and values.</li> <li>2. To formulate key strategic actions to be incorporated in our local strategic plans.</li> <li>3. To support the prioritisation of our key actions for our annual plans and actions.</li> <li>4. To build relationships and trust within this key leadership group.</li> </ol>
<b>Authority</b>	<p>Hawke's Bay Health Sector Leadership Forum:</p> <ul style="list-style-type: none"> <li>• Has authority to give advice and make recommendations to HBDHB and Health Hawke's Bay Ltd (HHB)</li> <li>• Has no formal authority to make decisions that will bind HBDHB or HHB unless such specific authority has been delegated to it</li> </ul>
<b>Accountability</b>	All members will remain accountable through their own organisation's governance structure. It is recognised that HBDHB has overall responsibility for ensuring that the local health services are appropriately delivered and for improving the health status of the local population.
<b>Membership</b>	<ul style="list-style-type: none"> <li>• HBDHB Board and Executive Management Team Members</li> <li>• Health Hawke's Bay Limited Directors and Executive Team</li> <li>• Hawke's Bay Clinical Council Members</li> <li>• Hawke's Bay Maori Relationship Board Members nominated by Ngati Kahungunu Iwi Inc (NKII) and Wai 692</li> <li>• Hawke's Bay Health Consumer Council Members</li> <li>• Pasifika Health Leadership Group</li> </ul>
<b>Chair</b>	The Chair shall rotate between HBDHB, HHB and NKII
<b>Format and Frequency</b>	Six-monthly workshops
<b>Reporting</b>	Key issues and decisions to be reported to the Forum. An agreed summary to be presented to the HBDHB and HHB Ltd Boards.
<b>Secretariat</b>	Provided through the HBDHB Company Secretary.

# TE PĪTAU Health Alliance (Hawke's Bay) AGREEMENT

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**BETWEEN**  
**HAWKE'S BAY DISTRICT HEALTH BOARD**  
**AND**  
**HEALTH HAWKE'S BAY LIMITED – TE ORANGA HAWKE'S BAY**

**DECEMBER 2018**

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## Our vision

**HEALTHY  
HAWKE'S BAY  
TE HAUORA O  
TE MATAU-Ā-MĀUI**

*Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.*

## Our values

**Tauwhiro** – delivering high quality care to patients and consumers

**Rāranga te tira** – working together in partnership across the community

**He kauanuanu** – showing respect for each other, our staff, patients and consumers

**Ākina** – continuously improving everything we do

## TE PĪTAU HEALTH ALLIANCE (HAWKE'S BAY) AGREEMENT

**DATE:** 19 DECEMBER 2018

### 1 THE PARTIES (each a Party) are:

- Hawke's Bay District Health Board (DHB)
- Health Hawke's Bay Limited – Te Oranga Hawke's Bay (PHO)

### 2 KEY INFORMATION

1. **Commencement Date: 1 July 2018**

2. **Te Pītau Governance Group Members:**

**Core members will be:**

- Three Directors of Health Hawke's Bay Ltd
  - Bayden Barber - Chair
  - Jeremy Harker
  - Jason Ward
- Three Members of Hawke's Bay District Health Board
  - Ana Apatu
  - Hine Flood
  - Helen Francis - Deputy Chair
- HBDHB Maori Relationship Board NKII representative
  - Beverly Te Huia
- Hawke's Bay Clinical Council representative
  - David Rodgers
- Hawke's Bay Health Consumer Council representative
  - Rachel Ritchie

**As the Scope of our alliance activities expands to cover them, representatives from other parts of the Hawke's Bay health sector may be added, eg:**

- Community Pharmacy
- Aged Care
- NGOs

### 3 OUR AGREEMENT

In consideration of the mutual promises given and received by each of us in this Agreement, we agree that we will be bound by and perform this alliance Agreement.

We agree that our alliance shall be known as 'Te Pītau'

Our Agreement comprises the following parts:

**Part A: Our Commitment** - is a statement of our background, our commitment to a whole-of-system decision making process, our purpose, principles and commitment to success. We agree that the remainder of this Agreement will be interpreted in accordance with the statements made in Part A.

**Part B: How We Will Succeed** – is a statement of how we will work together, in particular, to achieve success by completing our alliance activities and meeting and exceeding our objectives.

**Part C: How We Will Work Together** - details the processes that we have agreed to apply to how we will work together.

**Part D: Term of Te Pītau** - details how long we expect to work together for and, if or when necessary, how we will wind up our alliance.

**Schedule 1** – includes the scope and annual activities of Te Pītau

## PART A: OUR COMMITMENT

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Part A of this Agreement is a statement of our background, our commitment to a whole-of-system decision making process, our purpose, principles, values and commitment to success.

### 1. Scope of Te Pītau

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- 1.1 **Who We Are:** We, the Parties to Te Pītau, are the DHB and PHO for the Hawke's Bay district.
- 1.2 **Our Leaders:** We are led by our Te Pītau Governance Group, made up of those governance, management and clinical leaders and other key stakeholders, who can successfully lead Te Pītau to complete our alliance activities and achieve our objectives.
- 1.3 **Our Purpose:** We have formed Te Pītau to improve health outcomes for our populations, through:
- 1.3.1 transforming, developing, evolving and integrating primary and community healthcare services, consistent with commitments made within the 2018 Clinical Services Plan, i.e.:
- **achieve equity with a particular focus on those with unmet needs**
  - **create a culture that is person and whanau centred**
  - **co-design and prioritise services to meet the needs of populations with the poorest health and social outcomes**
  - **make health easy to understand**
- 1.3.2 eliminating inequities in primary care access and health care delivery
- 1.3.3 making (and assisting the DHB to make) strategic health care decisions on a "whole-of-system" basis;
- 1.3.4 providing direction and building relationships within our primary and community health system;
- 1.3.5 assessing the primary and community health care needs of our populations;
- 1.3.6 planning health care delivery in our District that is amenable to primary and community settings, to make the best use of health resources;
- 1.3.7 balancing a focus on the highest priority needs areas in our communities, while ensuring appropriate care across all our populations;
- 1.3.8 determining models to be commissioned from delegated funding pools
- 1.3.9 establishing Service Level Alliances to advise on the development, delivery and monitoring of primary and community health services within the scope of our alliance;
- 1.3.10 monitoring the effectiveness and health outcomes of groups of services that fall within the scope of our alliance; and
- 1.3.11 informing our populations and other stakeholders of our performance in achieving our objectives.

1.4 **Te Pītau Activities:**

1.4.1 Our alliance activities are defined in the scope of Te Pītau. It is anticipated that this scope will be initially restricted to specific service areas, but will expand over time. Te Pītau, in carrying out its activities, may not be involved in all healthcare services in our District.

1.4.2 The scope and activities of Te Pītau (including objectives) are set out in Schedule 1.

1.5 **Our Conduct:** We will conduct our activities and achieve our objectives, by acting consistently with our Te Pītau Principles.

1.6 **What We Are Not:**

1.6.1 Te Pītau does not directly provide healthcare services although we will make decisions and recommendations on what services should be funded by the Parties.

1.6.2 Te Pītau does not have any authority over, nor responsibility for, any services provided directly by any employees of the Parties.

1.6.3 We work collaboratively but are not collectively established as a legal entity.

## 2. **Overview of Decision Making**

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2.1 **Allocation of Decision Making:** At the core of this Agreement is a decision-making process that makes clear which decisions remain with the DHB, the PHO and the Government, and which decisions are devolved to us, the Parties.

2.2 **Clinician Input into Decision Making:** We recognise that clinical input is essential in all levels of decision making. At the alliance level, this will be achieved by ensuring all major Te Pītau activity decisions will involve input and support from the Hawke's Bay Clinical Council. At all other levels, this input will be provided through proactive involvement of appropriate clinicians.

2.3 **Māori Contribution to Decision Making:** We acknowledge our responsibilities under Te Tiriti o Waitangi and our desire to work with local Māori to enable them to contribute to Te Pītau decision making. Given the Memorandum of Understanding between HBDHB and Ngati Kahungunu Iwi Incorporated, this will be achieved through active engagement with HBDHB Māori Relationship Board (MRB) on all major Te Pītau decisions. At all other levels, we will ensure that a Māori perspective is present and/or represented in all decision making processes.

2.4 **Consumer Input into Decision Making:** We recognise that consumer input is essential in all levels of decision making. At the alliance level, this will be achieved by ensuring all major Te Pītau activity decisions will involve input and support from the Hawke's Bay Health Consumer Council. Consumer representatives will be involved in all co-design and decision making processes at all other levels.

2.5 **Other Input into Decision Making:** Where appropriate, we will work together with a wide range of different cultures, disadvantaged groups and communities to design the health services they need and engage them in our decision making processes.

2.6 **Decisions Made by Government:** The balancing side of the decision-making process is that it remains the role of the Government to determine the gross allocation of public funding, so as to achieve the best balance of outcomes for the population. Wherever possible this will involve discussion with clinicians, providers and/or the community through Te Pītau but we recognise that in some cases these decisions may be taken centrally.

2.7 **Decisions Made by the DHB:** We recognise that the DHB has two roles:

2.7.1 as a Party within Te Pītau, and

2.7.2 as the Government's agent, as the funder of health services in the District.

- 2.8 Te Pītau is intended, in part, to assist the DHB to fulfil its statutory objectives and functions as a funder of health services. The DHB will work within Te Pītau to fulfil those obligations where it is appropriate and practicable to do so.
- 2.9 However, we acknowledge that the DHB's statutory and other obligations will require it to make some decisions, which may affect Te Pītau, outside of this Agreement. Without limiting its ability to make those decisions, the DHB undertakes to make those decisions, insofar as is reasonably practicable, in good faith and having regard to Te Pītau's Principles. We agree that nothing in this Agreement limits the DHB's rights, powers, obligations or liabilities under any Law or other agreement.
- 2.10 **Decisions Made by the PHO:** Equally, we recognise that the PHO is subject to its own governance obligations. We also agree that nothing in this Agreement limits the PHO's rights or obligations, necessary to comply with its governance obligations under any Law or other agreement.

### 3. Te Pītau Principles

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- 3.1 We will conduct ourselves and undertake our alliance activities in a manner consistent with the Hawke's Bay Health Sector Vision and Values, and our Te Pītau Principles and will take all reasonable steps to ensure that our employees, contractors and agents do likewise.
- 3.2 We agree that every part of this Agreement must be read in such a way as to be consistent with, and ensure the integrity of, our commitments to Te Pītau Principles.
- 3.3 **Te Pītau Principles:** Te Pītau is founded on the following principles:
- 3.3.1 we will adopt a person and whanau centred, integrated, whole-of-system approach, and make decisions on a 'Best for System' basis;
  - 3.3.2 we will seek to make the best use of finite resources in planning and delivering health services to achieve improved health outcomes and equity for our populations;
  - 3.3.3 we will apply the principles of Te Tiriti o Waitangi and incorporate kaupapa Māori practice and whanau ora approaches within our alliance activities;
  - 3.3.4 we will conduct ourselves with honesty and integrity, and develop a high degree of trust;
  - 3.3.5 we will support clinical leadership and, in particular, clinically informed service development;
  - 3.3.6 we will promote an environment of high quality, performance and accountability, and low bureaucracy;
  - 3.3.7 we will strive to resolve disagreements co-operatively and, wherever possible, achieve consensus;
  - 3.3.8 we will adopt and foster an open and transparent approach to sharing information, subject only to statutory privacy principles;
  - 3.3.9 we will monitor and report on our achievements, including public reporting;
  - 3.3.10 we will be collectively responsible for all decisions and outcomes;
  - 3.3.11 we will operate as a unified team providing mutual support, appreciation and encouragement;
  - 3.3.12 we will conduct ourselves in accordance with best practice;
  - 3.3.13 we will support professional behaviour and leadership;

- 3.3.14 we will remain flexible and responsive to support an evolving health environment;
- 3.3.15 we will develop, encourage and reward innovation and challenge our status quo;
- 3.3.16 we will actively support and build on our successes; and
- 3.3.17 we commit to fully exploring the collective sharing and management of the risks and benefits arising from our alliance activities. Where we cannot manage risk collectively, our principle is to allocate responsibility for each risk to those of us who can best manage it.
- 3.3.18 we will each accept our own costs of all participation in Te Pītau activities, and we agree that any third party costs directly incurred by Te Pītau, shall be shared equally.

## PART B: HOW WE WILL SUCCEED

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Part B of this Agreement is a statement of how we will work together, in particular, to achieve success by completing our alliance activities and meeting and exceeding our objectives.

### 4. Commitments

---

#### 4.1 Shared Decision Making:

4.1.1 Each of us is fully committed to Te Pītau and carrying out our alliance activities to achieve our objectives. We acknowledge that this commitment is fundamental to Te Pītau's success.

4.1.2 We will work as one team, in a transparent, innovative and collaborative manner, to produce outstanding results.

#### 4.2 Shared Responsibility:

4.2.1 We both take responsibility for Te Pītau's success and our failures.

4.2.2 We both take responsibility for achieving consensus decisions within Te Pītau.

4.2.3 We both take responsibility for addressing all potential disputes within Te Pītau.

4.2.4 We will establish and maintain an environment within Te Pītau that encourages open, honest and timely sharing of information.

#### 4.3 Shared Accountability: We are both responsible collectively for identifying, managing and mitigating all risks associated with our alliance activities.

#### 4.4 Commitment to Good Faith: We will, at all times:

4.4.1 act in good faith and be fair, honest and ethical in our dealings with each other;

4.4.2 make all decisions on a Best for System basis and when making such decisions, will give predominate weight to the interests of Te Pītau over our own self-interest;

4.4.3 do everything that is reasonably necessary to enable each of us to undertake our alliance activities and perform our obligations under this Agreement;

4.4.4 not act in a manner that impedes or restricts each other's performance of our alliance activities and the performance of our obligations under this Agreement; and

4.4.5 do all things that are, or may reasonably be, expected of us so as to give effect to the spirit and intent of this Agreement and Te Pītau.

#### 4.5 Commitment to Consultation: We recognise that both of us may, in the course of undertaking our alliance activities and otherwise meeting our commitments under this Agreement, be required to consult with others who do not form part of Te Pītau. We will provide a reasonable opportunity to do so in a prudent and timely manner.

## 5. Service Level Alliances & Working Groups

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- 5.1 **Service Development:** Where Te Pītau identifies a service within its scope that requires transformational change, we may establish a Service Level Alliance (SLA) to:
- 5.1.1 Collaboratively co-design and recommend how the service should be delivered within the scope of Te Pītau;
  - 5.1.2 Monitor and report on the performance of a service within the scope of Te Pītau.
- 5.2 **Working Groups:** Clause 5.1 does not limit Te Pītau's ability to establish any other Working Groups that it considers necessary to advise it on any aspect of our alliance activities.
- 5.3 **Scope and Conditions:** A SLA or other Working Group will operate according to any directions, conditions or restrictions established by us. This will include the lines of accountability to the appropriate body within Te Pītau structures, and may include a direction to work collaboratively with others.

## 6. Services Planning

---

- 6.1 We will work together to decide how Te Pītau will carry out service planning for those services within its scope, which may include delegating decision making authority to our Te Pītau Governance Group.
- 6.2 Our Te Pītau Governance Group may, as a result of service model decisions or recommendations made, recommend to the DHB and/or PHO the method and form of contracting for the delivery of the service on a Best Practice basis.
- 6.3 The DHB and/or PHO will implement our Te Pītau Governance Group's decisions and recommendations, subject only to the provisions of clauses 2.9 and 2.10 respectively
- 6.4 In implementing our Te Pītau Governance Group's decisions or recommendation, the DHB and/or PHO (as appropriate) may:
- 6.4.1 undertake a procurement process based on the specification for the activity, work or service recommended by Te Pītau;
  - 6.4.2 enter into agreements/contracts with relevant providers, which may include Parties and/or others; and/or
  - 6.4.3 select from the Parties and other service providers those capable of providing the activity, work or service in accordance with the specification for the activity, work or service recommended by Te Pītau.

## PART C: HOW WE WILL WORK TOGETHER

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Part C of this Agreement details the structures and processes that apply to how we will work together.

### 7. Leadership Structure

---

#### 7.1 General Structure:

- 7.1.1 Te Pītau will be directed and lead by our Te Pītau Governance Group.
- 7.1.2 The day-to-day affairs of Te Pītau will be co-ordinated by our Te Pītau Support Team (made up of relevant members of the management and clinical leadership teams of the DHB and PHO) and supported by the Clinical and Consumer Councils, and the MRB.
- 7.1.3 Our Te Pītau Support Team will be led by the HBDHB Executive Director Primary Care
- 7.2 **Service Developments:** Our SLAs will be led and directed by a Service Level Alliance Leadership Team, acting within a scope of authority, agreed by the Parties.

### 8. Te Pītau Governance Group Terms of Reference

---

- 8.1 **Te Pītau Governance Group:** We agree that we will have a Te Pītau Governance Group whose primary function will be to lead us with respect to our alliance activities and Te Pītau, in accordance with this Agreement.
- 8.2 **Duties of our Te Pītau Governance Group:** The duties of our Te Pītau Governance Group include:
  - 8.2.1 promoting and supporting the vision, values and direction of Te Pītau;
  - 8.2.2 facilitating development and implementation of commitments and service changes set out in the 2018 Clinical Services Plan, as they apply to primary and community care
  - 8.2.3 role modelling Te Pītau Principles and setting challenging objectives;
  - 8.2.4 facilitating, empowering and enabling the achievement of Te Pītau objectives/outcomes;
  - 8.2.5 maintaining a coherent set of policies and procedures as necessary to undertake its duties;
  - 8.2.6 agreeing with the DHB and PHO, in accordance with clause 6:
    - (a) our alliance activities and objectives, including the systems and key performance indicators for assessing achievement of these;
    - (b) the work, activity and services to be provided to meet our Te Pītau objectives;
  - 8.2.7 establishing and/or supporting Service Level Alliances and other Working Groups as necessary to oversee the development and delivery of services that fall within the scope of Te Pītau;
  - 8.2.8 providing high level support and stakeholder interface;
  - 8.2.9 monitoring and encouraging inter-Party relationships and stakeholder engagement;
  - 8.2.10 agreeing and adopting transparent governance and accountability structures for Te Pītau; and

- 8.2.11 mentoring and championing Te Pītau and its Parties as reasonably required.
- 8.2.12 approving the allocation of delegated/devolved funding pools
- 8.2.13 approving system and district level measures and related allocation of incentives, in conjunction with the Clinical Council.

**8.3 Membership of Te Pītau Governance Group:**

- 8.3.1 At the date of this Agreement the appointed core members of our Te Pītau Governance Group are set out in the Key Information on page 5 of our Agreement.
- 8.3.2 Alternates for appointed core members from the Māori Relationship Board, Clinical Council and Health Consumer Council shall also be appointed
- 8.3.3 Membership of our Te Pītau Governance Group shall be reviewed annually by an Appointments Panel made up of the Chair's and CEO's of the DHB and PHO, who shall consider the level of interest in membership, the benefits of some rotation balanced with retaining some experience, and the need to maintain a good mix of perspectives, skills and experience.
- 8.3.4 The Appointments Panel shall make recommendations to the DHB and PHO Boards.
- 8.3.5 The appointment of all core members (and alternates) requires the formal approval of both the DHB and PHO Boards.
- 8.3.6 Our Te Pītau Governance Group may, by agreement, add representatives from other parts of the Hawke's Bay health sector as members at any time, and may remove such members as necessary.

**8.4 Involvement:**

- 8.4.1 We agree that the members' regular involvement in and attendance at our Te Pītau Governance Group meetings is critical to Te Pītau's success.
- 8.4.2 Should any core member from either the DHB or PHO be unable to attend a Te Pītau Governance Group meeting, they may nominate another member to act by proxy in relation to any decision to be made by the Governance Group.
- 8.4.3 Should any core member from the Māori Relationship Board, Clinical Council or Health Consumer Council be unable to attend a Te Pītau Governance Group meeting, they may request that their appointed alternate attend in their place.

8.5 **Chair:** The Chair of our Te Pītau Governance Group shall be the Chair of the PHO.

8.6 **Deputy Chair:** The DHB shall appoint one of the three DHB Board members to be the Deputy Chair

8.7 **Decision Making:** When making a decision, determination or resolution, our Te Pītau Governance Group (together and individually) must:

- 8.7.1 have regard to its duties, specified at clause 8.2 of this Agreement;
- 8.7.2 have regard to the intent of Agreement;
- 8.7.3 consider the matter before them in good faith and use their best endeavours to facilitate a consensus decision;
- 8.7.4 not prevent a consensus decision being made for trivial or frivolous reasons;
- 8.7.5 use all relevant information in a timely fashion;
- 8.7.6 actively seek and facilitate a consensus decision, determination or resolution; and

- 8.7.7 where consensus cannot be reached, any decision, determination or resolution will require the support of at least 75% of those present and/or otherwise able to vote on the issue.
- 8.8 **Reporting:** Our Te Pītau Governance Group will provide a report to the Parties following each Te Pītau Governance Group meeting, and an Annual Report about its performance.
- 8.9 **Implementing Decisions:** We will implement all decisions and directions of our Te Pītau Governance Group concerning our alliance and this Agreement.

## 9. **Service Level Alliance (SLA) Leadership Team**

---

- 9.1 **SLA Leadership Team:** We agree that our Te Pītau Support Team may appoint a leadership team (**SLA Leadership Team**), whose primary function will be to direct and lead a SLA and provide guidance and leadership to us with respect to those of our alliance activities that are within the scope of that SLA
- 9.2 **Duties of a SLA Leadership Team:** The duties of a SLA Leadership Team may include:
- 9.2.1 providing a vision, strategic leadership and direction;
  - 9.2.2 providing operational/project leadership and relationship management;
  - 9.2.3 recommending the model via which services should be delivered in the District; and
  - 9.2.4 monitoring and reporting on the performance of the service against its agreed outcomes;
- 9.3 **Consensus Decision-Making:** When making a decision, determination or resolution, a SLA Leadership Team (together and individually) must:
- 9.3.1 actively seek and facilitate a consensus decision, determination or resolution; and
  - 9.3.2 where consensus cannot be reached, any decision, determination or resolution will require the support of at least 75% of those present and/or otherwise able to vote on the issue.

## **PART D: TERM OF TE PĪTAU**

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Part D of this Agreement details how long we expect to work together for and, if or when necessary, how we will wind up Te Pītau.

### **10. Term**

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This Agreement commences upon the Commencement Date specified in the Key Information and continues in effect until:

10.1 30 June 2028

10.2 The Parties may agree to renew this Agreement from this date, after following an agreed process having been initiated at least twelve months before this date.

### **11. Suspending Te Pītau Activities**

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11.1 **Suspension by our Te Pītau Governance Group:** Our Te Pītau Governance Group may suspend some or all of our alliance activities at any time.

11.2 **Suspension by the DHB or PHO:** The DHB or PHO may suspend some or all of our alliance activities, if it determines that it is necessary to do so to prevent a breach of a statutory, regulatory or contractual requirement (as acknowledged in clauses 2.9 and 2.10).

11.3 **Recommencement:** We will recommence the performance of our alliance activities only when directed to do so by our Te Pītau Governance Group.

### **12. Terminating Te Pītau**

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12.1 **Termination by the DHB or PHO:** We agree that the DHB or PHO may, in exceptional circumstances, terminate this Agreement if it determines that it is necessary to do so to prevent a breach of a statutory, regulatory or contractual requirement (as acknowledged in clauses 2.9 and 2.10).

12.2 **Termination by either Party:** We agree that either Party may terminate this Agreement due to ongoing Wilful Default by the other Party.

12.3 **Termination by Agreement:** We agree that this Agreement may be terminated by mutual agreement between the Parties.

**Executed as an Agreement**

**Executed** for Health Hawke's Bay Limited by:

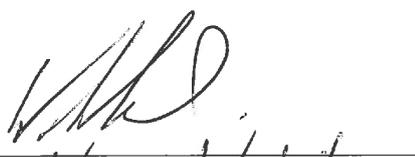
in the presence of



Director/Authorised Signatory



Director/Authorised Signatory



Witness signature

Wayne Woodcock

Full name

CEO

Occupation

Havelock North

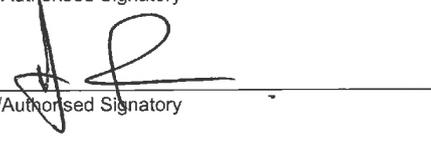
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**Executed** for Hawke's Bay District Health Board by:

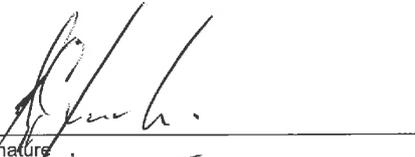
in the presence of



Director/Authorised Signatory



Director/Authorised Signatory



Witness signature

HELEN FOOTWORTH

Full name

COMPANY SECRETARY

Occupation

Havelock North

Address

**Schedule 1 - Scope of Te Pītau**

- 1 The ultimate scope of Te Pītau may include any/all those publically funded primary and community healthcare services and activities, within the Hawke's Bay Health Sector that are amenable to delivery in a primary and community healthcare setting.
- 2 On an ongoing basis, the scope of Te Pītau will generally be determined by agreement to establish specific Service Level Alliances or Working Groups. General issues may be included within the scope as agreed from time to time.
- 3 The initial scope of Te Pītau and our alliance activities for 2018/19 shall include the following:

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pītau Involvement 2018/19
Community Mental Health & Addictions	Yes	Yes	Multi-stage redesign and re-procurement of community based mental health and addictions services ahead of July 2020 go-live	<ul style="list-style-type: none"> <li>• Total indicative operating envelope &lt;\$20m per annum (including DHB contracts and Primary Care directorate PVS transfers into provider arm)</li> <li>• PHO Mental Health packages of care (c\$1m) in-scope</li> <li>• Will be informed by national Mental Health &amp; Addictions Inquiry</li> </ul>	<p>Receive regular SLA updates on progress of service design and provide governance oversight of the process in line with Te Pītau Principles.</p> <p>Approve the work of the SLA as design authority, in order to progress proposed model of care into the procurement phase.</p>

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pītau Involvement 2018/19
End of Life	Yes	Yes	Review of existing services supporting patients at the end of life, and redesign within existing resource envelope	<ul style="list-style-type: none"> <li>Operating envelope to be confirmed, but will include DHB contracts (most notably hospice services) and PHO discretionary funding</li> <li>Likely to also include internal DHB provider PVS relating to hospital palliative care services</li> </ul>	<p>Receive regular SLA updates on progress of service design and provide governance oversight of the process in line with Te Pītau Principles</p> <p>Approve the work of the SLA as design authority, in order to progress proposed model of care into the procurement phase</p>
Community Pharmacy	Yes	No	Development, review and prioritisation of developmental schemes within Schedule 3b of the new Integrated Community Pharmacy agreement	N/A	Receive regular SLA updates for discussion and incorporation into the wider strategic approach
Integrated Care Teams (ICT)	Yes	No	Phased programme of work to test, refine and implement the model for extended integrated care teams operating seamlessly around the enrolled patient list	<ul style="list-style-type: none"> <li>Year one activity likely to include District Nursing services (Primary Care directorate PVS transfers into provider arm)</li> </ul>	<p>Receive regular SLA updates on progress of service design pilots and provide governance oversight of the process in line with Te Pītau Principles</p> <p>Review recommendations and guide the prioritisation of work to further iterate ICT design</p>

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pitau Involvement 2018/19
Youth Services	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of primary health and wellbeing services targeted at young people	TBC	Receive proposal around potential scope and configuration of this work stream.  Endorse establishment of SLA
Urgent and On-Day Primary Care Access	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of primary care services meeting urgent and on-day healthcare needs	TBC	Receive proposal around potential scope and configuration of this work stream.  Endorse establishment of SLA
Health of Older People	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of services to keep older people well and independent. Will build on internal strategic programme within HBDHB	TBC	Receive proposal around potential scope and configuration of this work stream.  Endorse establishment of SLA
Rural Localities Model	No	No	Develop a framework for the development of sustainable rural services	N/A	Review intelligence relating to the development of rural services in line with the stated priorities of rural communities  Commission focus work on underlying themes relating to sustainability (e.g. workforce, technology, clinical governance)  Oversee development of a framework approach to the development of sustainable rural services

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pitau Involvement 2018/19
Primary Care Innovation & Development	No	No	Develop the framework for the evolution of primary healthcare in line with the Hawke's Bay CSP	N/A	<p>Review intelligence relating to existing innovation and development of enrolment-based primary care, including structural considerations that impact the pace of change</p> <p>Review recommendations and guide the prioritisation of work to further iterate primary care innovation and development</p>
System Level Measures	No	No	Ownership of the Hawke's Bay System Level Measures framework	N/A	<p>Review and critically evaluate progress against the System Level Measures for Hawke's Bay</p> <p>Provide commentary to the Boards of HBDHB and HHB concerning delivery against these priorities</p> <p>Review recommendations and prioritise the development of measures within future iterations of the framework</p>

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pitau Involvement 2018/19
Primary Healthcare KPI framework	No	No	Development and ownership of a set of key performance indicators by which to assess the quality of primary healthcare in Hawke's Bay	N/A	<p>Review recommendations and prioritise the selection of measures for the framework</p> <p>Critically evaluate reported progress and plans to mitigate adverse variances against the agreed KPIs</p>
Information Systems	TBC	No	Primary healthcare governance input to the development of the Information Systems strategy for Hawke's Bay	N/A	<p>Receive regular updates on progress against the IS Strategy.</p> <p>Review recommendations and prioritise the development of primary healthcare priorities within the Strategy</p>





## MEMORANDUM OF UNDERSTANDING

Between  
Ngāti Kahungunu Iwi Incorporated  
and  
Hawke's Bay District Health Board

September 2014

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## **1.0 Purpose**

Each party agrees that the purpose of the Memorandum of Understanding is to establish, formalise, record and promote a collaborative working relationship that meets their respective goals, objectives and aspirations.

## **2.0 Partners**

The partners are Ngāti Kahungunu Iwi Incorporated (NKII) and the Hawke's Bay District Health Board (HBDHB).

In acknowledgement of the special relationship between Ngāti Kahungunu Iwi and the Crown both parties agree that NKII has an important role to play in the development and implementation of the strategies for the health and wellbeing of all Māori (including other Iwi, Mataawaka) in the geographical area covered by the HBDHB (Wairoa – Central Hawke's Bay).

The relationship between the HBDHB and NKII will determine HBDHB health policy, joint planning processes and tangible policy advice that will improve the health status for all Māori in the HBDHB region within the Kahungunu Rohe.

## **3.0 Relationship Principles**

This is a 'high trust relationship', which will be demonstrated by cooperation and good faith activating the principles of participation, partnership, protection.

These principles include:

- 3.1 The partners recognise and respect the autonomy of the other.
- 3.2 The partners commit to open discussion, positive negotiation and a problem solving approach to all matters related to fulfilling the partnership.
- 3.3 The partners recognize and respect the diverse strengths and contributions each bring to the partnership.
- 3.4 The partners will share responsibility in decision making on all matters related to fulfilling the purpose of this partnership.

#### 4.0 Hawke's Bay Health Sector 'Vision & Values

Ngāti Kahungunu Iwi and the Hawke's Bay District Health Board agree on the Vision and Values for the Hawke's Bay health sector:

**HEALTHY HAWKE'S BAY  
TE HAUORA O TE MATAU Ā MĀUI**  
**Excellent health services working in partnership to improve the health  
and wellbeing of our people, and to reduce health inequities within our  
communities.**

*Tauwhiro - delivering high quality care to patients and consumers.*

*Raranga te tira - working together in partnership across the community.*

*He Kauanuanu - showing respect for each other, our staff, patients and consumers.*

*Ākina - continuously improving everything we do.*

These will be reflected in our relationship through our agreement to:

- 4.1 Tauwhiro**  
Jointly work towards 'health and wellbeing' to remove health inequity by implementing the New Zealand Health Strategy and the strategies of Ngāti Kahungunu Iwi.
- 4.2 Raranga te tira**  
Ensure the HBDHB Māori Health Strategy reflects the consensus view of the HBDHB and NKII.
- 4.3 He Kauanuanu**  
Act in good faith to foster good understanding, mutual respect of values, fairness, equity and cultural appreciation.
- 4.4 Ākina**  
Work together 'pokohiwi ki te pokohiwi' to ensure the highest quality and culturally appropriate services are continually developed and made available to all.

#### 5.0 Partnership Managers

The parties will nominate managers to manage the operational issues arising from this partnership agreement.

**Details of the current Partnership Managers are contained in Schedule One.**

##### 5.1 Review of Agreement

The designated Partnership Managers will operationally review this Agreement once a year.

Both parties agree that regular monitoring of progress with particular regard to the continued relationship building and maintenance would be beneficial. This will be achieved through the various relationship meetings identified below. In addition, a more formal annual governance review will be undertaken through MRB.

## 6.0 Issues Resolution

In the event of an issue or conflict, the parties agree that this will be referred to the **'Conflict Resolution Managers' referred to in Schedule One.**

## 7.0 Collaborative Partnership Arrangements

Both parties will ensure that participation is achieved at all levels:

### 7.1 Māori Relationship Board

The relationship will be primarily managed and maintained on behalf of NKII, through the NKII designated Kahungunu Health Sector Representatives, of the Māori Relationship Board (MRB).

The relationship will be primarily managed and maintained on behalf of the HBDHB, through the HBDHB Board members appointed to the Māori Relationship Board (MRB).

The parties shall agree on the Terms of Reference (ToR) for MRB (Current ToR is attached as Appendix 1 to this MoU). The ToR may be reviewed and updated by agreement, as required.

### 7.2 Strategic Planning

NKII will make provision for HBDHB input into their Iwi health strategic planning and likewise the HBDHB will include MRB in all strategic planning. HBDHB and NKII will provide support and information to assist each other in their planning processes.

### 7.3 Governance

Chairs of each of the Parties (or their representatives) agree to meet regularly to review the ongoing strength of this relationship.

### 7.4 Executive Management

The HBDHB Chief Executive Officer will meet with the NKII Chief Executive regularly; to ensure all relationship management processes and structures are working effectively.

HBDHB will include NKII in the recruitment and appointment process for key management positions within HBDHB of importance to Māori health improvement.

### 7.5 Māori Operational Advice

Operational planning and advice is provided to HBDHB by the HBDHB Māori Health Services. Any operational advice required of or by NKII is to be sought through the GM Maori Health HBDHB. MRB and NKII representatives are not to be used at an operational level without the consent of the Partnership Managers for this Agreement.

### 7.6 Partnership Work Program (PWP)

A PWP will be developed and maintained by the Partnership Managers, which will outline the agreed areas of engagement and the processes and structures that will be utilized for those engagements.

**7.7 Meetings**

A record of all meetings at each level of participation above shall be maintained and shared by the parties. Such records shall include:

- *Date and attendees*
- *Minutes or record of discussions and outcomes*
- *Actions identified, progress and resolution of actions*

**7.8 Communication**

- 7.8.1 Communication will be timely, comprehensive, open, honest and professional.
- 7.8.2 Both parties will operate a “no surprises” policy with each other.
- 7.8.3 Information exchanged may not be passed to a third party without the consent of the author.
- 7.8.4 The parties agree that ‘data’ remains the property of the party providing it, whether it remains in its original form, or is refined, or is aggregated with information from another source.
- 7.8.5 No information may be published, given or sold to a third party without prior written agreement of the party that has provided the data.
- 7.8.6 If either party is approached by the media regarding joint work, they will consult with the other party as to where a joint media release is required.

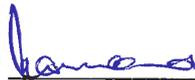
**8.0 Resources**

- 8.1 Both parties recognise the autonomy and independence of each other, but will work together to promote good health in a way that maximises health outcomes through the effective use of resources.
- 8.2 By working together, the parties will implement effective systems, procedures and assurance measures that reduce wastage, paper work and delays by reducing duplication of effort and resources.
- 8.3 All direct costs associated with the operation of MRB will be borne by HBDHB.
- 8.4 In recognition of the indirect costs associated with MRB and the provision of all other information, policy, specialist advice and support by NKII, at GM Maori Health HBDHB request, HBDHB will pay to NKII an annual sum of \$25,000 (adjusted annually by Contribution to Cost Pressure [CCP] or by agreement between the parties).
- 8.5 All other costs involved in managing and maintaining this relationship shall be borne by the party incurring the costs and/or as outlined in the PWP.

## 9.0 Partnership Representatives

Signatories to the Memorandum of Understanding will be:

### 9.1 Ngāti Kahungunu Iwi Inc.



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Chair  
Ngāti Kahungunu Iwi Inc.

Date 29.10.14

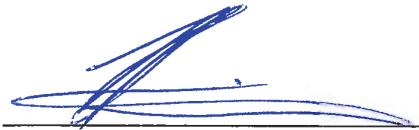


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Chief Executive Officer  
Ngāti Kahungunu Iwi Inc.

Date 15/10/14.

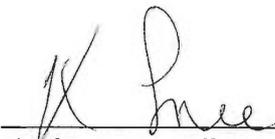
### 9.2 Hawke's Bay District Health Board



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Chair  
Hawke's Bay District Health Board

Date 29/10/14



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Chief Executive Officer  
Hawke's Bay District Health Board

Date 15/10/14

## 10.0 Schedule One

Details in this Schedule may be changed by either partner at any time without the need for a formal variation to the MoU. Each partner must seek approval from the other partner of any such changes.

### 10.1 Partnership Managers

Name	Email	Mobile
Jenny Smith Director Health & Wellbeing Ngāti Kahungunu Iwi Inc.		
Tracee Te Huia General Manager Māori Hawke's Bay District Health Board		

### 10.2 Partnership Resolution Managers

Name	Email	Mobile
Dr Adele Whyte Chief Executive Officer Ngāti Kahungunu Iwi Inc.		
Dr Kevin Snee Chief Executive Officer Hawke's Bay District Health Board		

Appendix I – Terms of Reference



TERMS OF REFERENCE

Hawke's Bay District Health Board  
Maori Relationship Board

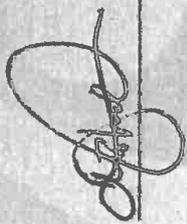
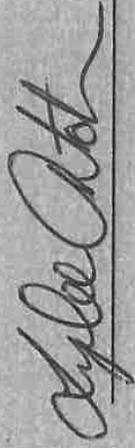
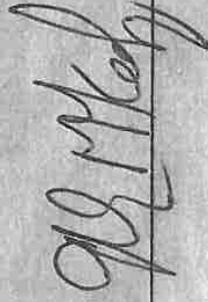
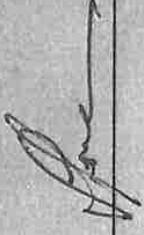
September 2014

<p><b>Purpose</b></p>	<p>The purpose of the Māori Relationship Board (MRB) is to maximise the relationship between the Hawke's Bay District Health Board (HBDHB) and Ngāti Kahungunu Iwi Inc. (NKII), to benefit the Māori population within the Kahungunu rohe principally by identifying and removing health inequities and instituting processes that support Māori centric models of health care.</p>
<p><b>Functions</b></p>	<p>The functions of the MRB are to:</p> <ul style="list-style-type: none"> <li>a) Identify and convey the needs and aspirations for health and wellbeing of the Māori population within Hawke's Bay.</li> <li>b) Ensure effective plans are jointly developed and maintained by HBDHB and NKII to address health inequities and to foster mana motuhake.</li> <li>c) Monitor and make recommendations on the implementation of these plans.</li> <li>d) Monitor the strategic development and performance of HBDHB delivered and funded services, to ensure they support the removal of disparities and are responsive to the needs of Māori.</li> <li>e) Monitor the operational performance of services targeted particularly at Māori.</li> <li>f) Prioritise the use of funding and access to services.</li> </ul> <p>The aim of the MRB's advice is to:</p> <ul style="list-style-type: none"> <li>a) Identify and reduce/remove existing and potential health inequities.</li> <li>b) Promote and enhance whānau models of care</li> <li>c) Monitor the patient care experience for Māori ensuring all services are accessible, appropriate and responsive to meet their needs.</li> <li>d) Ensure all funding and services are appropriate, recognise agreed values and provide value for money.</li> </ul>
<p><b>Level of Authority</b></p>	<p>The MRB has the authority to provide tangible advice and make recommendations to the HBDHB Board. The Kahungunu Health Sector representative members of MRB will decide and progress any documentation that requires NKII Board Endorsement through the appropriate NKII processes.</p> <p>Ngāti Kahungunu Iwi endorsement can, and is only to, be provided by the Ngāti Kahungunu Iwi Inc. Board.</p>

<p><b>Membership</b></p>	<p>Members of MRB:</p> <ul style="list-style-type: none"> <li>▪ Will be appointed for any period that terminates no later than four months after the end of the term of the HBDHB Board that appointed them. (Note: The full term of a Board is three years).</li> <li>▪ Members may be reappointed by the 'new' Board.</li> </ul> <p>The appointment of a Board member to MRB terminates if the member ceases to be a member of the Board.</p> <p>Remuneration will be based on the Cabinet Fees Framework which provides for payment for each member's attendance at meetings or workshops, up to a maximum of ten per year.</p> <p>Composition:</p> <ul style="list-style-type: none"> <li>• Chairman of Ngāti Kahungunu Iwi Incorporated, or alternate</li> <li>• No less than two and no more than six HBDHB Board members, at least two of whom should be Māori</li> <li>• Community members (up to six nominated by NKII or from the community)</li> <li>• One Ahuriri District Health Representative.</li> </ul> <p>HBDHB Board members who are not committee members may attend this committee as observers, and with the approval of the committee chair, have the right to speak.</p>
<p><b>Chair</b></p>	<p>The Chair shall be appointed by the HBDHB Board from the HBDHB Maori Board members on MRB. HBDHB shall consult with NKII on this appointment.</p>
<p><b>Quorum</b></p>	<p>A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.</p>
<p><b>Meetings</b></p>	<p>MRB may have up to eight meetings or workshops per year, at times and places agreed by the Chair. The Standing Orders adopted by HBDHB apply to MRB meetings, however Tikanga will take precedence.</p>
<p><b>Reporting</b></p>	<p>The Chair shall report on MRB business to the Board, with such recommendations as the MRB may deem appropriate.</p>
<p><b>Minutes</b></p>	<p>Minutes of all meetings and outcomes of all workshops will be circulated to all members of the Committee within one week of the meeting/workshop taking place. HBDHB Board members will be sent a copy of the minutes/outcomes, on request.</p>

# Memorandum of Understanding

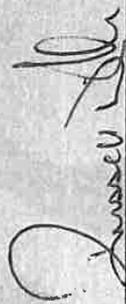
Partnership between Ngāti Kahungunu Iwi Incorporated and Hawke's Bay District Health Board September 2014



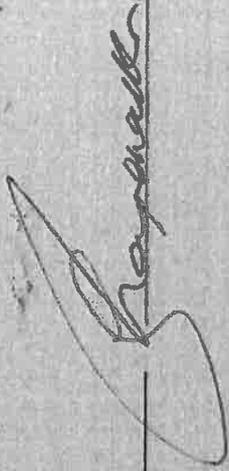

# Memorandum of Understanding

Partnership between Ngāti Kahungunu Iwi Incorporated and Hawke's Bay District Health Board      September 2014







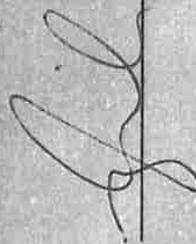




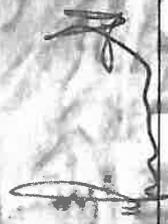












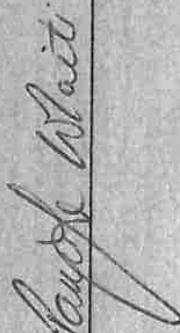


# Memorandum of Understanding

Partnership between Ngāti Kahungunu Iwi Incorporated and Hawke's Bay District Health Board      September 2014

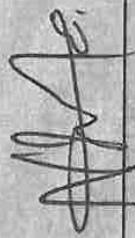
  
Chief Executive Officer  
Ngāti Kahungunu Iwi Inc.

Chair  
Ngāti Kahungunu Iwi Inc

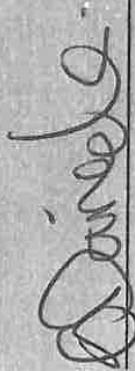


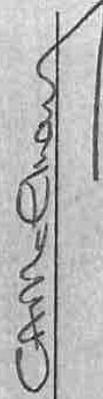
Chief Executive Officer  
Hawke's Bay District Health Board





Chair  
Hawke's Bay District Health Board







## TERMS OF REFERENCE

### MATARIKI GOVERNANCE GROUP

#### 1. PREAMBLE

1.1 The Matariki Hawke's Bay Regional Economic Development Strategy and Action Plan (HBREDS) was adopted in July 2016. The strategy was developed collaboratively between local authorities, tangata whenua, business leaders and government agencies.

1.2 The Matariki Governance Group (MGG) has been formed to acknowledge these cross-sector partnerships and to provide the leadership required to support economic outcomes for the region of Hawke's Bay.

1.3 The Matariki Governance Group recognises that sustainable economic success across our region is made possible when we combine health, social, cultural, environmental and business initiatives.

#### 2. PARTIES

2.1 Each of the following stakeholders/local authorities is a Member of the Matariki HBREDS Governance Group and is a party to this Terms of Reference:

Central Hawke's Bay District Council	Mayor or nominee
Hastings District Council	Mayor or nominee
Hawke's Bay Regional Council	Mayor or nominee
Napier City Council	Mayor or nominee
Wairoa District Council	Mayor or nominee
Heretaunga Tamatea	Chairperson or nominee
Mana Ahuriri Trust	Chairperson or nominee
Maungaharuru-Tangitū Trust	Chairperson or nominee
Ngāti Hineuru	Chairperson or nominee
Ngāti Kahungunu Iwi Incorporated	Chairperson or nominee
Ngāti Pahauwera Development Trust	Chairperson or nominee
Tātau Tātau o Te Wairoa	Chairperson or nominee
Business Hawke's Bay	Chairperson or nominee
Hawke's Bay District Health Board	Chairperson or nominee

### **3. DEFINITIONS**

For the purpose of this Terms of Reference:

- 3.1 "Executive Steering Group" (ESG) means the Matariki HBREDS Executive Steering Group.
- 3.2 "Matariki Governance Group" (MGG) means the Matariki HBREDS Governance Group.
- 3.3 "Hawke's Bay Region" for the purposes of this document means the region as defined in the Matariki Regional Economic Development Strategy.

### **4. THE PURPOSE OF THIS TERMS OF REFERENCE**

4.1 The purposes of this Terms of Reference are to:

- (a) set out the purposes, functions, powers, and duties of the MGG and its members in accordance with the requirements of the term of reference;
- (b) define the responsibilities of the MGG; and
- (c) provide for the administrative arrangements of the MGG.

### **5. MEMBERSHIP OF THE MATARIKI GOVERNANCE GROUP (MGG)**

5.1 The Members of the Matariki Governance Group are as outlined in Section 2.1. Each member is to be represented on the MGG by one person only.

5.2 In the event any elected MGG member is unable to participate then they may nominate alternative representation in their absence.

5.3 Each MGG member has full and equal voting rights.

### **6. FUNCTIONS**

6.1 The functions, powers and duties of the MGG are specified in the following objectives:

- (a) provide direction to the Executive Steering Group, on matters associated with delivery and implementation of Matariki HBREDS;
- (b) provide insights based on knowledge of the region and the area of expertise brought to the table in order to advance the successful delivery and stated objectives of Matariki HBREDS;
- (c) oversee the development, implementation, maintenance, monitoring and evaluation of Matariki HBREDS; and
- (d) act as a connection to the Government for regional investment and enable the development and submission of Provincial Growth Fund Applications;

## **7. OBLIGATIONS OF MEMBERS**

7.1 Each member of the MGG will:

- (a) appoint its chief executive officer, or appropriate level of executive, to the Executive Steering Group (ESG) to ensure representation of Māori, Business, Local and Central Government across Hawke's Bay;
- (b) participate in the preparation of and agree to the development and implementation of Matariki HBREDS;
- (c) contribute technical expertise and resources to maintain an effective MGG and ESG capability; and
- (d) provide to the MGG the information of reports that may be required by the MGG to discharge its powers, functions and duties;

## **8. MAINTAIN THE EXECUTIVE STEERING GROUP (ESG)**

8.1 The MGG will maintain the functions, powers and duties of the ESG as specified in the following ESG objectives:

- (a) provide advice to the Governance Group or other stakeholder forums and entities on matters associated with Matariki HBREDS;
- (b) implement, as appropriate, the decisions of the MGG;
- (c) provide guidance to Matariki HBREDS Project Teams, groups and sub committees in terms of refinements to the scope, vision and the implementation;
- (d) provide insights based on knowledge of the region and the area of expertise brought to the table;
- (e) constructively challenge the interpretation of data as it is collected; and
- (f) manage the development, implementation, maintenance, monitoring, and evaluation of the Matariki HBREDS Strategy
- (g) review and provide feedback to applicants, the MGG and the Provincial Development Unit on the development and submission of Provincial Growth Fund Applications;

8.2 ESG Membership will comprise local authorities, tangata whenua, business and government agencies as specified in the ESG Terms of Reference.

## **9. REMUNERATION**

9.1 Each Member of the MGG shall be responsible for remunerating its representative on the MGG for the cost of that person's participation in the MGG.

## **10. MEETINGS**

10.1 The MGG shall hold three (3) meetings per year

10.2 The quorum of the MGG is eight (8) Members.

10.3 MGG meetings are not a local authority meeting as defined under Part 7 of the Local Government Official Information and Meetings Act 1987. As such MGG meetings are not public meetings however the agendas and minutes are treated as official information under that Act, as related to Council activity.

## **11. VOTING**

11.1 Members of the MGG shall use their best endeavours to obtain consensus.

11.2 Each Member has one vote at a meeting of the MGG or when the MGG is required at any time to make a decision in respect of an action to be taken by the MGG.

11.3 All actions to be taken by the MGG must first be approved by way of a majority vote of all Members that are present and voting.

11.4 The Senior Regional Official shall have observer status on the MGG and also the ESG.

11.5 A casting vote shall not be used.

11.6 Members may express their differences of opinion with the collective decisions of the MGG made as a result of the voting process, however all members agree to publicly support MGG decisions in order to advance the objectives of Matariki HBREDS.

## **12. ELECTION OF CO-CHAIRS**

12.1 The MGG will appoint Co-Chairs for the Group at the first meeting.

12.2 On an annual basis the election of Co-Chairs will occur.

## **13. ADMINISTRATION**

13.1 Administration for the MGG will be via Matariki HBREDS Programme Management Services. The Administering Authority is responsible for the provision of administrative and related services that may from time to time be required by the MGG.

## **14. GOOD FAITH**

14.1 In the event of any circumstances arising that were unforeseen by the parties at the time of adopting this Terms of Reference, the parties hereby record their intention that they will negotiate in good faith to add to or vary this Terms of Reference so to resolve the impact of those circumstances in the best interests of: (a) the Members of the Matariki HBREDS Governance Group collectively; and (b) the Hawke's Bay community represented by the Members of the MGG collectively.

**15. VARIATIONS**

15.1 Any Member may propose a variation, deletion or addition to these Terms of Reference by putting the wording of the proposed variation, deletion or addition to a meeting of the MGG.

15.2 The Terms of Reference will only be amended upon a unanimous vote and resolution passed by the MGG and duly recorded in writing.

**16. REVIEW OF THE TERMS OF REFERENCE**

16.1 The Terms of Reference will be reviewed and if appropriate amended by the MGG at its first meeting of each financial year.

16.2 The adoption of an amended Terms of Reference revised under clause 16.1 will be undertaken in accordance with section 15 above.

**17. ADOPTED BY**

17.1 The Matariki Governance Group Co-Chairs directed by the mandate of the table

Full Name:.....

Position:.....

Date:.....

Signature:.....

Full Name:.....

Position:.....

Date:.....

Signature:.....

## **Schedule 2: Committees'/Council's Terms of Reference**

[Community and Public Health Advisory Committee \(CPHAC\)](#)

[Disability Support Advisory Committee \(DSAC\)](#)

[Hospital Advisory Committee \(HAC\)](#)

[Finance, Risk and Audit Committee \(FRAC\)](#)

[Maori Relationship Board \(MRB\)](#)

[Pasifika Health Leadership Group \(PHLG\)](#)

[Appointments and Remuneration Committee \(ARAC\)](#)

[Hawke's Bay Clinical Council](#)

[Hawke's Bay Health Consumer Council](#)



## TERMS OF REFERENCE

### Hawke's Bay District Health Board Community and Public Health Advisory Committee

December 2013

<p><b>Purpose</b></p>	<p>The purpose of the Community and Public Health Advisory Committee (CPHAC) is to advise the Board on relevant strategic issues and the operational performance of the "primary, community and population health" services, delivered or funded by the Hawke's Bay District Health Board (HBDHB).</p>
<p><b>Functions</b></p>	<p>The functions of CPHAC are to:</p> <ol style="list-style-type: none"> <li>1. Provide strategic oversight of the services through ensuring:             <ol style="list-style-type: none"> <li>a) Effective planning and service development.</li> <li>b) Consistency with HBDHB vision and values</li> <li>c) Alignment with Strategic Framework and local priorities.</li> <li>d) Appropriate national, regional and local integration and collaboration with other services and agencies.</li> <li>e) Effective prioritisation of health resources.</li> </ol> </li> <li>2. Monitor the operational performance of the services.</li> </ol> <p>The aim of CPHAC's advice is to:</p> <ol style="list-style-type: none"> <li>1. Specifically support the development and achievement of HBDHB goals, objectives and targets.</li> <li>2. Generally contribute to:             <ol style="list-style-type: none"> <li>a) Improving the health of the Hawke's Bay community, including the reduction in health disparities.</li> <li>b) Enhancing the patient care experience, including quality of care, access and reliability of services.</li> <li>c) Reducing (or at least controlling) the per capita costs of care and enhancing value for money.</li> </ol> </li> </ol>
<p><b>Level of Authority</b></p>	<p>CPHAC has the authority to give advice and make recommendations to the HBDHB Board.</p>
<p><b>Membership</b></p>	<p>All members of the HBDHB Board shall be appointed as members of CPHAC.</p> <p>The appointment of a Board member to CPHAC terminates if the member ceases to be a member of the Board.</p> <p>Remuneration will be based on the Cabinet Fees Framework.</p> <p>Terms and Conditions of appointment are determined by the NZPHD legislation.</p>

<b>Chair</b>	The Chair is appointed by the HBDHB Board.
<b>Quorum</b>	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
<b>Meetings</b>	<p>Meetings will be held as required.</p> <p>Workshops may be held from time to time.</p> <p>Matters may be dealt with between meetings through discussion with the Chair and other relevant members of the Committee.</p> <p>The Standing Orders adopted by HBDHB apply to committee meetings.</p>
<b>Reporting</b>	The Chair shall report on Committee business to the Board with such recommendations as the Committee may deem appropriate.
<b>Minutes</b>	Minutes will be circulated to all members of the Committee within one week of the meeting taking place.



## TERMS OF REFERENCE

### Hawke's Bay District Health Board Disability Support Advisory Committee

December 2013

<b>Purpose</b>	The purpose of the Disability Support Advisory Committee (DSAC) is to advise the Board on relevant strategic issues and the operational performance of the “disability, mental health and addiction, and health of older persons” services, delivered or funded by the Hawke's Bay District Health Board (HBDHB).
<b>Functions</b>	<p>The functions of DSAC are to:</p> <ol style="list-style-type: none"> <li>1. Provide strategic oversight of the services through ensuring: <ol style="list-style-type: none"> <li>a) Effective planning and service development</li> <li>b) Consistency with HBDHB vision and values</li> <li>c) Alignment with Strategic Framework and local priorities.</li> <li>d) Appropriate national, regional and local integration and collaboration with other services and agencies.</li> <li>e) Effective prioritisation of health resources.</li> </ol> </li> <li>2. Monitor the operational performance of the services.</li> </ol> <p>The aim of DSAC's advice is to:</p> <ol style="list-style-type: none"> <li>1. Specifically support the development and achievement of HBDHB goals, objectives and targets.</li> <li>2. Generally contribute to: <ol style="list-style-type: none"> <li>a) Improving the health of the Hawke's Bay community, including the reduction in health disparities.</li> <li>b) Enhancing the patient care experience, including quality of care, access and reliability of services.</li> <li>c) Reducing (or at least controlling) the per capita costs of care and enhancing value for money.</li> </ol> </li> </ol>
<b>Level of Authority</b>	DSAC has the authority to give advice and make recommendations to the HBDHB Board.
<b>Membership</b>	<p>All members of the HBDHB Board shall be appointed as members of DSAC.</p> <p>The appointment of a Board member to DSAC terminates if the member ceases to be a member of the Board.</p> <p>Terms and conditions of appointment are determined by the NZPHD legislation.</p> <p>Remuneration will be based on the Cabinet Fees Framework.</p>

<b>Chair</b>	The Chair is appointed by the HBDHB Board.
<b>Quorum</b>	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
<b>Meetings</b>	<p>Meetings will be held as required.</p> <p>Workshops may be held from time to time.</p> <p>Matters may be dealt with between meetings through discussion with the Chair and other relevant members of the Committee.</p> <p>The Standing Orders adopted by HBDHB apply to committee meetings.</p>
<b>Reporting</b>	The Chair shall report on Committee business to the Board, with such recommendations as the Committee may deem appropriate.
<b>Minutes</b>	Minutes will be circulated to all members of the Committee within one week of the meeting taking place.



## TERMS OF REFERENCE

### Hawke's Bay District Health Board Hospital Advisory Committee

December 2013

<p><b>Purpose</b></p>	<p>The purpose of the Hospital Advisory Committee (HAC) is to advise the Board on relevant strategic issues and the operational performance of the "hospital and related" services, delivered or funded by the Hawke's Bay District Health Board (HBDHB).</p>
<p><b>Functions</b></p>	<p>The functions of HAC are to:</p> <ol style="list-style-type: none"> <li>1. Provide strategic oversight of the services through ensuring:             <ol style="list-style-type: none"> <li>a) Effective planning and service development.</li> <li>b) Consistency with HBDHB vision and values</li> <li>c) Alignment with Strategic Framework and local priorities.</li> <li>d) Appropriate national, regional and local integration and collaboration with other services and agencies.</li> <li>e) Effective prioritisation of health resources.</li> </ol> </li> <li>2. Monitor the operational performance of the services.</li> </ol> <p>The aim of HAC's advice is to:</p> <ol style="list-style-type: none"> <li>1. Specifically support the development and achievement of HBDHB goals, objectives and targets.</li> <li>2. Generally contribute to:             <ol style="list-style-type: none"> <li>a) Improving the health of the Hawke's Bay community, including the reduction in health disparities.</li> <li>b) Enhancing the patient care experience, including quality of care, access and reliability of services.</li> <li>c) Reducing (or at least controlling) the per capita costs of care and enhancing value for money.</li> </ol> </li> </ol>
<p><b>Level of Authority</b></p>	<p>HAC has the authority to give advice and make recommendations to the HBDHB Board.</p>
<p><b>Membership</b></p>	<p>All members of the HBDHB Board shall be appointed as members of HAC.</p> <p>The appointment of a Board member to HAC terminates if the member ceases to be a member of the Board.</p> <p>Terms and conditions of appointment are determined by the NZPHD legislation.</p> <p>Remuneration will be based on the Cabinet Fees Framework.</p>

<b>Chair</b>	The Chair is appointed by the HBDHB Board.
<b>Quorum</b>	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
<b>Meetings</b>	<p>Meetings will be held as required.</p> <p>Workshops may be held from time to time.</p> <p>Matters may be dealt with between meetings through discussion with the Chair and other relevant members of the Committee.</p> <p>The Standing Orders adopted by HBDHB apply to committee meetings.</p>
<b>Reporting</b>	The Chair shall report on Committee business to the Board with such recommendations as the Committee may deem appropriate.
<b>Minutes</b>	Minutes will be circulated to all members of the Committee within one week of the meeting taking place.



## TERMS OF REFERENCE

### Hawke's Bay District Health Board Māori Relationship Board

September 2014

<p><b>Purpose</b></p>	<p>The purpose of the Māori Relationship Board (MRB) is to maximise the relationship between the Hawke's Bay District Health Board (HBDHB) and Ngāti Kahungunu Iwi Inc. (NKII), to benefit the Māori population within the Kahungunu rohe principally by identifying and removing health inequities and instituting processes that support Māori centric models of health care.</p>
<p><b>Functions</b></p>	<p>The functions of the MRB are to:</p> <ol style="list-style-type: none"> <li>a) Identify and convey the needs and aspirations for health and wellbeing of the Māori population within Hawke's Bay.</li> <li>b) Ensure effective plans are jointly developed and maintained by HBDHB and NKII to address health inequities and to foster mana motuhake.</li> <li>c) Monitor and make recommendations on the implementation of these plans.</li> <li>d) Monitor the strategic development and performance of HBDHB delivered and funded services, to ensure they support the removal of disparities and are responsive to the needs of Māori.</li> <li>e) Monitor the operational performance of services targeted particularly at Māori.</li> <li>f) Prioritise the use of funding and access to services.</li> </ol> <p>The aim of the MRB's advice is to:</p> <ol style="list-style-type: none"> <li>a) Identify and reduce/remove existing and potential health inequities.</li> <li>b) Promote and enhance whānau models of care</li> <li>c) Monitor the patient care experience for Māori ensuring all services are accessible, appropriate and responsive to meet their needs.</li> <li>d) Ensure all funding and services are appropriate, recognise agreed values and provide value for money.</li> </ol>
<p><b>Level of Authority</b></p>	<p>The MRB has the authority to provide tangible advice and make recommendations to the HBDHB Board.</p> <p>The Kahungunu Health Sector representative members of MRB will decide and progress any documentation that requires NKII Board Endorsement through the appropriate NKII processes.</p> <p>Ngāti Kahungunu Iwi endorsement can, and is only to, be provided by the Ngāti Kahungunu Iwi Inc. Board.</p>

<p><b>Membership</b></p>	<p>Members of MRB:</p> <ul style="list-style-type: none"> <li>▪ Will be appointed for any period that terminates no later than four months after the end of the term of the HBDHB Board that appointed them. (Note: The full term of a Board is three years).</li> <li>▪ Members may be reappointed by the 'new' Board.</li> </ul> <p>The appointment of a Board member to MRB terminates if the member ceases to be a member of the Board.</p> <p>Remuneration will be based on the Cabinet Fees Framework which provides for payment for each member's attendance at meetings or workshops, up to a maximum of ten per year.</p> <p>Composition:</p> <ul style="list-style-type: none"> <li>• Chairman of Ngāti Kahungunu Iwi Incorporated, or alternate</li> <li>• No less than two and no more than six HBDHB Board members, at least two of whom should be Māori</li> <li>• Community members (up to six nominated by NKII or from the community)</li> <li>• One Ahuriri District Health Representative.</li> </ul> <p>HBDHB Board members who are not committee members may attend this committee as observers, and with the approval of the committee chair, have the right to speak.</p>
<p><b>Chair</b></p>	<p>The Chair shall be appointed by the HBDHB Board from the HBDHB Maori Board members on MRB. HBDHB shall consult with NKII on this appointment.</p>
<p><b>Quorum</b></p>	<p>A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.</p>
<p><b>Meetings</b></p>	<p>MRB may have up to eight meetings or workshops per year, at times and places agreed by the Chair. The Standing Orders adopted by HBDHB apply to MRB meetings, however Tikanga will take precedence.</p>
<p><b>Reporting</b></p>	<p>The Chair shall report on MRB business to the Board, with such recommendations as the MRB may deem appropriate.</p>
<p><b>Minutes</b></p>	<p>Minutes of all meetings and outcomes of all workshops will be circulated to all members of the Committee within one week of the meeting/workshop taking place. HBDHB Board members will be sent a copy of the minutes/outcomes, on request.</p>



**TERMS OF REFERENCE**

**Hawke's Bay District Health Board  
Finance Risk and Audit Committee**

**March 2019**

<p><b>Purpose</b></p>	<p>The purpose of the Finance Risk and Audit Committee (FRAC) is to advise and assist the Hawke's Bay District Health Board (HBDHB) to meet governance responsibilities relating to output performance, finance, people, health &amp; safety clinical quality &amp; patient safety risk management, audit and compliance.</p>
<p><b>Functions</b></p>	<p>The functions of FRAC are to:</p> <p><b>1. Output Performance</b></p> <ul style="list-style-type: none"> <li>a) Monitor the operational performance and other service related outputs of HBDHB, including performance of the provider arm.</li> <li>b) Ensure appropriate strategies and actions are in place to achieve target levels of performance</li> </ul> <p><b>2. Finance:</b></p> <ul style="list-style-type: none"> <li>a) Monitor the overall financial performance of HBDHB, including the performance of the Provider Arm.</li> <li>b) Monitor the capital plan and the overall financial position of HBDHB.</li> </ul> <p><b>3. People, Health &amp; Safety:</b></p> <ul style="list-style-type: none"> <li>a) Monitor, review and ensure the effectiveness of strategies and plans aimed at developing and maintaining an appropriate, diverse, motivated and high performing workforce including, workplace safety staff wellbeing and engagement.</li> <li>b) Determine the organisation's health &amp; safety charter, strategy, framework, structure and policy.</li> <li>c) Ensure the organisation meets all its obligations and desire to protect the health and safety of all people for whom it is responsible.</li> </ul>

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**4. Clinical Quality & Patient Safety**

- a) Ensure appropriate patient safety and clinical quality measures are in place, are maintained and managed, and positive outcomes are achieved.
- b) Monitor and support the Clinical Council performance in providing clinical governance oversight and advice on clinical quality and patient safety issues in Hawkes Bay.

**5. Risk Management**

- a) Monitor and review the adequacy and performance of HBDHB risk management framework, strategies, processes and reporting.
- b) Ensure all risks to achieving organisational goals are appropriately identified, mitigated and managed

**6. Audit:**

- a) Provide assurance that all audit processes required by statute and the Board are completed.
- b) Ensure all issues identified by audits are appropriately addressed.

**7. Compliance:**

- a) Ensure HBDHB is complying with all relevant statutory, regulatory and policy obligations and requirements.
  - b) Specific detailed duties are set out in Schedule A attached.
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<p><b>Level of Authority</b></p>	<p>FRAC has the authority to give advice and make recommendations to the HBDHB Board.</p> <p>FRAC is authorised by the Board to investigate any activity it deems appropriate. It is authorised to seek any information from any officer or employee of the organisation all of whom are directed to co-operate with any request made by the Committee.</p> <p>FRAC is authorised to engage any firm of accountants, lawyers or other professionals as the Committee sees fit to provide independent counsel and advice to assist in any review or investigation on such matters as the Committee deems appropriate.</p>
<p><b>Membership</b></p>	<p>Members of FRAC:</p> <ul style="list-style-type: none"> <li>▪ Will be appointed for any period that terminates no later than four months after the end of the term of the HBDHB Board that appointed them. (Note: The full term of a Board is three years).</li> <li>▪ Members may be reappointed by the 'new' Board.</li> </ul> <p>The appointment of a Board member to FRAC terminates if the member ceases to be a member of the Board.</p> <p>Remuneration will be based on the Cabinet Fees Framework.</p> <p>Composition:</p> <ul style="list-style-type: none"> <li>• HBDHB Chair</li> <li>• Up to ALL other Board members, but there shall be no less than two</li> <li>• Up to two independent non-Board members (external advisers) where the required skills are not available from existing Board members.</li> </ul> <p>HBDHB Board members who are not committee members can attend this Committee as observers, and with the approval of the Committee Chair have the right to speak. The Committee Chair can ask for</p> <ul style="list-style-type: none"> <li>▪ Specific comment from observers on agenda items.</li> </ul>

<b>Chairperson</b>	The Chair is appointed by the HBDHB Board. The Chair shall not be the HBDHB Chair
<b>Quorum</b>	A quorum will be half the members if the number of members is even and a majority if the number of members is odd.
<b>Meetings</b>	<p>The Committee shall meet monthly (other than January).</p> <p>All meetings shall be held with the public excluded.</p> <p>Matters may be dealt with between meetings through discussion with the Chair and other relevant members of the Committee.</p> <p>The Standing Orders adopted by HBDHB apply to committee meetings.</p>
<b>Reporting</b>	<p>The Chair shall report on Committee business to the Board with such recommendations as the Committee may deem appropriate.</p> <p>The Committee shall recommend approval of the interim and annual financial statements and other audit obligations along with any other certificates requiring approval to the Board.</p>
<b>Minutes</b>	Minutes will be circulated to all members of the Committee and HBDHB Board, within one week of the meeting taking place.

**SCHEDULE A – FRAC DETAILED DUTIES**

**Based on “Good Practice Guide for Audit Committees in the Public Sector” Issued by the Office of the Auditor General in March 2008**

<b>Duties</b>	<p><b>1. Output Performance</b></p> <p>The duties of the Committee in respect to Output Performance shall be to:</p> <ul style="list-style-type: none"> <li>• Monitor the overall output performance of HBDHB, with a particular focus on the performance of the Provider Arm</li> <li>• Monitor achievement of Ministry of Health Targets</li> <li>• Monitor Elective Services performance, including discharges, case weights and waiting times (ESPI)</li> <li>• Monitor achievement of System Level Measures</li> <li>• Ensure effective strategies and plans are put in place to ensure a balanced approach is taken to the delivery of output performance targets and objectives</li> </ul> <p><b>2 Finance</b></p> <p>The duties of the Committee in respect to Finance shall be to:</p> <ul style="list-style-type: none"> <li>• Monitor the overall financial performance and financial position of the HBDHB.</li> <li>• Monitor Capital Plan against actual.</li> <li>• Review any additional budget requests or commitment of funds above the Chief Executive’s delegated financial authority limit and make recommendations to the Board on these.</li> </ul> <p><b>3 People, Health &amp; Safety</b></p> <p>The duties of the Committee in respect to People, Health and Safety shall be to monitor, review and ensure the effectiveness of strategies and plans aimed at developing and maintaining an appropriate, diverse, motivated and high performing workforce, including workplace safety, staff wellbeing and engagement. Specifically this will include:</p> <p>3.1 Review of workforce indicators with a focus on:</p> <ul style="list-style-type: none"> <li>• Staff numbers (contracted FTE), recruitment and vacancies</li> </ul>
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- Ethnic diversity - particularly Maori and Pacific Island
- Staff wellness (annual leave, sick leave, flu vax, EAP etc.)

3.2 Develop, monitor and review the HBDHB's health and safety management system including:

- Reviewing reports that reflect ongoing compliance with the Health & Safety at Work Act (2015) and HBDHB health & safety strategy and policy
- Review key performance indicators and reports showing staff related events, identified risks and corrective actions

3.3 Review and monitor reports showing the impact of strategies, policies and actions aimed at developing and maintaining high levels of staff engagement and satisfaction, through:

- Staff engagement surveys
- 'Stocktakes'
- Staff feedback

#### **Clinical Quality & Patient Safety**

The duties of the Committee in respect of Clinical Quality and Patient Safety relate primarily to ensuring that there is effective clinical governance applied to all healthcare related activities in Hawkes Bay. This means moving the organisation towards a culture where safe, high quality person-centred care is ensured by all those involved in the patient's journey. Specifically this requires the Committee to:

- a) Support and monitor Clinical Council's performance of its clinical governance function and its provision of advice on clinical quality and patient safety issues in Hawkes Bay.
- b) Ensure appropriate patient safety and clinical quality measures are in place, are maintained and managed, and positive outcomes are achieved.
- c) Regular review of clinical risks and quality control including:
  - Risk practices and policies and the adequacy and effectiveness of systems controls
  - Quality Control.
  - Sentinel reports.
  - Infection risks management.

## Risk Management

The duties of the Committee in respect to Risk Management shall be to review the adequacy of the Board's risk management of the organisation as a whole including

3.4. Regular review of technology system risks with a focus on:

- Adequacy of systems to achieve objectives
- IT Disaster Recovery Planning.

3.5 Review of HBDHB's risk management programme to ensure:

- Adequate monitoring of critical risks and responsibilities for risk management.
- A robust identification and assessment process and an early warning system are in place.
- Risk management policies and strategies reflect the Board's views and priorities.
- Risks and risk management are regularly reported to the Board in meaningful format.
- Compliance of HBDHB's risk management systems with public sector Risk management standards as set out in "Guidelines for Managing Risks in the Australian and New Zealand Public Sector: "SAA/NZ HB 143:1999.
- Adequacy of Business Continuity Management and linkage to IT Disaster Recovery Planning

2.1 Project Risks focusing on:

- Overall project register.
- NRH completion risk around the completion of projects, establishment risk and change management risk.

2.2 Operating Risks:

- Includes review of annual insurance placement including ensuring adequate cover is provided.

2.3 Other Risks: **Includes safety policies.**

- Policies and procedures to minimise and manage conflicts of interests among Board members, management and staff.
- Policies and procedures to minimise and manage risks in contracting of health services.
- Reputation and communication.

- Other monitoring responsibilities as determined by the Board.

#### **4 Audit**

3.1 The duties of the Committee in respect to Audit shall be to:

- Provide assurance to the Board that all audit processes required by the Board or by statute are completed.
- Ensure that there is an open avenue of communication between the Internal Auditor, the external auditors and the Board. The Internal Auditor and external auditors have direct access at any time to each other and the Committee.
- Consider, in consultation with the external auditors and the Internal Auditor, the audit plans and scope of the external auditors and internal auditors, ensuring that co-ordination of audit effort is maximised.
- Work with other committees of the Board to ensure an integrated approach to all audit processes.
- Review annually and, if necessary propose for formal Board adoption, amendments to the Committee's Terms of Reference.

3.2 In addition the Committee shall review:

- The external audit strategy plans and all audit outcomes.
- The interim results and financial statements.
- The annual results and financial statements.
- Any internal audit plans and a summary of outcomes of specific audits.
- Clinical audits and Audits of funding contracts, including those currently undertaken within the arrangement with Central TAS.

3.3 With respect to meetings where Audit business is to be considered:

- The Chief Executive Officer, Chief Financial Officer, Internal Auditor and representatives of the external auditors shall normally attend. All other Board members shall have the right to attend.
- The Committee may instruct any officer or employee of the HBDHB to attend any meeting and provide pertinent information as necessary.

- The Internal Auditor reports functionally to the Chair of the Audit Committee (and administratively to the Chief Financial Officer).
- The acceptance of findings of the Audit Committee by the Board shall not relieve the Board from any of its responsibilities.
- At least once a year, the Committee shall meet with the external auditors without the presence of executive management to discuss any matters that either the Committee or the external auditors believe should be discussed privately.

3.4 Specific Responsibilities of the Committee shall be:

3.4.1 *Financial*

- Review with management and the external auditors:
  - HBDHB's interim and annual financial statements.
  - The external auditors' audit of the financial statements and report thereon (where applicable).
  - Any significant changes which have been required in the external auditors' audit plan.
  - Any significant difficulties or disputes with management encountered during the course of the audit.
  - Other matters related to the conduct of the audit which are to be communicated to the Committee under generally accepted auditing standards.
  - HBDHB's accounting and financial reporting practices and policies with regard to the application of current accounting standards, legislation and other appropriate standards.
  - Significant transactions which are not a normal part of HBDHB's business.

3.4.2 *Financial and Other Risks and Internal Control*

- Consider and review with management and the Internal Auditor the HBDHB's Financial Risk Analysis report.
- Enquire of management, the Internal Auditor, and the external auditors about significant Financial and other Risks or exposures and evaluate the steps taken to minimise such Financial Risk to the organisation.

- Consider and review with management and the Internal Auditor significant findings and management's responses thereto.
- Consider and review with the external auditors and the Internal Auditor:
  - The adequacy of the organisation's systems of internal control including computerised systems controls and security.
  - All audit processes including audit of risk management
  - Any related significant findings and recommendations of the external auditor including the management letter and of the internal auditor, together with management's responses there to.
  - Consider and review the six monthly management statutory compliance reports.
- Consider and review with management and the Internal Auditor the HBDHB's Policies and Procedures in relation to:
  - Delegated Signing Authorities for financial transactions and contract authority.
  - Capital Expenditure approvals.
- Consider and review with management and the Internal Auditor HBDHB's Business Continuance planning.

#### 3.4.3 *External Audit*

- The appointment of the Audit Office as the Board's external Auditor is mandatory as outlined in Section 43 of the NZPH&D Act 2000 and Section 156 of the Crown Entities Act 2004.
- According to the Acts audits are not limited to financial audit.

#### 3.4.4 *Internal Audit*

- Consider and review with management and the Internal Auditor:
  - Significant internal audit reports and summary of internal audit activity.
  - Any difficulties encountered in the course of internal audit, and any restrictions placed on

internal audit scope of work or access to required information or personnel.

- The internal audit plan of future audits to be conducted.
- Any changes which have been required in the previously approved internal or external audit plan.
- The internal audit department's Charter.
- Consider the appropriateness of the internal audit function from time to time.

#### *3.4.5 Statutory*

- Review whether statutory and regulatory financial and other obligations have been met by HBDHB, including any certifications required from directors under legislation.
- Review whether any disclosure documents reflect a true and fair view and comply with relevant legislation.

## **5 Compliance**

The duties of the Committee in respect to Compliance are to ensure that HBDHB is complying with all relevant statutory, regulatory and policy obligations and requirements





## TERMS OF REFERENCE

### Hawke's Bay District Health Board Pacific Health Leadership Group

16 July 2013

<b>Purpose</b>	The purpose of the Pacific Health Leadership Group (PHLG) is to provide appropriate advice to Hawke's Bay District Health Board (HBDHB) through the Community & Public Health Advisory Committee (CPHAC) to improve the health status of the Pacific people within the HBDHB area and reduce health disparities.
<b>Functions</b>	<p>The functions of the PHLG are to:</p> <ol style="list-style-type: none"> <li>Identify and convey the needs for health and wellbeing of the Pacific people within Hawke's Bay.</li> <li>Ensure an appropriate plan is jointly developed and maintained by HBDHB to address identified issues.</li> <li>Monitor the operational implementation of this plan.</li> <li>Monitor the strategic development and performance of HBDHB delivered and funded services, to ensure they support the reduction in disparities and are responsive to the needs of Pacific people.</li> <li>Monitor the operational performance of services targeted particularly at Pacific people.</li> </ol> <p>The aim of the PHLGs advice is to:</p> <ol style="list-style-type: none"> <li>Reduce existing health disparities and improve the health of the Hawke's Bay Pacific people.</li> <li>Enhance the patient care experience for Pacific people through ensuring all services are accessible and responsive to meet their needs.</li> </ol>
<b>Level of Authority</b>	The PHLG has the authority to give advice and make recommendations to the HBDHB Board through CPHAC.
<b>Membership</b>	<ul style="list-style-type: none"> <li>• Up to eight (8) members shall be appointed to the PHLG by CPHAC for terms of up to two (2) years,</li> <li>• Members may be reappointed.</li> <li>• General criteria for membership shall consist of a mix of:             <ul style="list-style-type: none"> <li>- Nominated by their community, having demonstrated relevant skills and links to that community</li> <li>- Knowledge and experience in the health sector</li> <li>- Experience of working in a multi-agency environment</li> <li>- Knowledge and experience of the disability sector</li> <li>- Governance, strategic and policy skills</li> </ul> </li> <li>• At least two members of PHLG shall have attributes to 'represent' Pacific youth issues.</li> <li>• Remuneration will be based on the Cabinet Fees Framework for HBDHB Committee Members.</li> </ul>
<b>Chair</b>	The Chair shall be elected by the PHLG and endorsed by CPHAC.

<b>Quorum</b>	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
<b>Meetings</b>	Meetings will be held quarterly, or more frequently at the request of the Chair. Workshops may be held from time to time. The Standing Orders adopted by HBDHB apply to PHLG meetings.
<b>Reporting</b>	Following each meeting, the Chair shall report on PHLG business to the CPHAC Chair, with such recommendations as the PHLG may deem appropriate.
<b>Minutes</b>	Minutes will be circulated to all members of the PHLG within one week of the meeting taking place. CPHAC and HBDHB Board members will be sent a copy of the minutes, on request.
<b>Support</b>	The PHLG shall be supported by the Director of Population Health / Health Equity Champion and the Pacific Health Development Manager.



## TERMS OF REFERENCE

### Hawke's Bay District Health Board Appointments and Remuneration Advisory Committee

Board Approved: January 2019

<b>Purpose</b>	The purpose of the Appointments and Remuneration Advisory Committee (ARAC) is to advise the Hawke's Bay District Health Board (HBDHB) on general remuneration policy and all employment issues relating to the CEO.
<b>Functions</b>	<p>The functions of ARAC are to:</p> <ul style="list-style-type: none"> <li>a) Periodically review and make recommendations regarding HBDHB remuneration policy.</li> <li>b) Undertake the processes required and make recommendations on all CEO employment related issues, including: <ul style="list-style-type: none"> <li>- appointment</li> <li>- termination</li> <li>- remuneration package / terms and conditions <sup>1</sup></li> <li>- performance targets</li> <li>- performance review <sup>2</sup></li> </ul> </li> <li>c) Review (and endorse) any CEO proposed adjustments to the remuneration packages of the CEO's direct reports.</li> </ul>
<b>Level of Authority</b>	<p>ARAC has the authority to give advice, and make recommendations, to the Board.</p> <p>There may be situations where the Committee may need to investigate and deal with confidential issues regarding the CEO. In those situations the Board may resolve to delegate to the committee the power to act on the Board's behalf. The Committee shall keep members of the Board fully informed, on a confidential basis, of significant developments in relation to these issues as may be practicable in the circumstances.</p>
<b>Membership</b>	<p>Members of ARAC:</p> <ul style="list-style-type: none"> <li>▪ Will be appointed for any period that terminates no later than four months after the end of the term of the HBDHB Board that appointed them. (Note: The full term of a Board is three years).</li> <li>▪ Members may be reappointed by the 'new' Board.</li> </ul> <p>The appointment of a Board member to ARAC terminates if the member ceases to be a member of the Board.</p> <p>Remuneration will be based on the Cabinet Fees Framework</p> <p>Composition:</p> <ul style="list-style-type: none"> <li>▪ HBDHB Chair</li> </ul>

<sup>1</sup> Terms and conditions of employment can not be finalised by the Board without the consent of the State Services Commissioner.

<sup>2</sup> The Chair shall normally conduct the annual performance review of the CEO and report to ARAC.

	<ul style="list-style-type: none"> <li>▪ Up to four additional HBDHB Board Members (to ensure appropriate diversity)</li> </ul> <p>No member of ARAC shall be an employee of HBDHB</p>
<b>Chair</b>	<ul style="list-style-type: none"> <li>▪ The HBDHB Chair shall be the Chair of ARAC unless otherwise determined by the Board</li> </ul>
<b>Quorum</b>	<ul style="list-style-type: none"> <li>▪ A quorum of members of the committee will be three.</li> </ul>
<b>Meetings</b>	<ul style="list-style-type: none"> <li>▪ A minimum of two meetings shall be held each year provided that any member of the committee or the CEO may request a meeting anytime he or she considers it necessary</li> <li>▪ The committee may have in attendance such members of management, including the CEO and such persons as external remuneration experts, as it considers necessary to provide appropriate information and explanations</li> <li>▪ All HBDHB Board members will be entitled to attend meetings of the Committee as observers and with the approval of the committee chair may have the right to speak.</li> <li>▪ The Standing Orders adopted by the Board will apply to Committee meetings.</li> </ul>
<b>Reporting</b>	<ul style="list-style-type: none"> <li>▪ After each Committee meeting the Chair shall report the Committee findings and recommendations to the Board</li> <li>▪ The CEO shall be responsible for drawing to the Committee's immediate attention any material matter that relates to the HBDHB's remuneration policies, legislative change that has the potential to significantly impact on the HBDHB's remuneration policies, or employee relations matter arising out of the application of the HBDHB's remuneration policies or remuneration initiatives.</li> </ul>
<b>Minutes</b>	<ul style="list-style-type: none"> <li>▪ Minutes will be circulated to all members of the Committee within one week of the meeting taking place. HBDHB Board members will be sent a copy of the minutes, on request.</li> </ul>



**TERMS OF REFERENCE**

**Hawke's Bay Clinical Council**

**September 2019**

<p><b>Purpose</b></p>	<p>The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system.</p>
<p><b>Functions</b></p>	<p>The Hawke's Bay Clinical Council (Council)</p> <ul style="list-style-type: none"> <li>• Provides clinical advice and assurance to the Hawke's Bay health system management and governance structures.</li> <li>• Works in partnership with the Hawke's Bay Health Consumer Council to ensure Hawke's Bay health services are organised around the needs of people.</li> <li>• Provides oversight of clinical quality and patient safety.</li> <li>• Provides clinical leadership to the Hawke's Bay health system workforce.</li> <li>• Ensures decisions and recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety and experience of care for individuals; improved health and equity for all populations; best value for public health system; and improved experience of providing care).</li> </ul>
<p><b>Level of Authority</b></p>	<p>The Council is appointed by, and is accountable to, the CEO of HBDHB.</p> <p>The Council has the authority to provide advice and make recommendations, to the CEOs and Boards of HBDHB and Health Hawke's Bay Limited (as appropriate).</p> <p>To assist it in this function the Council may:</p> <ul style="list-style-type: none"> <li>• Request reports and presentations from particular groups</li> <li>• Establish sub-groups to investigate and report back on particular matters</li> <li>• Commission audits or investigations on particular issues</li> <li>• Co-opt people from time to time as required for a specific purpose.</li> </ul> <p>The Council's role is one of governance, not operational or line management.</p> <p><b>Delegated Authority</b></p> <p>The Council has delegated authority from the CEOs and Boards to:</p> <ul style="list-style-type: none"> <li>• Make decisions and issue directives on quality clinical practice and patient safety issues that:             <ul style="list-style-type: none"> <li>▪ Relate directly to the function and aims of the Council as set out in the Terms of Reference; and</li> <li>▪ Relate directly to the provision of, or access to, HBDHB publicly funded health services; and</li> <li>▪ Are clinically and financially sustainable</li> </ul> </li> </ul> <p>All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the HBDHB.</p>
<p><b>Membership</b></p>	<p>Members appointed by tenure shall normally be appointed for three years, whilst ensuring that approximately one third of such members 'retire by rotation' each</p>

	<p>year. Such members may be reappointed but for no more than three terms. Members appointed by role/position do not have a finite term.</p> <p><i>By role/position:</i></p> <ul style="list-style-type: none"> <li>• Chief Medical Officer Primary Health Care</li> <li>• Chief Medical &amp; Dental Officer Hospital</li> <li>• Chief Nursing &amp; Midwifery Officer</li> <li>• Chief Allied Health Professions Officer</li> <li>• Midwifery Director</li> <li>• Chief Pharmacist</li> <li>• Clinical Director Health Improvement &amp; Equity</li> <li>• Clinical Lead PHO Clinical Advisory and Governance Committee</li> </ul> <p><i>By Appointment (tenure):</i></p> <ul style="list-style-type: none"> <li>• General Practitioner x 2</li> <li>• Senior Medical / Dental Officer x 2</li> <li>• Senior Nurse x 3</li> <li>• Senior Allied Health Professional</li> </ul> <p>When making appointments, consideration must be given to maintaining a wide range of perspectives and interests within the total membership, ensuring in particular that Māori health and rural health interests and expertise are reflected.</p>
<b>Chair</b>	The Council will annually elect a chair and deputy, or co-chairs.
<b>Quorum</b>	A quorum will be a majority of the members appointed at the time
<b>Meetings</b>	<p>Meetings will be held monthly at least ten times per year, or more frequently at the request of the chair/co-chairs.</p> <p>Meetings will generally be open to the public, but may move into “public excluded” where appropriate and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee.</p> <p>A standing reciprocal invitation has been extended to the Hawke’s Bay Health Consumer Council for a representative to be in attendance at all meetings.</p> <p>Matters may be dealt with between meetings through discussion with the chair/co-chairs and other relevant members of the Council.</p>
<b>Reporting</b>	<p>The Council will report through HBDHB and Health Hawke’s Bay Limited Chief Executives (as appropriate) to the respective Boards.</p> <p>A monthly report of Council activities/decisions will be placed on the DHB website when approved.</p>
<b>Minutes</b>	Minutes will be circulated to all members of the council within one week of the meeting taking place.



**TERMS OF REFERENCE**

**Hawke's Bay Health Consumer Council**

**August 2018**

<p><b>Purpose</b></p>	<p>The Hawke's Bay Health Consumer Council (Council) works collaboratively with the Hawke's Bay District Health Board (HBDHB) and Health Hawke's Bay governance and management teams, and the Hawke's Bay Clinical Council to develop effective partnerships in the design and function of an effective health system in Hawkes Bay that meets the needs of the people.</p> <p>Through true partnership, the Council provides a strong and viable voice for the community and consumers, on health service planning and delivery. The Council seeks to enhance consumer engagement and experience through service integration across the sector, the promotion of equity and ensuring that services are organised and provided to meet the needs of all consumers.</p> <p>Through effective processes and communications, the Council receives, considers and disseminates information from and to HBDHB, Health Hawke's Bay, consumer groups and communities.</p> <p>The Council also has a quality improvement role to advise and encourage best practice and innovation.</p>
<p><b>Functions</b></p>	<p>The functions of the Council are to:</p> <ul style="list-style-type: none"> <li>• Ensure, coordinate and enable appropriate consumer engagement across the Hawke's Bay, Central Region and national health systems.</li> <li>• Identify, advise on and promote a 'Partners in Care' approach to the implementation of 'Person and Whanau Centred Care into the Hawkes Bay health system, including input into the development of health service priorities and strategic direction, the reduction of inequities, and the enhancement of consumer engagement, patient safety, clinical quality and making health easy to understand.</li> <li>• Participate, review and advise on reports, developments and initiatives relating to Hawkes Bay health services and the availability and/or dissemination of health related information.</li> <li>• Ensure regular communication and networking with the community and relevant consumer groups.</li> <li>• Link with special interest groups, as required for specific issues and problem solving.</li> </ul> <p>For the avoidance of doubt, the Council will not:</p> <ul style="list-style-type: none"> <li>• Provide clinical evaluation of health services</li> <li>• Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust processes exists.</li> <li>• Be involved in the HBDHB or Health Hawke's Bay contracting processes.</li> </ul>
<p><b>Level of Authority</b></p>	<p>The Council has the authority to give advice and make recommendations to HBDHB and Health Hawke's Bay senior management and Board.</p>

<p><b>Membership</b></p>	<p>There shall be fourteen (14) members on the Council, plus an independent Chair. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible services and care from the Hawke's Bay health sector. Although appointed to reflect the consumer voice in a particular area of interest, they will not be regarded as representatives of any specific organisation or community.</p> <p>Members will be appointed to reflect the following areas of interest:</p> <ul style="list-style-type: none"> <li>• Women's health</li> <li>• Child health</li> <li>• Youth health</li> <li>• Older persons health</li> <li>• Chronic conditions</li> <li>• Mental health</li> <li>• Alcohol and other drugs</li> <li>• Sensory and Physical disability</li> <li>• Intellectual and Neurological disability</li> <li>• Rural health</li> <li>• Maori health</li> <li>• Pacific health</li> <li>• Primary health</li> <li>• High deprivation populations</li> </ul> <p>When making appointments, consideration must be given to maintaining a demographic balance that generally reflects that of the population.</p> <p>Members shall be appointed by the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the respective boards), following consultation with the consumer and community groups in each of the areas of interest, as appropriate.</p> <p>Members shall be appointed for terms of two years. Members may be reappointed but for no more than three terms.</p> <p>Remuneration shall be paid based on the Cabinet Fees Framework applicable to HBDHB Statutory Committees.</p>
<p><b>Chair</b></p>	<p>The Chair shall be appointed by the HBDHB Board on the recommendation of the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the Health Hawke's Bay Board) following consultation with Council members. Appointments shall be for terms ending no later than four months after the end of the term of the HBDHB Board that appointed them (Note: The full term of a Board is three years).</p> <p>The Chair may be paid additional fees and allowances, depending on the level of commitment involved in addition to Council meetings.</p>
<p><b>Meetings</b></p>	<p>Meetings will be held monthly, excluding January, or more frequently at the request of the Chair.</p> <p>Meetings will generally be open to the public but may move into "public excluded" where appropriate, and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee.</p> <p>A standing reciprocal invitation has been extended to the Hawke's Bay Clinical Council for a representative to be in attendance at all meetings.</p>

<p><b>Reporting</b></p>	<p>The Council will report to the CEOs of HBDHB and Health Hawke’s Bay, and through the CEOs to the respective HBDHB and Health Hawke’s Bay boards.</p> <p>A monthly report of Council activities and recommendations will be placed on HBDHB and Health Hawke’s Bay websites once approved.</p>
<p><b>Minutes</b></p>	<p>Minutes will be circulated to all members and Chair of the Council, within one week of the meeting taking place.</p> <p>Minutes of those parts of any meeting held in “public” shall be made available to any member of the public, consumer group, community etc, on request.</p>

## Schedule 3: Conflict of Interest Guidelines for DHBs

[www.health.govt.nz/](http://www.health.govt.nz/)

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**Foreword**

The New Zealand health and disability sector is an inherently close community, where people with specialist skills and knowledge are in high demand. Conflicts of interest both actual and potential are an inevitable result of this environment. The existence of conflicts is not itself a cause for concern, provided that they are managed in an appropriate manner, by individuals and boards collectively.

Effective conflict of interest management is an essential part of meeting the public's high standards for those working in the public health and disability system. These guidelines seek to underline the importance of appropriately managing conflicts in a complex and 'interest rich' environment. The process is essentially two-fold: the full and timely identification and disclosure of interests and conflicts, and then determining and implementing an appropriate response to such disclosures on an ongoing basis.

This guidance has been written to assist District Health Boards (DHBs) in their efforts to continually improve board processes and meet good practice governance expectations. As such, we trust that it will be of assistance to all DHB board members, office holders, committees and delegates.

Stephen McKernan  
Director-General, Ministry of Health

This document provides guidance on moving toward the goal of good practice in public sector governance. It is not legal advice, and does not create new legal obligations, or extend existing ones.

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## **Part One – Introduction**

### ***Purpose of the Guidelines***

These guidelines promote good practice in managing conflicts of interest in District Health Board (DHB) decision-making. They reflect and build on recommendations set out in a number of relevant publications (listed as further reading in Appendix One).

The guidelines are intended to provide a basis for assessing existing DHB conflict of interest policies and practices and for producing robust policy in the future. They are also aimed specially at assisting DHB boards to inspire confidence and maintain integrity in the public health sector, through impartial and transparent decision making. This document takes the form of:

- a brief summary of key concepts around managing conflicts of interest in the public sector (Part Two)
- a practical framework to assist in the recognition, disclosure and response to conflicts of interest (Part Three).

### ***Target audience***

These guidelines are aimed at the following DHB people, referred to generically as ‘members’ in these guidelines:

- board Chairs, Deputy Chairs, and members (both elected and appointed)
- board committee members
- delegates of boards and committees (ie, those exercising authority on the board’s behalf)
- other office holders (eg, Crown monitors).

They may also assist DHB employees who assist boards with conflict of interest management, and they provide some useful information for other DHB decision-making processes.

### ***Limitation of Guidelines***

The variety and broad nature of DHB operations mean that a single set of specific rules cannot be established. Conflicts of interest differ in nature and need to be considered on a case-by-case basis. These guidelines are not:

- an exhaustive step by step guide
- a substitute for legal advice
- a set of legal requirements
- intended to create additional legal obligations.

## Part Two – Basic Concepts

This part discusses the environment in which DHBs operate in and how this impacts on managing interests. It also discusses important legal concepts. These two aspects are built on in Part Three to provide a practical framework for dealing with conflicts of interest.

### ***Implications of DHBs being public entities***

It is common for people involved in DHB governance to have a background in the clinical, community or private sectors. To successfully transition to a DHB board, members need to understand the distinctive aspects of the public sector environment.

### **The principles of impartiality and transparency**

DHBs are public entities owned by the Crown. They use public funds, and act for the benefit of the public.

Members of Parliament, the media, and the public expect people who govern DHBs, whether elected or appointed members, to act impartially. They expect that decisions will not be influenced by favouritism or improper personal motives, will be transparent, and that public resources will not be misused for private benefit. As the Office of the Auditor-General's report *Management of conflicts of interest in the three Auckland DHBs* states:<sup>5</sup>

Public perceptions are important. It is not enough that public sector members or officials are honest and fair; they should also be clearly seen to be so.

Impartiality and transparency have a cost. Process costs and time are obvious examples. Being impartial and transparent may at times mean making a decision that is not the most directly financially advantageous to the DHB. Those in governance roles must remember that 'commercial return', though extremely important, is not the only or overriding concern.

### ***Good practice***

These guidelines endorse a 'good practice' approach to conflicts of interest – an approach which extends beyond strict legal compliance.

This framework has three dimensions:

- the legal dimension (which involves compliance with statute and other law)
- the ethical dimension
- the good practice dimension.

Acting ethically requires legal compliance, and implementing good practice encompasses both legal compliance and sound ethical behaviour. Further comment on this can be found in Appendix Three.

### ***Conflicts of interest will occur in the DHB sector***

The New Zealand health and disability sector is a close community. Conflicts of interest are inevitable.

The existence of conflicts is not itself a cause for concern – provided that conflicts are disclosed and responded to (both individually and collectively) in an appropriate manner. Commonly, in a situation in which a conflict of interest has become an issue, the person concerned has neither taken advantage of

<sup>5</sup> Office of the Auditor-General. 2007. *Management of Conflicts of Interest in the Three Auckland District Health Boards*. Wellington: Office of the Auditor-General, p 13, para 1.21.

the situation for their personal benefit nor been influenced by improper personal motives. However, their failure to appropriately disclose and manage conflicts can cause a real or perceived unfairness.

It is critical to understand that a perception of a conflict can be just as significant as an actual conflict. Whether or not the person would actually compromise himself or herself is not the only relevant consideration.<sup>6</sup> This is the nature of conflicts of interest in the public sector environment. A reasonable test would be how the situation would be perceived if it were drawn to the public's attention.

### ***Disclosure is more than technical compliance***

These guidelines promote full and open disclosure as the foundation of good interest management.

It is necessary for members to regularly review their own interests, and to fully disclose them as early as possible. This allows all concerned to understand and manage the true nature, extent, and (potential) implications of an interest. Proper disclosure of conflicts of interest errs on the side of more disclosure, rather than less. It is also a continual process over the course of DHB business, as interests and conflicts often change.

### ***Disclosures need to be actively managed***

Disclosure is only the first step. A board and its members must then consider how they will respond to interests that arise. The Office of the Auditor-General states:

Simply declaring a conflict of interest is not usually enough. Once a conflict of interest has been identified and disclosed, the public entity may need to take further steps to remove any possibility – or perception – of public funds or an official role being used for private benefit.<sup>7</sup>

Response to a disclosure – that is the board's action following disclosure – is just as important as the disclosure itself. A board acting lawfully must consider what (if anything) it should do in the light of a disclosure, both inside and outside the boardroom. Should a member continually have ongoing conflicts of interest that prevent the member from participating in a large number of board matters, the Chair should consider bringing this matter before the Minister as it is likely that the member cannot perform their role to the reasonable expectations of the position. Part Three addresses the practical elements of board responses.

### ***Consequences of inappropriate management***

The potential costs and consequences of a conflict of interest not being appropriately managed can be serious. These may include cost, time, damage to the reputation of individuals and DHBs, contract cancellation, litigation, public and media scrutiny, and criminal investigation.

### ***Relevant legislation***

Most legislative provisions relating to conflicts of interest for DHBs are set out in the New Zealand Public Health and Disability Act 2000 (the NZPHD Act). A few sections in the Crown Entities Act 2004 (the CE Act) also apply, such as that dealing with the disclosure of interests before appointment, however the majority are excluded via the NZPHD Act.<sup>8</sup>

<sup>6</sup> Office of the Auditor-General. 2004. *Christchurch Polytechnic Institute of Technology's Management of Conflicts of Interest Regarding the Computing Offered On-Line (COOL) Programme*. Wellington: Office of the Auditor-General, pp23–4.

<sup>7</sup> Office of the Auditor-General. 2007. *Managing Conflicts of Interest: Guidance for public entities*. Wellington: Office of the Auditor-General, Part 4.

<sup>8</sup> See clause 36(7), Schedule 3, NZPHD Act: 'Sections 62 to 72 of the Crown Entities Act 2004 do not apply to a DHB'.

The NZPHD and CE Acts phrase conflicts of interest requirements in a slightly different manner. However, the basic underlying intents are broadly similar. By comparison, there are significant differences between the conflict of interest provisions in the Companies Act 1993 and the NZPHD Act.<sup>9</sup>

Members should familiarise themselves with the legislative framework applicable to DHBs. Appendix Two lists relevant provisions.

### **Interpretation**

This section discusses some basic terms that are central to the practical steps in Part Three of this document: 'interest', 'transaction' and conflict of interest'.

#### **Interest**

The term 'interest' refers to a non-DHB duty, role or pecuniary interest that has the potential to overlap with a member's DHB role. This might be another public role, but is usually personal or private in nature.

#### **Transaction**

'[T]ransaction, in relation to a DHB, means –

- the exercise or performance of a function, duty, or power of the DHB; or
- an arrangement, agreement, or contract to which the DHB is a party; or
- a proposal that the DHB enter into an arrangement, agreement, or contract.'<sup>10</sup>

A wide interpretation of this provision is preferred, which means that 'transaction' is potentially applicable to nearly everything that a DHB does, including a proposed exercise of a function, duty or power. Such an interpretation advances transparency, and is consistent with a good practice approach.

#### **Conflict of Interest**

The NZPHD Act uses the term 'interested in a transaction' for what is commonly understood to be a 'conflict of interest'. For the purposes of these guidelines, these two phrases are interchangeable.

The NZPHD Act further defines 'conflict of interest' in relation to a person and a DHB under section 6(1) to include 'the employment or engagement of the person, or of the person's spouse or partner, as an employee or contractor of the DHB'.

Under the NZPHD Act, a member will be 'interested in a transaction' (or have a conflict of interest) where a member:<sup>11</sup>

- a) 'is a party to, or will derive a financial benefit from, the transaction; or
- b) has a financial interest in another party to the transaction; or
- c) is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is:
  - (i) the Crown; or
  - (ii) a publicly-owned health and disability organisation;<sup>12</sup> or

<sup>9</sup> For example, section 144 of the Companies Act 1993 outlines a default position which allows interested directors to vote as if they were not interested in the transaction, as opposed to the NZPHD Act which has a default position of excluding interested members.

<sup>10</sup> Section 6(1), NZPHD Act.

<sup>11</sup> Section 6(2)(a)–(e), NZPHD Act.

<sup>12</sup> The NZPHD Act currently defines publicly-owned health and disability organisations as DHBs, the Pharmaceutical Management Agency, the New Zealand Blood Service and Crown Health Financing Agency.

- (iii) a body that is wholly owned by one or more publicly-owned health and disability organisations; or
- d) is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
- e) is otherwise directly or indirectly interested in the transaction.'

In the first four categories, the concern is with the member having some form of direct or indirect financial interest in what the DHB is doing. Non-financial interests (and financial interests not caught by the first four categories) are included in the fifth category, which should be interpreted broadly.

In effect, if a member stands to gain or benefit – whether financially or otherwise, and whether directly or indirectly – from what the DHB is doing, then it is likely that a conflict exists.

However, the NZPHD Act notes that a person will not have a conflict where their interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in carrying out their duties. What is remote or insignificant will depend on the circumstances. A person is not classed as interested in a transaction simply because they are being paid as a DHB board member.<sup>13</sup>

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<sup>13</sup> Section 6(3), NZPHD Act.

### Part Three – Practical Guidance

This part sets out guidance on what is ‘good practice’ in recognising, disclosing, and responding to both interests and conflicts of interest.

The basis of the approach is that full and early disclosure of interests will make conflicts of interest easier to identify, and facilitate earlier opportunities for management, with the end goal being a more effective response.

Managing interests and conflicts of interest can be broken down into the following stages:

- recognising interests and conflicts of interest
- disclosing interests and conflicts of interest
- responding to disclosures.

Transactions and interests can change, and new interests/conflicts can arise at any time. Members and boards need to ensure they are aware of interests and how they relate to their DHB’s transactions.

#### ***Recognising interests and conflicts of interest***

The first step in managing a member’s conflict of interest is to recognise the interest at hand. The member should consider anything from which they may gain real or perceived benefit, either financial or non-financial. Some examples of interests members should consider are:

- shares they own
- their having made a donation or received a gift
- their being an adviser, employee or director of another business or organisation
- their being a member of a professional body
- their family affiliations
- any business proposals they are developing.

Consideration of interests is not a one-off exercise. Members should regularly review their interests and ensure the board’s interests register is kept up to date. It is the member’s duty to ensure the register is kept current.

The next step is for the member to recognise that a conflict arises out of that interest. Early recognition, coupled with early and full disclosure, ensures the best chance of effective management. Some considerations in particular should be kept in mind.

- Areas for concern will be at the intersection of overlapping and potentially competing interests.
- Although the NZPHD Act and CE Act frameworks place a particular emphasis on financial interests, other interests are significant both legally and ethically.
- Conflicts of interest are not confined to a commercial transaction such as a tender process or contract. Involvement in policy and strategy can also lead to conflicts, often more difficult to manage than those arising from confined commercial transactions.
- If in doubt, members should consider whether a third party (such as a court or the public) would see an issue to exist. Consultation with the board Chair may assist individual members. Board Chairs, in turn, may wish to discuss matters with the Deputy Chair.

The practice of identifying conflicts of interest is ongoing. Conflicts of interest can evolve through changes in the dimensions of either a transaction or an interest. One appropriate time to consider them is upon receipt of a meeting agenda and board papers.

***Disclosing interests and conflicts of interest***

These guidelines promote an ongoing process of full disclosure of interests and conflicts of interests at the earliest opportunity.

Disclosing 'interests' (typically in positional terms, such as 'director of XYZ Ltd'), as opposed to 'conflicts of interest', is not expressly required by the NZPHD Act. However, it is recommended that such 'interests' are in fact disclosed (with regular updates), for the purpose of alerting members to potential issues and effectively creating an 'early warning system'.

The obligation to disclose an interest or conflict of interest is firmly on the member with the relevant interest or conflict.

In considering disclosure, it is helpful to address what should be disclosed, when, how, and to whom.

**What should be disclosed?**

In the case of an interest, the details disclosed should allow an independent observer to understand what the member's interest is, and why and how it might impact on their role on the board.

In the case of a conflict of interest, disclosure should enable an independent observer to understand the nature of the conflict, and how it could benefit the member (or other parties as per section 6(2)(d) of the NZPHD Act) and impact on the member's role on the board.

A disclosure should also provide relevant information such that other members can make an informed decision about how best to manage the actual or potential conflict of interest, both inside and outside the boardroom.

In order to achieve this, members should provide specific information, including (as relevant):

- the position at issue: that is, the role (eg, manager of finance or director), and its functions and duties specifically in relation to the transaction (in case of a conflict)
- in the case of a conflict, the potential value (direct and indirect) of the transaction to the member, if this can be measured
- the way in which the interest or conflict will or may impact on the performance of the member's DHB role
- an explanation of any personal benefit – perceived, actual or potential; direct or indirect; financial or otherwise – resulting from the transaction
- historical and contextual information needed to properly understand the disclosure
- possible future involvements and benefits.

Members should always err on the side of caution and provide more contextual information than less. This could include historical details indicating their level of involvements in interests or transactions, or could mention possible future interests or conflicts. As mentioned above, public perception is an important consideration.

An inclination to withhold information, or to disclose in a confined or narrow way, may indicate a reason for concern about the adequacy of the disclosure.

A simple example of a conflict of interest statement made during a meeting could be:

Mr X declared his conflict of interest in relation to item Y, because he is a director of Z, which provides aged residential care services. The conflict arises because even though Z does not currently supply services to the DHB, it is considering putting in a tender to the DHB.

**When should disclosures be made?**

Disclosures should be made at the earliest opportunity. In the case of conflicts, this is required by the NZPHD Act,<sup>14</sup> which states that:

A member of a board of a DHB who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the board.

'As soon as practicable' should be literally interpreted: disclosure may take place in between meetings, on receipt of agendas for meetings, or at the meetings themselves.

There are several avenues open for disclosure of both interests and conflicts of interest.

*Prior to appointment or election*

The first opportunity for disclosure arises before a person becomes a member of a board, as follows.

- In the case of appointment, applicants should disclose interests and conflicts of interest when providing information to allow the Minister of Health (or the board, in the case of committees) to decide whether to make an appointment.<sup>15</sup>
- In the case of election, all candidates must give a statement to the electoral officer that discloses any conflicts of interest that the candidate has with the DHB as at the date of the candidate's notice of consent, or states that the candidate has no such conflicts of interest as at that date; and discloses any such conflicts of interests that the candidate believes are likely to arise in the future, or states that the candidate does not believe that any such conflicts of interest are likely to arise in future.<sup>16</sup>

*First board meeting*

It is good practice to formally disclose those initial interests or conflicts at the member's first board meeting. Members are required to ensure the statement they provide to the Minister or electoral officer is entered into the board's interests register. This enables the board to question the nature of the interest where necessary, and provides a minuted record of the disclosure to the board.

*Ongoing at meetings and outside meetings*

Initial disclosures are not the end of the disclosure process. Disclosure is a continuous process as new interests and conflicts emerge over time, and existing interests and conflicts change in nature.

DHBs should ensure they have mechanisms which allow:

- disclosure at any stage between two meetings
- pre-meeting disclosure (ie, disclosure after an agenda has been set but prior to the meeting itself taking place)
- disclosure at a meeting, whether it is public or 'in committee'.

All meeting agendas should include standing items to accommodate disclosure and updating of both interests and conflicts of interest.

<sup>14</sup> Clause 36(1), Schedule 3, NZPHD Act.

<sup>15</sup> Section 31(1)(c), CE Act.

<sup>16</sup> Clause 6, Schedule 2, NZPHD Act.

**How and to whom should disclosures be made?**

A disclosure should be made in writing where possible and, where writing is not possible, verbally and then retrospectively in writing. Recording disclosures in writing ensures a degree of transparency: paper trails assist in managing perception, and can help to prevent difficulties of recollection if questions arise later. Disclosure must be in both the interests register<sup>17</sup> and recorded in the boardminutes.

Disclosures should be made to a central contact person (see below) and to the board at the first meeting following the disclosure. Where it becomes apparent at a meeting that there is a conflict of interest, this should be raised at the appropriate points in the agenda (ie, the declarations of interest standing agenda item and the item to which the interest or conflict relates).

*Central contact person*

DHBs should nominate a central contact person for administering interest matters (eg, a board secretary or legal advisor). This person should:

- be a contact point for disclosure outside of meetings
- maintain a register recording the nature of members' interests and conflicts
- be able to provide input into the development of agendas
- receive copies of all appointment disclosure statements for elected and appointed members
- assist the board in establishing and reviewing policies and procedures on conflicts of interest.

A central contact person can implement disclosure procedures such as ensuring that disclosures made outside of meetings are communicated to board members before board meetings.

*Interests register*

The DHB is required by statute to maintain an interests register for the purposes of recording:

- any disclosure of interests in transactions<sup>18</sup>
- the filing of the initial statements from elected and appointed members (made to the electoral officer and the Minister respectively)<sup>19</sup>
- 'any relevant change in the member's circumstances affecting a matter disclosed in that statement [which must be] entered in that register as soon as practicable after the change occurs'.<sup>20</sup>

This register should be used to record both interests and conflicts of interest. Record-keeping ensures transparency and enabling the proactive management of interests.

Registers need to be kept up to date and accurate to be of any use. This requires regular review, a process that the central contact person and the board should share.

DHBs should maintain electronic and hard copies of the register (the latter constituting the legally required component). Disclosures should then be entered into each, and the electronic copy sent out to members with the board papers as a regular reminder.

**Responding to disclosures**

Disclosure is not the end of the process. Effective and appropriate administration of conflicts of interest depends on active and appropriate responses.

<sup>17</sup> Clause 36(3) and (6), Schedule 3, NZPHD Act.

<sup>18</sup> Clause 36(1), Schedule 3, NZPHD Act.

<sup>19</sup> Clause 36(6)(a), Schedule 3, NZPHD Act.

<sup>20</sup> Clause 36(6)(b), Schedule 3, NZPHD Act.

Responding to a conflict of interest requires a collective effort on the part of the member concerned and the other members of the board. Response strategies may range from no action at all through to action taken outside the boardroom, such as the member removing his or herself from an employment or financial situation.

Chairs have added responsibilities, including the responsibility to ensure that processes are followed and that a high standard of care is met.

### Proactive steps

Although management of a disclosure focuses on responding or reacting to disclosures of conflicts, proactive steps can also be taken earlier in the process.

The early identification of interests can, in some circumstances, provide an opportunity to address potential impacts. For example, if an interest has the potential to attract negative public comment, a strategy could be implemented to provide assurance that the board is aware of the risk and has a clear plan if the interest does result in a conflict. Under the 'no-surprises' principle, boards should keep the Minister informed if public comment on a member's situation is likely.

Updating the register and noting in the minutes any deliberate or circumstantial resolution of a potential conflict situation may also be appropriate (eg, shares being sold, or a contract ending).

### Reactive steps

The nature of the conflict of interest environment is such that reactive management will be a more common strategy.

The first part of any response by the board (to disclosures of both interests and conflicts) should include establishing that the nature and extent of the interest or conflict is understood. If not, the board should make further enquiries of the member or management in order to obtain the information needed.

In instances where the board decides that a situation does not amount to a conflict of interest (taking a good practice approach), it is still appropriate to formally record or declare the disclosure and assessment.<sup>21</sup>

At the simplest level, response to a disclosure may involve no more than recording the disclosure and requiring the 'conflicted' member to leave the relevant part of the meeting.

Any strategy relating to a conflict must comply with clause 36 of Schedule 3 to the NZPHD Act. Under this clause, a member of a board who has a conflict (and makes a disclosure of an interest in a transaction) must not take part in any deliberation or decision relating to the transaction, must not be included in the quorum for any decision or deliberation on the matter, and must not sign any document relating to the entry into a transaction or the initiation of the transaction.<sup>22</sup>

However, a conflicted member of the board may continue to take part in relation to the deliberation (but not decision) of the transaction in question if the majority of the other members of the board agree.<sup>23</sup> The waiver should be used only when absolutely necessary and with great caution. The board must be aware of the potential risk that the conflicted member could be in a position to disclose information to a third party.

<sup>21</sup> Office of the Auditor-General. 2007. *Managing Conflicts of Interest: Guidance for public entities*. Wellington: Office of the Auditor-General, para 4.30.

<sup>22</sup> Clause 36(2), Schedule 3, NZPHD Act. Note that the Minister of Health has power to waive or modify this provision if the public interest supports such an action, pursuant to clause 37 of Schedule 3 to the NZPHD Act.

<sup>23</sup> Clause 36(4), Schedule 3, NZPHD Act.

The exemption described above lends itself to situations where a member's participation in discussion is necessary to ensure appropriate information or expertise is made available to the board or committee. If that information or expertise can be accessed from a non-conflicted person (eg, an external expert or non-board member), the board should carefully consider doing so, instead of exempting the conflicted member to participate.

Boards should exercise caution to ensure that use of the exemption does not become common practice. They must comply with the requirement to note an exercise of the exemption in board minutes, and that the entry in the minutes must also give the majority's reasons for giving it and that what the member says in any deliberation of the board relating to the transaction concerned.<sup>24</sup> There is also a requirement to list such exemptions in the DHB's annual report.<sup>25</sup>

The management strategy adopted will depend on the nature of the disclosure and the way in which the conflict of interest impacts on the DHB and its operations. The strategy should:

- protect the integrity of the board and the DHB
- protect the integrity of the member concerned
- manage perceptions which could arise from the conflict
- preserve valuable and critical inputs into decision-making
- apply beyond the boardroom as appropriate: managing the implication of a conflict may involve the DHB in a wider sense and include a transaction that would not usually be handled by the board (eg, matters within the sphere of management's delegated authority)
- take account of information security. Both parties need to recognise the variety of communication mediums that need to be monitored, and anticipate any situations in which information pertaining to a transaction involving a conflict of interest might be divulged to the member concerned.

The detail of any strategy will require careful assessment. Relevant factors include:

- the type and the extent of the person's conflicting interest
- the nature or significance of the particular decision or activity being undertaken by the DHB
- the degree to which the person's other interest could affect, or be affected by, the DHB's decision or activity
- the nature or extent of the person's current or intended involvement in the DHB's decision or activity
- the practicability of any options for avoiding or mitigating the conflict
- the depth of the connection between the interests.

The risk to be assessed is not just the risk of actual misconduct by the particular member or official involved. It is also the risk that the DHB's capacity to make decisions lawfully and fairly may be compromised, and that the reputation of the DHB and wider State services may be damaged.

In making such an assessment, the board needs to consider how the situation could reasonably appear to an outside observer<sup>26</sup> and respond accordingly.

Possible strategies, so long as they comply where appropriate with clause 36 of Schedule 3 to the NZPHD Act, may include:

- excluding a member from the matter at issue
- utilising the clause 36 or 37 exemption process

<sup>24</sup> Clause 36(5), Schedule 3, NZPHD Act.

<sup>25</sup> Section 42(4), NZPHD Act.

<sup>26</sup> Office of the Auditor-General. 2007. *Managing Conflicts of Interest: Guidance for public entities*. Wellington: Office of the Auditor-General, para 4.31.

- imposing additional oversight or review on the member concerned
- excluding the member concerned from a committee or working group dealing with the issue
- re-assigning certain tasks or duties to another member or person
- reaching an agreement or imposing a prohibition, ensuring that the member concerned will not undertake particular actions
- placing restrictions on access to certain confidential information
- transferring the member concerned (either temporarily or permanently) to another position or task
- composing media statements and managing media strategy.<sup>27</sup>

Communication between DHB staff and members is likely to be carefully prescribed in a board's governance rules, to ensure roles and responsibilities are clearly understood. Such regulation is particularly important when a conflict of interest situation arises. Members must ensure that they do not communicate (and are not perceived to communicate) with DHB staff on any matter related to the conflict without prior board approval.

Occasionally a conflict of interest may be so significant or pervasive that the member will need to consider divesting themselves entirely of one or the other interest or role.<sup>28</sup> In the event that such a significant conflict exists, the member should not participate in conflicted activities until the conflict is resolved to the satisfaction of the Chair. Ineffective management of the conflict at an early stage might have the consequence that the member concerned must withdraw from both roles.

In addition, if the nature of an interest or conflict of interest changes, decisions pertaining to it may need to be reviewed.<sup>29</sup>

### Recording decisions

In all cases, a written record of any decision or strategy taken on an interest or conflict should be retained. Ideally, such a record should include: the initial facts, the nature of the assessment, action taken in response, possible future action to be taken in response and any mitigation strategies undertaken. Such written records increase transparency, and ensure that the DHB is clearly seen to have recognised and responded to the conflict.

<sup>27</sup> Ibid, paras 4.28 and 4.29 suggests other mitigation strategies.

<sup>28</sup> Ibid, para 4.34.

<sup>29</sup> Ibid, para 4.36.

**Appendix One – Further Reading**

Office of the Auditor-General. 2007. *Management of Conflicts of Interest in the Three Auckland District Health Boards.*

Office of the Auditor-General. 2007. *Good Practice Guide: Managing conflicts of interest: Guidance for public entities.*

Office of the Auditor-General. 2004. *Christchurch Polytechnic’s Management of Conflicts of Interest regarding the Computing Offered On-line (COOL) Programme.*

State Services Commission. November 2009. *Board Appointment and Induction Guidelines.*

**Appendix Two – Relevant Legal Provisions**

<b>APPLICABLE LEGISLATION: by group</b>		
<b>Group</b>	<b>Act</b>	<b>Reference</b>
Board	NZPHD Act  CE Act	Section 6 Section 42(4) Clause 6, Schedule 2 Clauses 36–40, Schedule 3 Clause 6, Schedule 4 Section 31
Delegates	NZPHD Act	Section 6 Clauses 39–40, Schedule 3
Statutory advisory committees: community and public health advisory committees disability support advisory committees hospital advisory committees	NZPHD Act	Section 6 Clause 6(3), Schedule 4 Clauses 38–39, Schedule 4
Other committees	NZPHD Act	Section 6 Clause 38, Schedule 3 Clauses 38–39, Schedule 4

### Appendix Three – Good Practice

The good practice approach to conflict management has three elements. These are further explained below.



#### The legal dimension

Good faith and integrity are not just aspirations confined to concept of good practice, but legal requirements.<sup>30</sup>

Applicable legislation, which includes statute and other law, prescribes certain minimum standards and processes that must be met and followed. These include collective duties owed to the Minister,<sup>31</sup> and individual duties owed to the Minister and the DHB.<sup>32</sup>

Individual duties of board members include duties that each board member must, when acting as a board member:

- ‘... act with honesty and integrity’<sup>33</sup>
- ‘... act in good faith and not pursue his or her own interests at the expense of the entity’s interests’.<sup>34</sup>

In addition to these statutory obligations, members are increasingly seen as owing fiduciary duties: obligations to act in the best interest of dependant parties. Such a duty exists in relationships where one party places a special trust, confidence and reliance in the other in exercising discretion or expertise on their behalf.

#### The ethical dimension

Regardless of whether any legal requirement applies, a conflict of interest will always involve ethical considerations.<sup>35</sup>

Failure to meet appropriate ethical standards in connection with conflicts of interest is open to criticism on the grounds that the conduct falls short of the ethical standards expected of those in public office. This will not necessarily involve a legal breach.

<sup>30</sup> Refer to Appendix Two for relevant legal provisions as set out in the NZPHD Act and CE Act.

<sup>31</sup> Section 58, CE Act.

<sup>32</sup> Sections 26 and 59, CE Act.

<sup>33</sup> Section 54, CE Act.

<sup>34</sup> Section 55, CE Act.

<sup>35</sup> Office of Auditor-General. 2004. *Christchurch Polytechnic’s Management of Conflicts of Interest regarding the Computing Offered On-Line (COOL) Programme*, p 24.

The Office of the Auditor General specifies integrity, honesty, transparency, openness, independence, good faith, and service to the public as the values and ideals within which public business ought to be conducted.<sup>36</sup> Any decision-making in regard to conflicts of interest should be conducted in line with these principles.

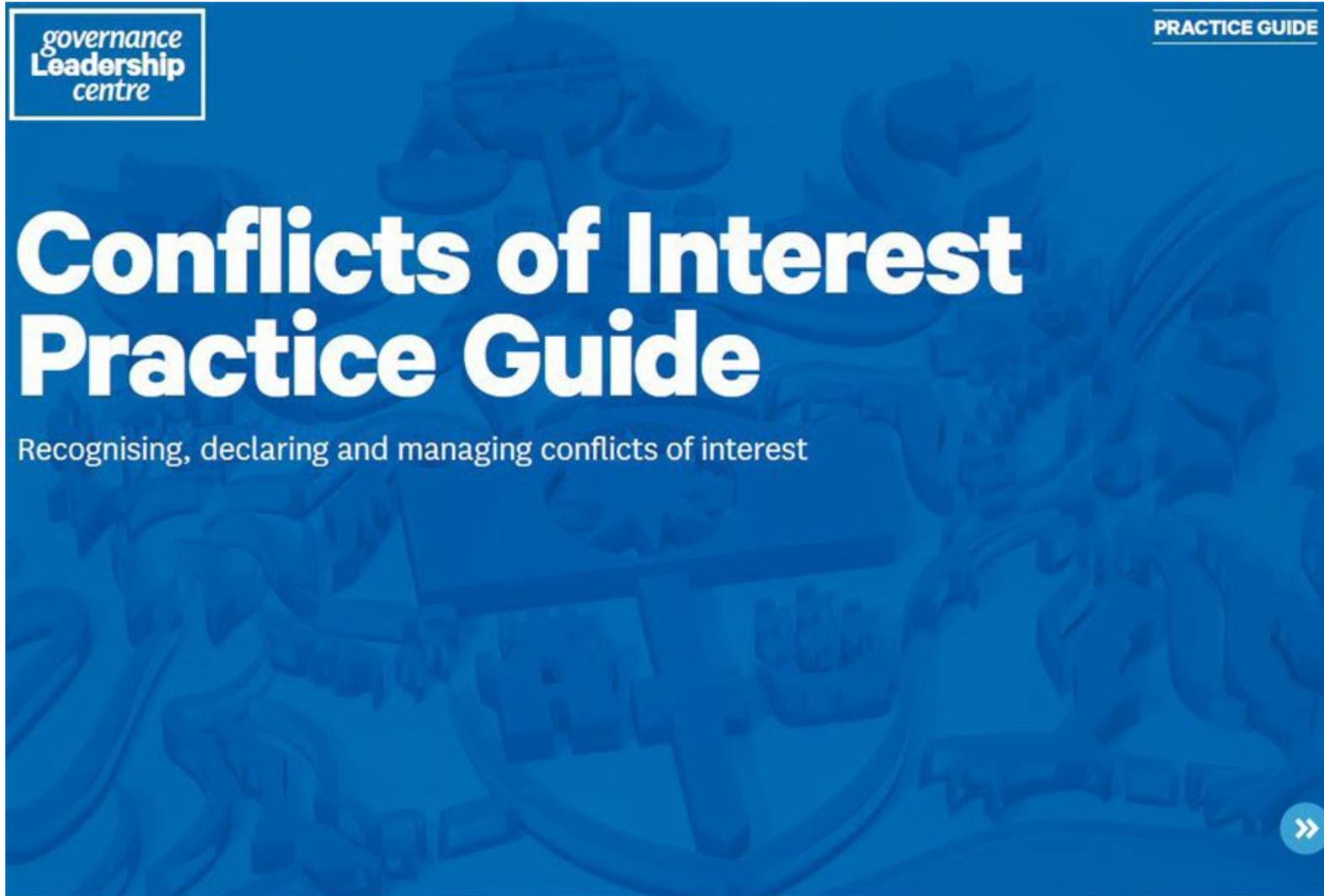
**The 'good practice' dimension**

'Good practice' entails and extends the legal and ethical dimensions described above.

'Good practice' – sometimes referred to as best practice – is what boards and members should adhere to in order to meet appropriate standards. Good practice refers to the way in which a board meets ethical and legal requirements.

Good practice has two elements. First, there must be appropriate processes and systems in place, and second, boards and board members to adopt a common sense and precautionary approach.

<sup>36</sup> Office of the Auditor-General. 2007. *Managing Conflicts of Interest: Guidance for public entities*. Wellington: Office of the Auditor-General, p 15.



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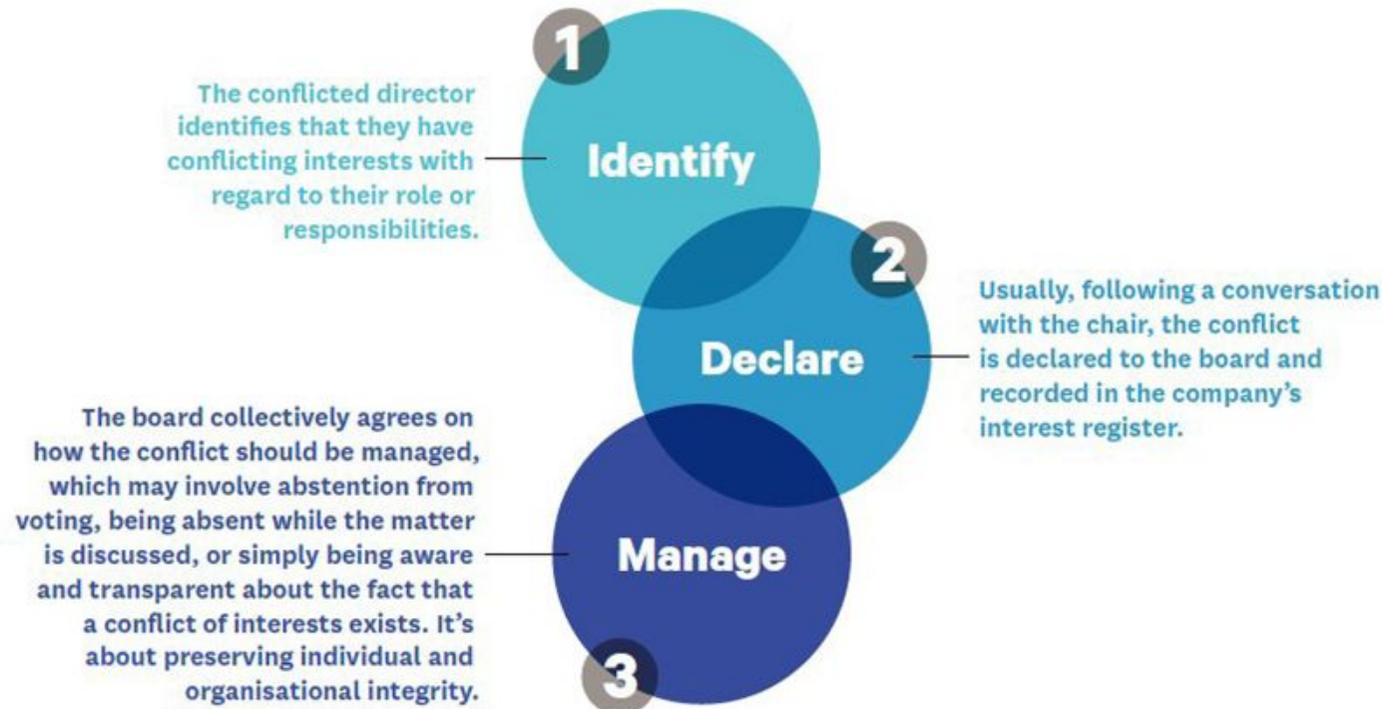
*“A conflict of interests can arise where two different interests overlap.”*

*This guide provides directors with an overview of how to recognise and manage conflicts of interest in the boardroom, along with a useful lens through which to observe and model good practice.*

It’s about more than just understanding legislation. Even where there is no statutory requirement to disclose interests, if the associated risks and implications are not managed, they can lead to significant consequences, including reputational damage and loss of shareholder and stakeholder value.

The existence of a conflict of interests does not necessarily mean that the director concerned has done anything wrong. What it means is that the conflict needs to be managed.

**It is crucial for boards to have procedures in place to deal with conflicts of interest. The process for handling a conflict of interests or conflict of duties consists of three steps:**



## What is a conflict of interests?

*“A conflict of interests occurs when a director has multiple interests, one of which will or might impact the motivation for an act in another”*

Directors often have to make tough decisions including decisions relating to conflicts of interest or biases. For example:

- What level of board remuneration should we recommend for ourselves?
- Can I provide services to my company, beyond my role as a director?
- Will I support a company merger, knowing that the resulting restructure may cost me my position on the board?

Biases which commonly surface in board decision making include divided loyalties and self-interest. These biases can create conflict for the director and can affect professional judgement and the ability to remain impartial. Put simply, directors are often put in situations where they try to serve two interests at once.

It is important to understand the New Zealand context. As a small country, New Zealand has a relatively small pool of professional directors and a highly interconnected business community. This can impact the probability of conflicts of interest occurring.

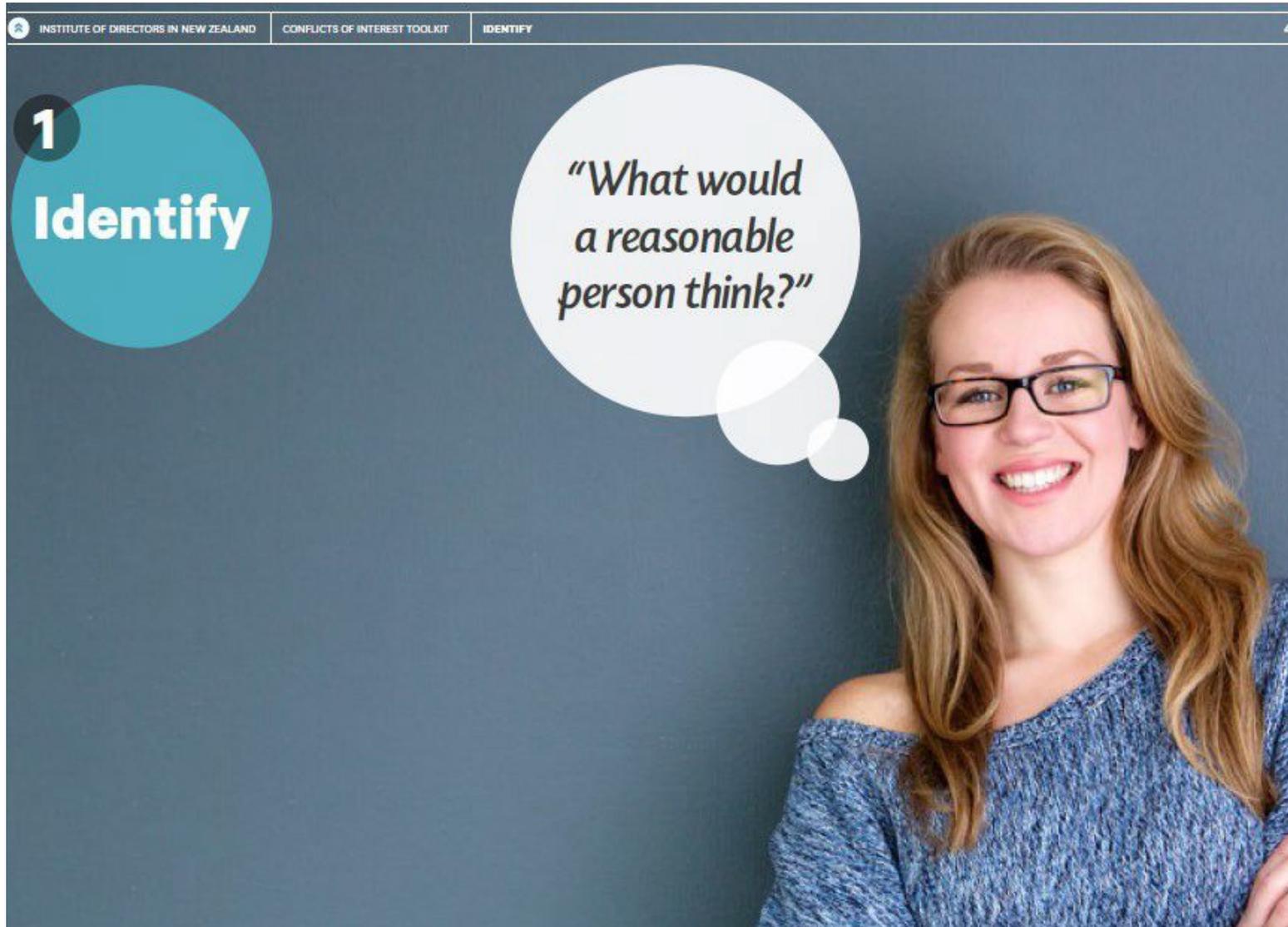
The Companies Act 1993 is clear that directors must not take improper advantage of their position and they are legally

required to act in the best interests of the company. The Companies Act also contains provisions relating to the disclosure of conflicts of interests in transactions. NZX rules apply in the case of publicly listed companies.

Specific legislation applies to members of the governing boards of local councils, crown entities, district health boards and education boards and bodies (school boards of trustees and tertiary education institution councils).

Currently, there are no codified statutory obligations in the Incorporated Societies Act 1908 regarding declarations of interest. The Law Commission's recent review of the Act recommends that it be replaced by a modern statute likely to include requirements for dealing with conflicts of interest.

However, irrespective of whether particular legislation applies, common law requires directors and other board members to carry out their duties fairly and free from prejudice.



1

## Identify

*“What would a reasonable person think?”*

*The Companies Act (section 139) defines the circumstances in which a director is “interested in a transaction.”*

These include:

- where the director is a party to the transaction or has a material financial interest in a party
- where the director or an entity they are a director of may derive a material financial benefit
- where the director is closely related to someone who may derive such a benefit or
- where the director may be otherwise directly or indirectly materially interested in the transaction.

The scope and extent of what constitutes an interest varies across the range of statutory rules concerning conflicts of interest. Directors, trustees and other fiduciaries should be aware of the legislation which applies to their organisations.

### Common examples

- Directors approving transactions to which the company is a party and which directors are also a party or where directors have a direct or indirect material interest in a transaction.
- Directors using confidential information received in their capacity as directors.
- Directors owning property adjacent to the company’s property, whose value may be affected by company activity.
- Directors offering their services or acting in an advisory capacity (financial or legal) to the company, clients of the company or to a competitor.
- Directors taking up opportunities offered to but declined by the company.

One way to identify whether a conflict of interests may exist is to ask whether a “*reasonably informed objective observer would infer from the circumstances that the director’s judgement is likely to be influenced to the detriment of the company’s best interests*”. If we look closely, this tells us two things.

1. The test for a conflict of interests is an objective one. We are asking whether a reasonable observer might see a conflict.
2. That the potential for a conflict of interests is equally important to recognise. Note that the question asked is whether the circumstances make it *likely* that a director’s judgement will be influenced, not necessarily that it *has been* or *will be* so.

# 1 Identify

## What is the difference between an actual and a potential conflict?

**An actual conflict** is where circumstances are or could be perceived to influence a director's judgement to the detriment of the company.

**A potential conflict** occurs where it is reasonably probable that in future, an actual conflict of interests will come into play.

### Example

- John is a director of Company X. Company X is currently engaged with Company Y, a supplier. John's daughter Lucy is considering applying for a role in distribution at Company Y. *While there isn't an actual conflict yet, as she has not cemented her plans with regard to the position at Company Y, if she does apply for the role a conflict will need to be managed.*

It is important to note here that an **actual** conflict is not required to present itself before the situation is treated as though it has. **Potential** or **perceived** conflicts of interest must also be addressed by a director when considering how to execute their duties.

If directors are unsure whether a conflict may exist, they should discuss the matter with the chair.

## Perceived conflicts

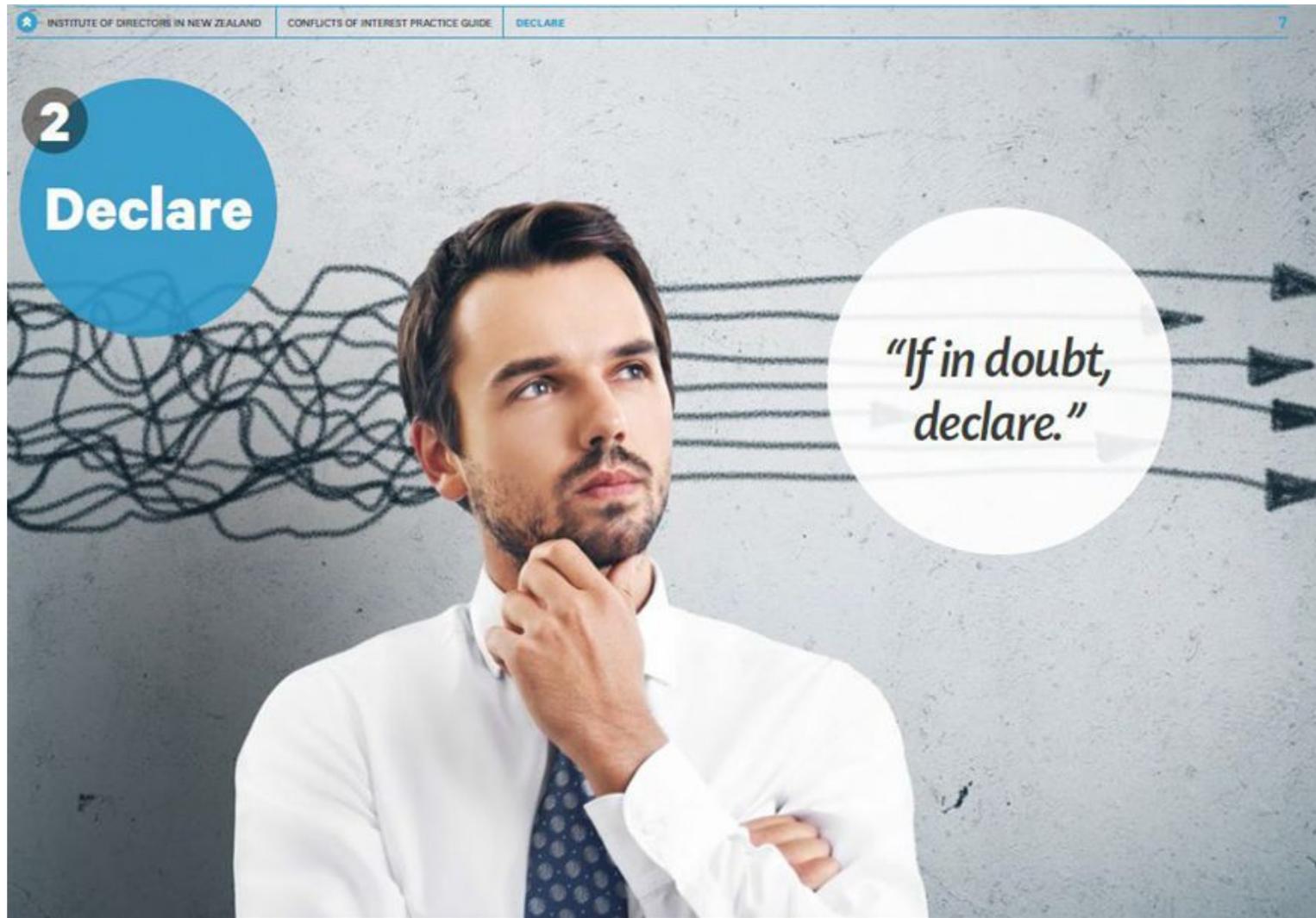
In certain circumstances, there may be a perception of a conflict of interests where the interests come close but do not intersect. In these situations, careful management is still required. Not taking steps to manage these risks can undermine a company's reputation and hiding conflicting interests can give rise to perceptions or allegations of misconduct.

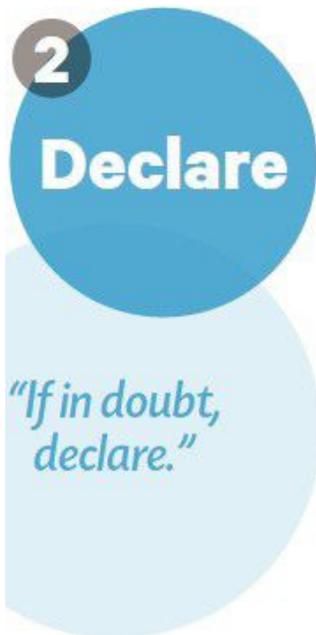
At the end of the day, shareholders and stakeholders alike should be left in no doubt that any director with conflicting interests (or potentially conflicting interests) is appropriately motivated and free from bias. Whether that bias is real or perceived is sometimes a matter of debate, but the tests remain the same:

*What would a reasonable person think?*

*What would this look like as headline news?*

*Would you be willing to stake the company's (and your personal) brand and reputation on the impartiality and good faith of your decision?*





*Once it has been established that a director has an actual, perceived or potential conflict of interests, two things must occur.*

It is the responsibility of the director concerned to declare the interest to the board. There are statutory and other rules that require disclosure in some form. Some regulations require disclosure to be in writing and recorded in the minutes of the meeting or an interests register, or both.

The board (led by the chair) is then collectively responsible for the decision regarding what action is to be taken.

**Interests register**

Conflicted directors of companies registered under the Companies Act must have their interests noted in the company's interests register. If there is more than one director on the board, a declaration to the board is also required. All particulars of interests register entries made during the relevant accounting period must also be stated in the company's annual report. Please see Appendix 1 for a sample interests register and disclosure template.

Maintaining an interests register as a standing board meeting agenda item is good practice.

It is also worth noting that while some organisations may not be legally bound to make declarations in writing or in a register, transparency is good governance. With the potential damage to the organisation, the imperative in a conflicts of interest situation is always, "If in doubt, declare."

**Registered companies**  
Obligations of registered companies are covered under the Companies Act 1993. NZX listing rules also apply to listed companies.

**Crown Entities**  
Obligations of Crown Entities are covered in the Crown Entities Act 2004.

**District Health Boards (DHBs)**  
Obligations of DHBs are covered in the New Zealand Public Health and Disability Act 2000.

**Education Institutions**  
Obligations of school Boards of Trustees are covered in schedule 6 clause 8 of the Education Act 1989.  
Obligations of Tertiary Education Institution Councils are covered in Section 175 of the Education Act 1989.



**3**  
**Manage**

*“What is in the best interests of the organisation?”*

***Once a real or potential conflict of interests has been identified and declared, the board has a collective responsibility to determine what course of action should be taken.***

In dealing with conflicts of interests, regard should be given to legislative requirements and best business practice or convention. The IoD holds that “procedures for participating in board decisions where directors have a personal interest should ensure the protection of the legal and ethical positions of those involved while preserving the general principle that a company should be entitled to the collective wisdom of all its directors”.

Speaking broadly, in most conflict of interest scenarios, the board has two options:

1. The board agrees the conflict exists, and:
  - a. the director withdraws from the meeting for the course of discussion and doesn't vote, or
  - b. the director stays for the course of discussion and doesn't vote, or
  - c. the director stays for the course of discussion and votes.
2. The board agrees that there is no (or no significant) conflict.

It is important that boards ensure minutes accurately reflect all decisions/declarations, including the rationale for the chosen course of action. The minutes are the collective memory of the board and evidence of the decision-making process. In cases where the judgement of a board or director is questioned, they are also potentially evidentiary.

Under the Companies Act an 'interested' director is legally able to:

- attend a meeting at which the matter is to be considered
- be counted as a part of the quorum of the meeting
- sign a document relating to the transaction on behalf of the company and
- do any other thing in his or her capacity as a director in relation to the transaction.

However, some companies may also have additional procedures set out in their constitution.

NZX listing rules currently require that conflicted directors of listed companies neither be included as a part of the quorum of the meeting nor vote on the matter in question.

***For legal provisions relating to other types of entities see Appendix 2.***



### Right to participate in discussion

A classic tension in conflicts of interest scenarios occurs when the person with the best knowledge about an issue is conflicted. A director must exercise a high degree of care and thought in balancing the best interests of the company with the need to operate, insofar as is possible, free from bias.

Generally speaking, it is best practice that the conflicted directors should not participate except to the extent established by the board. Examples include stating their position, answering questions or speaking to matters of fact. At a minimum, conflicted directors should volunteer to withdraw from at least part of the meeting to facilitate full and frank discussion of the conflict matter.

It is also in the board's interests that it ensures a director is able to put their 'hand on their heart' and say they were not present in a discussion where it was not appropriate.

There may be an exception if the board consents and the conflicted director believes that the board will otherwise make an unsound decision.

In certain circumstances, requiring a conflicted director to be absent from discussion may not be realistic or practical. The Law Commission has noted that a particular conflicted individual may be key to the functioning of the organisation and have valuable information to contribute. In fact, a director may be appointed for their industry experience, which can result in a conflict that needs to be managed.

In such cases it is particularly important that the board is able to show it has clear and robust processes in place for managing the conflict.

### Right to vote

In most circumstances it is considered best practice that even if legislation and the company's constitution permit it, a conflicted director should not vote on the conflict matter and should offer to absent themselves during the vote. The board should feel free to decline this offer (through the chair) unless the conflicted director's presence is likely to adversely affect the voting process.

Statutory provisions can differ between types of organisation, but at the end of the day they denote the *minimum* standard of response or action required from a legislative perspective. This should not be perceived as a limit to which directors may apply good governance practice and, at all times, directors should keep their duty to *act in the best interests of the organisation* top of mind.

# Appendix 1

## Sample templates

### Interest register template:

(Useful to include in board meeting agendas/minutes for quick reference and to maintain currency)

<12/4/15> <Joe Smith>

COMPANY	NATURE OF INTEREST
Grandpa Figgs Ltd.	Director
Blog Holdings Ltd.	CEO
CMPC Property	Shareholder

### Template for recording conflicts of interests:

<b>Date of Disclosure</b>	12/4/2015		
<b>Type of Disclosure</b>	Conflict of Interests		
<b>Director Name</b>	Joe Smith		
<b>Details</b>	Family connection to tenderer for telecommunications contract		
<b>Approved by board?</b>	Yes	No	N/A
<b>Annual Report Disclosure?</b>	Yes	No	N/A
<b>If "No", Shareholder resolution?</b>	Yes	No	N/A

# Appendix 2

## Table of legal provisions regarding board conflict process requirements

<p><b>Crown Entities</b>                  Generally under the Crown Entities Act, a member who is interested in a matter relating to a statutory entity must not vote or take part in any discussion or decision of the board or any committee relating to the matter. The interested member must not sign any document relating to the entry into a transaction or initiation of the matter and does not count towards a quorum for the part of the meeting during which the matter is discussed. They must also take no part in any activity of the entity that relates to the matter in question.</p>
<p><b>District Health Boards</b>                  A member of a board who makes a disclosure under section 36 of schedule 3 of the New Zealand Public Health and Disability Act 2000, must not take part, after the disclosure in any deliberation or decision of the board relating to the transaction; or be included in the quorum for any such deliberation or decision; or sign any document relating to the entry into a transaction or the initiation of the transaction, unless the board permits otherwise.</p>
<p><b>Local authorities and committees</b>                  According to the terms of the Local Authority (Members' Interests) Act, members may not vote or take part in any discussion regarding a matter in which they have a pecuniary interest. Members are also required to disclose their interest to the committee or local authority meeting at which the matter in question is raised. This disclosure and an abstention from voting and discussion must be recorded in the minutes of the meeting.                   Notwithstanding the above, The Auditor General may, by his or her own accord or upon written application by the member concerned, declare that the above should not apply where it's application would be an impediment to the transaction of business, or where it would be in the best interests of the relevant electors or district inhabitants, that the subsection should not apply.</p>
<p><b>Education Institutions</b>                  The Education Act provides that unless they are present solely for the purpose of making a submission, giving evidence or answering questions, a conflicted school-board Trustee is to be excluded from any meeting of the board while it discusses, considers anything relating to, or decides the matter.                   In the case of conflicts occurring within the Council of a Tertiary Education Institution, the Education Act states that the conflicted member shall not (unless the council decides otherwise) be present during any deliberation of the council or committee with respect to that matter; or take part in any decision of the council or committee with respect to that matter.</p>

## References and further reading<sup>1</sup>

### Legal and regulatory, including particular sections used for this guide

[Companies Act 1993](#), s131, s139 (1), s140, s144 and s211 (1)e

[Crown Entities Act 2004](#), s31 (1)c, s55, and ss62-72

[New Zealand Public Health and Disability Act 2000](#), sch3, cl36

[Education Act 1989](#), s175 and sch6, cl8 (8)

[Local Authority \(Members' Interests\) Act 1968](#), s6

[NZX, NZSX & NZDX Main Board/Debt Market Listing Rules \(2013\)](#), rule 3.4.3, p43

### Other

[New Zealand Law Commission R129: A New Act for Incorporated Societies](#), 2014 (chapter 6 – Committees, officers, duties and arrangements for running societies: Conflicts of interest.)

Institute of Directors in New Zealand (Inc), [The Four Pillars of Governance Best Practice](#), 2014, p106-108

[Auditor General's Good Practice Guide: Managing conflicts of interest: Guidance for public entities](#), 2007

[Julie Garland McLellan's website](#) contains a range of Director's Dilemmas, which often illustrate conflicts of interest in the boardroom and offer different perspectives on how to deal with them.

[State Services Commission, Members' interests and conflicts. Guidance for Crown Entities.](#)

[Financial Markets Authority, Corporate Governance In New Zealand: Principles and Guidelines](#), Principle 1: Ethical Standards, 2014

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**Schedule 4: Board Code of Conduct and Ethics**

**HAWKE'S BAY  
DISTRICT HEALTH BOARD**

**BOARD CODE OF CONDUCT &  
ETHICS**

**Amended May 2014**

## **Board Code of Conduct and Ethics**

### **PURPOSE**

This Code of Conduct and Ethics sets out key principles by which board members will conduct themselves.

The principles in the Code endeavour to address potential differences in attitudes and behaviours of board members. Board members are ultimately accountable for the successful performance of the District Health Board and their actions, both public and private, should support the decisions and activities of the organisation.

Some sections of the Code will be further supported by ongoing development of the organisation's policies.

### **PRINCIPLES**

#### **Fiduciary Responsibility**

Each board member has a duty to ensure that the District Health Board is properly governed. To meet this obligation, board members will:

- Act in good faith;
- Act with honesty and integrity;
- Exercise reasonable care, diligence and skill in their duties at all times; and
- Lay aside all private and personal interests in their decision-making.

#### **Commitment**

In accepting the position of board member, the member has made a commitment to undertake the work of the board, and to commit the time required to acquit these responsibilities. Board members will make every effort to attend scheduled meetings, but recognise that there will be occasional conflicts which require the courtesy of notice.

#### **Board members:**

- Agree to be diligent in preparing for and attending Board meetings; and
- Will endeavour to be as informed and as knowledgeable as they can be, about the responsibilities of the District Health Board and the issues presented to them, in order to arrive at the best decisions possible.

#### **Collective Responsibility**

Board members recognise that there may be tension at times between the concepts of collective accountability of board members and individual accountability to the public of elected members. Therefore, board members will conduct themselves in accordance with the following principles:

- Board members will clearly express their views at board meetings, and endeavour to achieve a particular decision and course of action by consensus. However, board members accept that once a decision has been formally reached by the board, this decision becomes the policy of the board.

- It is inappropriate for a board member to undermine a decision of the board or to engage in any action or public debate which might frustrate its implementation.
- Board members will not attempt to re-litigate previous decisions at future meetings of the board, unless the majority of members agree to re-open the debate.
- Board members will be mindful that personal actions should not bring the board into disrepute or cause a loss of confidence in the activities and decisions of the District Health Board.

### **Clarity of Roles**

Board members are responsible for the governance of the District Health Board. The board delegates to the Chief Executive responsibility for implementing the decisions of the board and responsibility for providing the board with free and frank advice to assist us in reaching high quality decisions.

Board members agree that, for the purposes of accountability, clarity between the roles of governance and management is essential and we must not become involved with management's activities.

Board members will endeavour to comment publicly only on policy and governance matters for which they are responsible, and to leave public comment on operational and management matters to the Chief Executive and management according to the District Health Board's Media Relations Policy.

### **Employment Relationship**

Board members will recognise their role as the employer of the Chief Executive and indirectly of all staff within the District Health Board. Board members will exercise this employment responsibility professionally and responsibly. To that end board members will:

- Be supportive of employees of the District Health Board, and will criticise neither employees nor the service provided by the District Health Board in public. Any concerns board members might have will be raised with the Board and/or Chief Executive, as appropriate;
- Exercise judgement and courtesy in respecting the protocol of communicating through the Chair and/or Chief Executive, (as appropriate), in raising matters with the Chief Executive and/or senior staff;
- Not attempt to influence any employee of the District Health Board to present material in a particular way, such that it might affect the outcome of a decision to be made by the board; and
- Exercise care in communicating privately with employees of the District Health Board, and will refer any staff with complaints or concerns back to the Chief Executive.

### **Complaints Procedures**

Board members will respect their role in providing a community voice to the activities of the District Health Board. Equally, however, board members will recognise that the organisation through the mandate of the board will have processes in place to seek public consultation, prioritise resources, establish waiting lists and times and respond to consumer complaints etc. To that end board members will:

- Advise residents/health consumers, who desire personal matters to be brought to the attention of the District Health Board, to follow the proper procedure for raising issues and registering complaints;
- Not advocate on behalf of an individual beyond advising them of the complaints procedure and later checking that the matter has been addressed satisfactorily by the organisation. ('Satisfactorily' refers to the procedures followed by the organisation in addressing the matter, not necessarily whether the outcome is as the individual would wish.) Should board members become aware of a

matter of real significance and/or urgency however, this shall be raised immediately with the Chief Executive who will discuss/agree/advise (as appropriate) how the matter will be addressed, and the board member advised of the outcome (with the Chair being kept informed of the whole process); and

- Not make commitments for board related work or expenditure which have not been previously approved by the District Health Board, nor create any liability for the District Health Board beyond authorised delegations.

### **Legislative Compliance**

Board members will acknowledge that being a board member brings with it an obligation to act at all times as a responsible member of society. Obeying the law, both in letter and in spirit, is the foundation on which HBDHB's ethical standards are built. Board members must respect and obey the laws of New Zealand and will be sufficiently aware of the laws of New Zealand in order to determine when to seek legal advice. To that end board members will:

- Be familiar with the New Zealand Acts and Regulations that govern the responsibilities as Board Members of the Hawke's Bay District Health Board, obey the law and be aware of and respect the processes of the law.
- Comply with the health and safety policies and procedures operating within the sites and facilities owned by the District Health Board.

### **Confidentiality**

Board members will recognise and acknowledge that they will receive information that is both public and private and that the release of information, and access to and handling of personal information, about any individual are governed by the Official Information Act 1982 and the Privacy Act 1993. In order to protect the organisation and individual board members from inappropriate use of information, board members will:

- Make themselves familiar with this legislation, and refer any requests for 'Official Information' to the Chief Executive.
- Not disclose publicly any business discussed while the public is excluded from a meeting, and/or information for which good reason exists (under the terms of the Official Information Act) for it to be withheld from the public, unless the board decides by resolution to make such information public.
- Accept that they may acquire information of a confidential nature, for example about health and disability providers and/or other local and national organisations. Board members will not use any such information for personal advantage, nor disclose it to any other person unless first authorised by the board.

### **Conflict of Interest**

Board members acknowledge that the NZ Public Health and Disability Act and the board's e Governance Manual sets out the definition and procedure for disclosure of members' interests. The Act states that:

1. A Board Member who is 'interested in a transaction' of the District Health Board must, as soon as practicable, disclose the nature of the interest to the Board.
2. The Board Member must not take part in any deliberation or decision of the Board relating to the transaction.
3. The disclosure must be recorded in the minutes and entered in a separate interests register.

“Interested in a transaction” is defined within the NZPHDA (Interpretation Section) as: *“if the Board Member:*

- (a) *is a party to, or will derive a material financial benefit from, the transaction;*
- (b) *has a material financial interest in another party to the transaction; or*
- (c) *is a director, Member, officer, or trustee of another party to, or person who will or may derive a material financial benefit from, the transaction; or*
- (d) *is the parent, child, or spouse (or de facto partner) of another party to, or person who will or may derive a material financial benefit from the transaction; or*
- (e) *is otherwise directly or indirectly materially interested in the transaction.”*

#### **Board members:**

- Recognise that at times there may arise a ‘perception of interest’ which is a wider interpretation than that defined in the legislation. Board members agree that the appropriate procedure is to raise such matters of interest in the first instance with the Chair, who will determine an appropriate course of action.
- Agree that the board may, where appropriate, decide that a board member who has declared an interest in matters to be discussed by the board should leave the meeting room for the duration of discussion on such matters.
- Will not use their official position for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducements and which could compromise their integrity.
- Will exercise care and judgement in accepting any gifts, and advise the Chair and/or board of any offer received.

#### **Media and Public Comment**

Long-established practice in the Public Service provides a robust base for sound practice in Crown Entities. Practice in the Public Service is based on the following principles:

- Ministers are responsible for defending or justifying the Government's policies and decisions.
- The role of the Public Service is limited to explaining government policy (including its rationale, underlying factual or research basis, and implementation). To that end:
  - explanations of policies or their implementation by departments, may only be given by Chief Executives or other employees expressly authorised to do so;
  - all explanations must be balanced, factual and impartial - generally this is taken to mean that explanations do not include expressions of views about political decisions, party politics or the discussions that culminated in policy decisions; and
  - Ministers should not be surprised by any explanation of policy given by a Public Servant.

In like manner, careful consideration needs to be given to commenting on the policies or decision made by the board and management to parties external to the organisation. Adverse comments regarding board and management decisions can impact negatively on the relationship between the board and management.

The District Health Board recognises the freedom of board members to communicate with the media, but board members agree that in doing so they should do so in a manner consistent with the principles of the Code of Conduct and the District Health Board’s Media Relations Policy. Primarily board members will seek to ensure that the board can function successfully and make informed decisions in the best interests of the public.

In accepting that each board member is entitled to their own views, board members will:

- Exercise care and judgement when commenting on unresolved policy or matters of public debate.
- Distinguish clearly to their audience whether they are speaking personally and communicating their own views, or whether they are speaking on behalf of the board and conveying policy decisions taken by the board.
- Recognise they may comment on matters relating to existing policy and practice which has been formally decided by the Board.
- Agree to refer the media to official spokespeople, where these have been appointed by the board to respond to specific issues.
- Refrain from acting in public in a manner that undermines other board members, and will not act for self promotion purposes at the expense of the image of the District Health Board itself.
- Ensure that their individual activities and contribution to any public debate or discussion should be consistent with the objective of maintaining a nonpartisan work environment for the board.

### **Consultation**

Board members will acknowledge that whilst they no longer have obligations to consult with the public in developing the Annual Plan and Statement of Intent (being mindful that 'consultation' is a term with specific meaning that has been derived from case law), they also need to acknowledge and respect a general philosophy and intention to engage with and welcome dialogue with the community. To that end board members will:

- Endeavour to keep an open mind during engagement with the public and be prepared to listen, to develop their understanding, and if appropriate to change their view.
- Ensure that the engagement process provides the public with an effective opportunity to give their views.
- Be respectful and attentive to members of the public.

**State Services Commission Standards of Integrity and Conduct**

Board members will seek to follow the Statement Services Commission Standards of Integrity and Conduct that are expected of public servants. The standards and expected behavior are:

**FAIR**

Board members will:

- Treat everyone fairly and with respect. Be professional and responsive.
- Work to make government services accessible and effective.
- Strive to make a difference to the well-being of New Zealand and all its people.

**IMPARTIAL**

Board members will:

- Maintain the political neutrality required to enable board members to work with current and future governments.
- Carry out the functions of the organisation, unaffected by the member's personal beliefs.

Support the organisation to provide robust and unbiased advice.

Respect the authority of the government of the day.

**RESPONSIBLE**

Board members will:

- Act lawfully and objectively.
- Use the organisation's resources carefully and only for intended purposes. Treat information with care and use it only for proper purposes.
- Work to improve the performance and efficiency of the organisation.

**TRUSTWORTHY**

Board members will:

- Be honest.
- Work to the best of their abilities.
- Ensure their actions are not affected by their personal interests or relationships. Never misuse their position for personal gain.
- Decline gifts or benefits that place a member under any obligation or perceived influence.
- Avoid any activities, work or non-work related, that may harm the reputation of the organisation or of the State Services.

# CODE OF PROFESSIONAL CONDUCT for Crown Entity Board Members

STATE SERVICES COMMISSION  
TE KAWA MATUAHIO



A code of conduct issued by the State Services Commissioner under the State Sector Act 1988, section 57 (3)

## ACTING IN THE SPIRIT OF SERVICE

Crown entities exercise significant powers, deliver public services and directly impact the lives of New Zealanders. To be effective, Crown entities must have the trust and confidence of New Zealanders and the Government.

Boards oversee the operations and performance of Crown entities. As board members you bring a spirit of service to the community, support for the Crown's responsibilities under the Treaty of Waitangi and an intrinsic desire to improve the wellbeing of New Zealand and New Zealanders to your role. A key requirement of your role is to act with the highest levels of integrity and professional and personal standards.

This Code sets out minimum standards of integrity and conduct. The board should put in place a **board charter** or **governance manual** to **guide its governance activities, which includes ethics provisions for board members** as appropriate to support these standards and suit the entity's particular circumstances.

This Code should be **read in conjunction with the** collective and individual duties of members as set out in the **Crown Entities Act 2004**. This code does not override **any** statutory provisions including those in **an entity's** empowering legislation, the **Crown Entities Act 2004**, the **State Sector Act 1988**, the **Public Finance Act 1989** and the **Companies Act 1993**. This code is not intended to limit the ability of an entity or statutory officer to act independently in regard to any statutorily independent function.

## RESPONSIBILITIES

### Honesty and integrity

You act with honesty and with high standards of professional and personal integrity. You are truthful, open and meet generally accepted standards of behaviour. You speak up in board meetings on decisions or advice that may be detrimental to the public interest.

### Care, diligence and skill

You exercise your powers with care, diligence and skill. You give proper consideration to matters and seek and consider all relevant information.

### Fairness

You deal with people fairly, impartially, promptly, sensitively and to the best of your ability. You do not act in a way that unjustifiably favours or discriminates against particular individuals or interests. You treat other members and staff employed by the entity with courtesy and respect.

### Statutory and administrative requirements

You understand and act in accordance with all statutory and administrative requirements relevant to your role. You play a full and active role in the work of the board and fulfil all your duties responsibly. You respect the principle of collective decision-making and corporate responsibility. This means once the board has made a decision, you support it. You follow board protocols for public comment.

### Proper use of position

When acting as a member, you do not pursue your own interests at the expense of the entity's interests. You do not misuse official resources for personal gain or for political purposes. You behave in a way that reflects well on the reputation of the entity and do not do anything to harm that reputation.

### Proper use of information

You use information you gain in the course of your duties only for its intended purpose and never to obtain an advantage for yourself or others or to cause detriment to the entity.

You are well informed about privacy, official information and protected disclosures legislation. You fully comply with entity procedures and only disclose official information or documents when required to do so by law, in the legitimate course of duty or when proper authority has been given.

### Conflicts of interest

You avoid wherever possible any conflicts of interest with your board role or the appearance of a conflict, current or future. You identify, declare and manage all interests. You become familiar with, and follow, all conflicts of interest requirements, including those of the board, the entity, and all statutory and professional requirements including the Crown Entities Act 2004, sections 62-72.

### Gifts and hospitality

You never seek gifts, hospitality or favours for yourself, members of your family or other close associates. You inform the Chair or other proper authority of any offer of gifts or hospitality and ensure that, where a gift or hospitality is accepted, it is recorded in a register in line with the entity's procedures.

### Political impartiality

You act in a politically impartial manner. Irrespective of your political interests, you conduct yourself in a way that enables you to act effectively under current and future governments. You do not make political statements or engage in political activity in relation to the functions of the Crown entity.

When acting in your private capacity, you avoid any political activity that could jeopardise your ability to perform your role or which could erode the public's trust in the entity. You discuss with the Chair any proposal to make political comment or to undertake any significant political activity while a board member.

These provisions apply to elected board members in the same way as to appointed members. However elected board members have a relationship with their constituency in addition to their accountability to the responsible Minister. You consider how you maintain that relationship while, as for all members, ensuring your actions do not jeopardise the effective governance of the entity.

### Speaking up

You report unethical behaviour when you see it. You treat all concerns raised by others seriously. You support the entity to have clear policies and procedures in place that help expose serious threats to the public interest, and encourage open organisation cultures where all staff feel safe speaking up.



**Schedule 5: Standing Orders for the Board and Board Committees**

**HAWKE'S BAY DISTRICT  
HEALTH BOARD**

**STANDING ORDERS**

**FOR THE BOARD AND BOARD COMMITTEES**

**June 2008**

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## 1 General

### 1.1 Interpretation

For the purpose of these Standing Orders

**Act** means the New Zealand Public Health and Disability Services Act 2000.

*HBDHB will comply with the requirements of the Act. If there is any inconsistency between the Act and these Standing Orders then the Act shall prevail.*

**Board Administrator** means the principal administrative officer of the board and its committees, and includes for the purpose of these Standing Orders any other officer so authorised by the board.

**Chair** means the chairperson of HBDHB and, where appropriate, also includes any person acting as the chairperson of any committee or sub-committee of the DHB (*refer Schedule 3, clause 27 of the Act*).

**CEO** means Chief Executive Officer of HBDHB.

**Committee** means a committee of the board, including:

- a) A Community and Public Health Advisory Committee;
- b) A Disability Support Advisory Committee;
- c) A Hospital Advisory Committee
- d) any committee established under clause 38 of Schedule 3 of the Act; and
- e) any subcommittee of a committee described in a) – d) above.

**CE Act 2004** means the Crown Entities Act 2004.

**Commissioner** means a person appointed by the Minister of Health under section 31 of the Act and who, by virtue of that section, has all the functions, duties and powers and protections of the board and of a member of the board including the chair, while he/she holds office as Commissioner.

**Deputation** means a request from any interest group in the community to make a presentation to the board or a committee.

**HBDHB** means Hawke's Bay District Health Board.

**Meeting** means any first, ordinary, special or emergency meeting of the DHB; and any meeting of any committee or subcommittee of the DHB. At any meeting of the board, any committee or subcommittee of HBDHB at which no resolutions or decisions are made, the provisions of section 4 of these Standing Orders in relation to public access need not apply.

**Member** means any person elected or appointed to the board of HBDHB or to any committee or subcommittee of the DHB.

**Minister** means Minister of Health.

**Minutes** means any minutes or other record of the proceedings of any meeting of the board and its committees.

**Ordinary meeting** means any meeting publicly notified by HBDHB in accordance with Schedule 3, clause 16 of the Act.

**NZPHD Act 2000** means the New Zealand Public Health and Disability Act 2000.

**Public excluded information** includes:

information which is:

- i) currently before a public excluded session; or
- ii) proposed to be considered at a public excluded session; or
- iii) had previously been considered at a public excluded session (other than information subsequently released by the DHB as publicly available information); and

Any minutes (or portions of minutes) of public excluded sessions (other than those subsequently released by the DHB as publicly available information); and

Any other information which has not been released by the DHB as publicly available information.

**Publicly excluded session** refers to those meetings or parts of meetings from which the public is excluded by the DHB pursuant to clauses 32 and 33 of Schedule 3 of the Act.

**Publicly notified** means notified to the resident population of the DHB by advertisements in one or more newspapers circulating in the district, or by advertisements of that kind and any or more of the following means: printed placards affixed to public places in the district; radio or television broadcasts; and/or notices available on the internet, e-mail or other electronic means.

**Statutory Committee** means: the Community and Public Health Advisory Committee (CPHAC); the Disability Support Advisory Committee (DSAC); and the Hospital Advisory Committee (HAC).

**Working day** means any day of the week other than:

Saturday, Sunday, Good Friday, Easter Monday, Anzac Day, Labour Day, Queen's Birthday, and Waitangi Day; Anniversary Day; and

A day in the period from 25 December through to 15 January of the following year.

## 1.2 Application of Standing orders

1.2.1 These Standing Orders shall, so far as applicable, extend to the proceedings of all HBDHB board and committee meetings of the DHB, including public excluded sessions.

1.2.2 All members of the board and its committees shall abide by the Standing Orders adopted by the board.

## 1.3 Chair's ruling is final

1.3.1 The chair shall decide all questions where these Standing Orders make no provision or insufficient provision.

1.3.2 In regard to order 1.3.1 the chair's ruling shall be final and not open to debate.

### 1.3.3 Disorderly persons may be excluded

At any meeting of the board or a committee, the chair may require a member of the public attending the meeting to leave if the chair believes on reasonable grounds that, if the person is permitted to remain, the behaviour of that person is likely to prejudice, or continue to prejudice, the orderly conduct of the meeting.

If any person who is required, pursuant to a ruling under Standing Orders, to leave a meeting:

- a) refuses or fails to leave the meeting; or
- b) having left the meeting, attempts to re-enter the meeting without the permission of the chair; then

any officer or employee of the HBDHB or member of the Police, may, at the request of the chair, remove or, as the case requires, exclude that member from the meeting.

(refer clause 35, Schedule 3 and clause 37, Schedule 4 of the Act)

#### **1.4 Suspension of Standing Orders**

1.4.1 The board or a committee may temporarily suspend Standing Orders during a meeting by a vote of three-quarters of the members present and voting, and the reason for the suspension shall be stated in the resolution of suspension.

1.4.2 Any motion to suspend one or more Standing Orders shall state the specific order or orders which it is proposed to be suspended.

#### **1.5 Alteration of Standing Orders**

1.5.1 After the adoption of the first Standing Orders of the DHB, the adoption of amended Standing Orders shall require, in every case, a vote of three-quarters of the members present.

#### **1.6 First meeting of the board following election**

1.6.1 a) The first meeting of the board following an election shall be called by the CEO as soon as practicable after the elected members have taken office on the 58th day after polling day.

b) The CEO shall give the persons elected or appointed to the board not less than ten (10) working days notice of the meeting.

c) The meeting shall be chaired by the chair of the board appointed by the Minister under clause 10 of Schedule 3 of the Act.

#### **1.7 Members**

##### **1.7.1 Members to give notice of addresses**

Every member of the board and a committee shall give to the CEO a residential or business address (together with, if desired, facsimile, email, or other address) to which notices and material relating to meetings and DHB business may be sent or delivered.

##### **1.7.2 Member receiving information**

If notice is sent to the address notified by the member, then the member is deemed to have received the notice of meeting two (2) working days after posting and the next working day if e-mailed or faxed.

## **1.8 Committees**

### **1.8.1 Standing or Special Committees**

The board may:

- a) appoint standing or special committees and the presiding members and other members of such committees;
- b) determine the duties of, and the matters which shall normally be referred to, such committees;
- c) determine whether the Standing Orders shall apply in full or part of the meetings of such committees.

### **1.8.2 Committees subject to the direction of the board**

Every committee is subject, in all things, to the control of the board and is required to carry out all directions given in relation to the committee or its affairs by the board.

### **1.8.3 Appointment or removal of committee members**

The board may at any time appoint or remove any member of a committee.

### **1.8.4 Members of committees**

The board may appoint to any committee any person who is not a member of the board if, in the opinion of the board, that person has knowledge which will assist the work of the committee. At least two members of every committee shall be members of the board.

The board must endeavour, where appropriate, to ensure representation of Maori on the committee.

### **1.8.5 Minimum number on committees**

The minimum number of members of a committee is three (3).

### **1.8.6 Tenure of committees**

Every non-statutory committee shall, unless sooner discharged, be deemed to be discharged on the coming into office of the members of the board elected or appointed, as the case may be, at or after the next general election following the appointment of the committee.

## **1.9 Chair ex officio member**

### **1.9.1 Chair ex-officio**

The chair shall be an ex-officio member of every committee of the board

### **1.9.2 Chair not obliged to apologise for absence**

Despite being ex-officio a member of every committee of the board the chair shall not be obliged to apologise for absence from any committee.

## 1.10 Powers of Delegation

### 1.10.1 Delegation to Committees

The board may, by written notice, delegate to any committee any of the functions, duties, or powers, of the board or of the DHB. Such a delegation does not prevent the board or DHB from performing the function or duty or exercising the power.

(refer to clause 39, Schedule 3 of the Act)

### 1.10.2 Committee use of delegated powers

Every committee to which any functions, duties or powers are delegated by the board may, without confirmation by the board, perform the function or duty, or exercise the power, in the same manner, subject to the same restrictions, and with the same effect, as if the delegate were the board or the DHB.

The committee must not delegate the delegated function, duty or power except in accordance with the provisions of the delegation or with the written consent of the board.

(refer to clause 40, Schedule 3 of the Act)

## 1.11 General Provisions as to meetings

1.11.1 The board and committees shall hold such meetings as are necessary in order to carry out its functions and responsibilities under the Act and, where applicable, its terms of reference.

1.11.2 Every member of the board or committee shall, unless lawfully excluded, have the right to attend any meeting of the board or committee.

1.11.3 Every meeting of the board and any committee shall be called, publicly notified, and conducted in accordance with:

- a) the NZPHD Act 2000; and
- b) the board's Standing Orders.

## 1.12 Special and emergency meetings

1.12.1 The board may hold special or emergency meetings.

1.12.2 A "special meeting" means a meeting called pursuant to –

- a) a resolution of the board; or
- b) a requisition in writing delivered to the CEO and signed by:
  - i) the chair of the board, or
  - ii) a majority of the total membership of the board (including vacancies).

which resolution or requisition shall specify the time and place at which the meeting is to be held and the general nature of the business to be brought before the meeting.

1.12.3 The chair shall give notice in writing of the time and place of a board meeting and of the general nature of the business, to every member of the board:

- a) at least three (3) working days before the day appointed for the meeting; or

- b) where the meeting is called pursuant to a resolution or requisition of the board, within such lesser period of notice, being not less than 24 hours, as is specified in the resolution.

**1.12.4 Notification of emergency meetings to members**

In the event of an emergency meeting being required, the chair shall convene such meetings on the written authority of the chair or of any five (5) board members, and for such meetings notice by letter, facsimile, telephone, or email shall be deemed to be sufficient.

**1.13 Notice to members of meetings**

- 1.13.1 The chair shall give notice in writing (by delivery or electronic transmission) to members of the time and place appointed from time to time for holding each ordinary meeting already scheduled and any special meetings, and the members shall attend such meetings without further notice.

**1.13.2 Agenda and agenda papers to be sent to members**

In the case of each meeting to which order 1.13.1 applies, an agenda detailing the business to be brought before that meeting, together with relevant agenda papers and associated reports, shall be sent to every member no less than two (2) working days before the day appointed for the meeting.

(refer clause 18, Schedule 3 of the Act)

**1.14 Meetings not invalid because notice not received**

- 1.14.1 No ordinary meeting, special meeting, or emergency meeting of the board shall be invalid because notice of the meeting was not received or was not received in due time by any member, if the chair made all reasonable efforts to ensure each member was given notice.

(refer clause 16, Schedule 3 of the Act)

## **2 Procedure at meetings**

### **2.1 Chair to preside at meetings**

- 2.1.1 a) The chair of the board shall preside at every meeting of the DHB at which he or she is present.
- b) The chair of any committee shall preside at every meeting of the committee at which he or she is present.
- c) The board may appoint a member of any committee to be the chair of that committee, and that power may be exercised by the committee where the board, on the appointment of the committee, does not appoint a chair. Any committee may from time to time appoint a deputy chair to act in the absence of the chair.
- d) If the chair of the board or of any committee, as the case may be, is absent from any meeting, the deputy chairperson (if any) of the board or committee, as the case may be, shall preside, but, if the chair and deputy chair are both absent, the members of the board or committee present, as the case may be, shall elect one of their number to preside at that meeting, and that person shall have and may at that meeting perform all the functions and duties and exercise the powers of the chair.

(refer clauses 27, Schedule 3 and 29, Schedule 4 of the Act)

### **2.2 Order of Business**

- 2.2.1 The board shall adopt an order of business which shall normally apply at ordinary meetings and may vary it from time to time.

### **2.3 Quorum**

- 2.3.1 The board or a committee cannot exercise any authority, power, or discretion, and no business of the board or committee, can be transacted, at any meeting of the board or committee, as the case may be, unless the quorum of members of the board or committee, is present at the meeting.

(Refer clauses 25, Schedule 3 and 27, Schedule 4 of the Act)

- 2.3.2 Subject to any exceptions in the Act, the quorum of members of the board is:

- a) if the total number of members of the board is an even number, half that number; but
- b) if the total number of members of the board is an odd number, a majority of the members.

### **2.4 Agenda**

- 2.4.1 The CEO shall prepare an agenda for each meeting in consultation with the chair.
- 2.4.2 The agenda paper will include any matters which the CEO considers the board or committee is likely to wish to exclude the public, provided that an indication of the subject matter likely to be considered in exclusion of the public shall be placed on the Agenda available to the public.

(refer to clauses 19(2), Schedule 3 and 21(2), Schedule 4 of the Act)

### **2.5 Extraordinary or urgent business at ordinary meeting**

**2.5.1** Only business on the agenda may be dealt with at any meeting of the board or a committee. Where an item is not on the agenda for a meeting, that item may be dealt with at the meeting if:

- a) The board by resolution so decides; and
- b) The presiding member explains at the meeting, at a time when it is open to the public,
  - i) the reason why the item is not on the agenda; and
  - ii) the reason why the discussion of the item cannot be delayed until a later meeting.

Despite the above, where an item is not on the agenda for a meeting:

- c) The item may be discussed at that meeting if:
  - i) The item is minor matter relating to the general business of the board; and
  - ii) The chair explains at the beginning of the meeting, at a time when it is open to the public, that the item will be discussed at the meeting; but
  - iii) No resolution, decision, or recommendation may be made in respect of that item except to refer the item to a later meeting of the board for further discussion.

(refer clauses 28, Schedule 3 and 30, Schedule 4 of the Act)

## **2.6 Decision to be decided by majority votes**

2.6.1 All acts of the board are to be done and all questions before the board are to be decided at a meeting by the majority of such members as are present and voted thereon. The chair does not have a second casting vote.

2.6.2 Any member may abstain from voting and have their abstention recorded in the minutes when requested.

## **2.7 Motions and resolutions**

2.7.1 Every endeavour shall be made to achieve consensus in decision-making.

2.7.2 Discussions on any proposal shall be broad and informal and constrained as to time by the guidance of the chair rather than through procedural motions.

2.7.3 Where there is a resolution, it shall require a mover and a seconder, but they do not have to be identified and recorded.

2.7.4

i) A motion is a proposal put before a meeting for consideration and discussion. Once a motion is before the meeting members shall confine discussion to the motion.

ii) Once passed, a motion is called a resolution, as its status changes from having been 'moved' to having been 'resolved'. Once the chair puts a motion to the vote, no further discussion should occur.

2.7.5 Silence when a motion is put shall be deemed to be a vote in support of the motion.

2.7.6 Votes for and against particular motions shall not be recorded, unless requested by a board or committee member or the chair.

2.7.7 When a motion has been seconded, and opened by the chair for discussion, an amendment may be moved and seconded by any member.

2.7.8 Board members are expected to contribute once only to discussion on a particular item, although the chair shall be entitled to summarise and guide debate.

2.7.9 No member shall speak on any question after it has been put by the chair, or during a vote.

2.7.10 In the case of a tied vote, the chair has no second or casting vote, and the question or motion is decided in the negative.

(refer clauses 29, Schedule 3 and clause 31, Schedule 4 of the Act).

2.7.11 A resolution reflects the will of the majority, and members should not criticise the resolution unless the member is taking steps to revoke the resolution.

2.7.12 Any resolution may be rescinded by a subsequent resolution at a subsequent meeting without recourse to procedural motions.

## **2.8 Requirement for a Seconder**

2.8.1 All motions or amendments moved at board or committee meetings must be seconded.

## **2.9 Speeches in English or Maori**

2.9.1 A member may address the chair or board in English or Maori. The chair may order that a speech be translated and printed in another language, and/or that an interpreter be present. Any member intending to make an address in Maori shall give the chair reasonable prior notice to enable an interpreter to be present.

## **2.10 Use of public excluded information**

2.10.1 No member, officer or other person is permitted to disclose to any person, other than a member or officer who was or is to be present, any information which has been or is to be presented to any meeting from which the public is properly excluded. No discussion, deliberations or decisions are to be disclosed following any such meeting except by way of release of information by the board.

## **2.11 Conflict of interest and interests**

2.11.1 The HBHDB Governance manual sets out the requirements of members in relation to conflicts of interest and members' interests:

2.11.2 A member of the board or committee who has an interest in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the board or committee, as the case may be.

2.11.3 A member of the board who makes a disclosure under Standing Order 2.11.2 must not (unless Standing Order 2.11.5. applies; or the Minister, by a waiver or modification of the application of this Standing Order under clause 37, Schedule 3 of the Act, permits the board; or the board under clause 39 of Schedule 4 permits a committee):

- a) take part, after the disclosure in any deliberation or decision of the board or committee, as the case may be, relating to the transaction; or
- b) be included in the quorum required by the Act for any such deliberation or decision; or
- c) sign any document relating to the entry into a transaction or the initiation of the transaction.

- 2.11.4 A disclosure under this Standing Order must be recorded in the minutes of the next meeting of the board or committee, as the case may be, and entered in the Interests Register maintained for the purpose.
- 2.11.5 However, a member of the board or committee who makes a disclosure under this Standing Order may take part in any deliberation (but not any decision) of the board or committee, as the case may be, relating to the transaction concerned if a majority of the other members of the board or committee, as the case may be, permits the member to do so.
- 2.11.6 If Standing Order 2.11.5 applies, the board or committee, as the case may be, must record in the minutes of its next meeting:
- a) the permission and the majority's reasons for giving it; and
  - b) what the member says in any deliberation of the board or committee relating to the transaction concerned.
- 2.11.7 Every member of the Board must ensure that:
- a) the statement completed by the member under sections 29(6) of the Act and 31(1)(c) of the CE Act (interests disclosure statement made before appointment), or clause 6 of Schedule 2 of the Act interests disclosure statement made before election), is incorporated in the Interests Register maintained under Standing Order 2.11.4; and
  - b) any relevant change in the member's circumstances affecting a matter disclosed in that statement is entered in that register as soon as practicable after the change occurs.

(Refer clauses 36, Schedule 3 and 38, Schedule 4 of the Act)

### **3 Minutes of proceedings**

#### **3.1 Minutes to be evidence of proceedings**

3.1.1 The board shall keep minutes of all its proceedings. Minutes of proceedings approved by the board and confirmed by the chair shall be prima facie evidence of those proceedings. Minutes shall be prepared on the basis that the minutes are not a verbatim record of proceeding.

3.1.2 No discussion shall arise on the substance of the minutes at the succeeding meeting, except as to their correctness.

3.1.3 The CEO shall ensure the minutes of meetings are kept. The minutes shall record:

- a) the date, time and venue of the meeting;
- b) the names of those members and officers present;
- c) identification of the chair
- d) apologies tendered, including arrival and departure times;
- e) any failures of a quorum
- f) any declarations of interests and/or conflicts of interest
- g) any decision of the board in relation to a declared interest or conflict of interest, including any waiver given by the majority of the board in accordance with Standing Orders 2.11.5 and 2.11.6.
- h) if a waiver is given to a member under Standing Orders 2.11.5 and 2.11.6, what the member says in any deliberation of the board or committee in relation to the transaction concerned
- i) a list of speakers under public comment and topics they cover
- j) a list of items considered
- k) resolutions pertaining to those items
- l) objections to words used
- m) all divisions taken
- n) contempt, censure and removal of any members
- o) resolutions to exclude members of the public
- p) the time the meeting concludes or adjourns.

#### **3.2 Approval of minutes**

3.2.1 The minutes and proceedings of every meeting shall be circulated to members and considered at the next meeting succeeding, and, if approved by that meeting, or when amended as directed by that meeting, shall be signed by the chair of such succeeding meeting.

3.2.2 Standing Order 3.2.1 applies only to meetings of the board and statutory committees. For other committees, a report of the proceedings shall be submitted to the next ordinary meeting of the board at which meeting the report shall be adopted, amended or otherwise dealt with.

#### **3.3 Minutes of last meeting before election**

3.3.1 The chair and the CEO shall be responsible for election confirming the correctness of the minutes of the last board or committee meeting, as the case may be, prior to the next election or appointment of members.

## **4 Admission of Public**

### **4.1 Meetings normally to be open**

4.1.1 All meetings of the board and committees shall be open to the public and news media in accordance with the Act.

(refer to clauses 31-35, Schedule 3 and 33-37, Schedule 4 of the Act)

4.1.2 The chair of the board or committee, as the case may be, shall make provision for public comment on agenda items at the beginning of each board and committee meeting.

4.1.3 Public comment during a meeting from any member(s) of the public present will be on the invitation of the board or committee chair.

### **4.2 Lawful reasons to exclude the public**

4.2.1 The board or committee may, by resolution, exclude the public from whole or part of the proceedings of any meeting only on one or more of the grounds specified in clause 32 of the Act in respect of the board, or clause 34 of Schedule 4 of the Act in respect of a committee.

### **4.3 Resolutions and motions to exclude public**

4.3.1 Any resolution to exclude the public shall state the general subject of each matter to be considered whilst the public is excluded, with the reason for passing that resolution in relation to that matter, and the grounds on which the resolution is based. The motion shall be put whilst the meeting is open to the public.

4.3.2 A resolution to exclude the public may provide for a person with, in the board's or committee's opinion, relevant knowledge to remain at the meeting. This resolution will briefly state the relevance of this knowledge to the matter being discussed.

(refer to clauses 33, Schedule 3 and 35, Schedule 4 of the Act)

### **4.4 Information to be available to public**

4.4.1 All information, except public excluded information provided to members at board and committee meetings shall be available to the public and news media unless a specific provision of the Act (including its Schedules) applies.

### **4.5 Availability of agendas and reports**

4.5.1 Any member of the public may, without payment of a fee, inspect at the board office during normal office hours, within a period of at least two (2) working days before every meeting, all agendas and associated reports (except public excluded information) circulated to members of the board and relating to that meeting. Any member of the public may take notes from any agenda or report inspected and, on payment of any prescribed amount, is to be given a copy of any part of an agenda or report requested as soon as practicable. Where a meeting is an emergency or special meeting, the agenda and reports are to be made available as soon as is reasonable in the circumstances.

### **4.6 Exclusion of reports to be discussed with public excluded**

4.6.1 The CEO may exclude from the reports made available, items from the reports that are reasonably expected to be discussed with the public excluded. These items are to be indicated on each agenda.

**4.7 Public entitled to inspect confirmed minutes**

4.7.1 The public are entitled, without charge, to inspect, take notes from, or receive copies of, confirmed minutes of any meetings or part of any meeting from which the public was not excluded.

**4.8 Request for minutes of meetings in closed session**

4.8.1 The board shall consider any request for the minutes of a meeting or part thereof from which the public was excluded in accordance with clauses 21(5) Schedule 3 and 23(4) of the Act.

**4.9 Privilege**

4.9.1 Oral statements at meetings and written statements contained in agenda, minutes shall enjoy privilege in accordance with clauses 24, Schedule 3 and 26, Schedule 4 of the Act.

**5. Other Provisions****5.1 Code of conduct/Code of ethics**

5.1.1 Any Code of Conduct and/or Code of Ethics adopted by or applied to the board shall apply to all members of the board and committees.

**5.2 Confidentiality**

5.2.1

- a) No member of the board or committee shall discuss business conducted in the public excluded section of a meeting or the business of the board or DHB, with any person who is not a member of the board or its management staff, unless authorised to do so by the chair.
- b) No member of the board shall release any information to any person not a member of the board or the DHB's management staff, or make any statement to the media, unless approved by the chair.

**5.3 Teleconferences**

5.3.1 In any teleconference no resolution of the board or committee may be voted on and no decision of the board or committee, as the case may be, may be made.

5.3.2 Each member taking part must acknowledge their participation and be able to hear each of the other members taking part. Members may not leave a teleconference unless they first obtain permission to do so from the presiding member.

5.3.3 A written record of a teleconference must be made by the member who presided in it.

**5.4 Application of model standing orders**

5.1.1 Where it is necessary to seek further guidance in respect of the Standing Orders, reference may be made to the "*Model Standing orders for Meetings of Public Bodies*" MP 9204:1993, issued by Standards New Zealand, which shall apply.

## **5.5 Statutory Advisory Committees**

### **5.5.1 Removal of Members**

A member can be removed by the board if that member has, without permission from the board and without reasonable excuse, been absent from four (4) consecutive meetings of the committee.

## Schedule 6: Board Member Remuneration, Fees and Expenses

### *Related Documents*

- a) Crown Entities Act 2004
- b) New Zealand Public Health and Disability Act 2000
- c) Fees Framework for Members Appointed to Bodies in which the Crown has an interest – Cabinet Office Circular CO(12)6

### **PURPOSE**

The purpose of this Schedule is to ensure the payment of fees and expenses to board members is in accordance with the requirements of the Crown Entities Act 2004 (as it references the Fees Framework), and to ensure that board members are aware of their entitlements and procedures to be followed for payment of fees and reimbursement of expense claims.

Remuneration and committee fees will be paid in accordance with the Cabinet Fees Framework for Members Appointed to Bodies in which the Crown has an interest and at levels indicated in that framework and/or set by the Minister of Health.

Reasonable travel associated with travel from a member's normal place of residence to a scheduled meeting of the board or a board committee may be incurred without prior consultation.

Members of the board travelling to meetings, or on board business, where the member is required to be away from their normal place of residence, are entitled to reimbursement of *out of pocket* travelling, meal and accommodation expenses actually and reasonably incurred. The expectation is that standard travel, accommodation, meals and other expenses are modest and appropriate to reflect public service norms. The Fees Framework expects the same standards and policies to apply to board members as would apply to staff of the "servicing department" and the DHB's own travel and expenses policy applies to board members.

When travel or other costs are incurred for the purpose of both HBDHB and another organisation, a fair apportionment shall be made between organisations, and only that part attributable to HBDHB shall be claimed.

Board members should consult with the board chair prior to incurring any other form of expense for which reimbursement is to be sought and such reimbursement requires the approval of the board chair. Reimbursement of non-standard items of expenditure by the board chair requires sign-off by the chair of the HBDHB Audit Committee. (**Note:** The board chair will not chair the Audit Committee).

### **BASE REMUNERATION**

#### ***Board***

Board Members' base remuneration is as determined by the Minister of Health from time to time and is currently set at the following rate:

Chair	\$42,000 per annum
Deputy Chair	\$25,500 per annum
Member	\$20,400 per annum

The Ministers letter advising of these rates, and the basis of their calculation is attached as Appendix 1 to this Schedule.

In addition to the base remuneration, the following fees are payable to members of certain committees:

### **Committees**

For the three statutory committees (CPHAC DSAC and HAC), each member is paid \$2,500 per annum. If a member attends less than 10 meetings per annum, the fee is pro-rated. Effectively, this equates to \$250.00 per meeting and the fees are paid in this way, with a check before the end of the financial year in April to ensure that total payments do not exceed \$2,500 for any member of any committee for which fees are payable. For the chairs of these committees, the payment is \$3,125 per annum or \$312.50 per meeting.

These committee fees have applied since the initial HBDHB Board came into office in December 2001 and were most recently amended as part of the Cabinet Office Circular CO(09)5: Fees Framework for Members Appointed to Bodies in which the Crown has an interest. These rates remained unchanged in CO(12)6.

Fees are also payable to members of the board's discretionary committees, the Finance Risk and Audit Committee and the Maori Relationship Board (including Board members), on the same basis as the above three statutory committees. If a member of any of HBDHB's board committees (statutory or discretionary) does not attend a committee meeting, they will not be entitled to payment for that meeting.

Meetings fees will be authorised by the Board Administrator who will check that no more than the maximum annual fee is paid in a financial year. Where a board member attends a committee for which no fee is paid the abbreviation "ANP" (attended not paid) will be entered on the attendance sheet. This is necessary so that accurate meeting attendance is recorded for the annual report.

### **LEAVE**

Where an individual receives an annual fee and is absent from board business for a period of greater than two (2) months then the annualised fee should be pro-rated to take account of this absence. (refer to Fees Framework, CO(12)6 para 70)).

### **WORK RELATED EXPENSES**

#### **Mileage and Parking**

Board Members may claim vehicle use and reimbursement of parking charges incurred in the course of their board duties. Payment for vehicle use will be calculated at the current IRD approved rate of 72 cents per kilometre.

#### **Taxis and rental cars**

Where appropriate or more economical, taxis or public transport may be used. Hawke's Bay DHB may provide vouchers for this purpose. It is not expected that Board Members will have the need to hire a vehicle for transportation. Should such a need arise; this should be approved in advance by the Board Chair.

## Telephone

*Board Members:* Telephone line rental is not reimbursed. Members may claim for any significant telephone charges for calls that are required to be made for purposes related to the performance of their duties.

*Board Chair:* HBDHB will provide a mobile phone for the board chair and pay for the rental and call charges on the basis that the phone is used predominantly for board-related business.

**Note 1:** As the board does not contribute to the costs of the chair's home phone, fax or internet connection (which are on occasions used for board business) it is not considered that any net benefit derives to the board chair for this arrangement.

**Note 2:** This arrangement also avoids the need for administrative processing and reconciliation of transactions that have relatively small costs attached.

## Travel out of Hawke's Bay

Board members may claim actual and reasonable travel, accommodation and meals expenses for meetings or functions elsewhere in New Zealand attended in their official capacity as board members.

Whenever practicable, bookings for air travel, accommodation and training courses should be made through HBDHB (via Corporate Office) so as to obtain the best discounted rates.

Where travel or other costs are incurred for the purpose of both HBDHB and another organisation, a fair apportionment shall be made between organisations, and only that part attributable to Hawke's Bay DHB shall be claimed.

Board members are governed by the same requirements that apply for travel by DHB staff, namely:

- Under normal circumstances air travel will be by economy.
- Travel tickets cannot be cashed in.
- An authorised airfare for business travel must not be exchanged or part exchanged for lower fares to enable a non-employee or partner to accompany the employee.
- Whenever practicable, air points accumulated by members through HBDHB business travel shall be used at the earliest opportunity for further business travel.
- For Airline Travel Clubs, HBDHB's policy for staff is that where an employee is required to undertake significant air travel as part of their role (at least 10 times per year) Airline Club membership will be subsidised by the organisation. The same consideration will be given to board members.

**Note: this is expected to apply to the board chair only**

- Accommodation is to be at an acceptable level and reasonable rates having regard to the public service nature of the office.
- HBDHB will meet reasonable personal telephone expenses but hotel phone usage should be kept to a minimum.
- HBDHB will meet reasonable daily expenses for items associated with travel out of Hawke's Bay such as taxis, parking, meals, etc. Such claims must be supported by receipts.
- Short term car parking facilities where the cost of parking accrues daily must not be used for extended periods. Airport parking should be restricted to the travel period only.
- HBDHB will not pay for or reimburse expenses for alcohol, video, dry cleaning, or laundry services.

**Overseas travel**

It is not expected that board members will be required to undertake overseas travel in the normal course of their duties. Any such travel must be explicitly approved by the full board.

**Training and conferences**

The board has a designated training budget for board development. In most cases this is issued for training relating to the legislative and governance requirements for board members.

Such training is paid for in full (and in most cases organised by) HBDHB using training providers approved by the Minister of Health. Additional requests for training by board members will be identified by the board chair during annual board Member's performance reviews and allocated fairly by the board chair up to the limit of the designated budget.

**Membership of Business/Professional Organisations**

HBDHB will not pay, contribute to or reimburse the membership fees for any business or professional organisations to which individual board members belong.

**Entertainment Expenses**

The board chair may need to incur entertainment expenses when acting for or representing the board. Should such a need arise, expenses are expected to be in keeping with the public service nature of the office. Reimbursement of such expenditure requires sign-off by the chair of the Finance Risk and Audit Committee. Expenditure above \$500 should have prior approval of the Chair of the Finance Risk and Audit Committee.

**Note: The Board Chair may not be elected Chair of the Finance Risk and Audit Committee**

Whenever practicable/appropriate, HBDHB facilities should be used for providing hospitality to business stakeholders.

It is not expected that other board members will incur expenses for entertainment. In the unusual event that such a need does arise (e.g. when formally acting on behalf of the board or the board chair) this must be discussed in advance with the board chair and be specifically approved by the board chair and/or chair of the Finance Risk and Audit Committee.

**Gifts, Koha and Donations**

It is not expected that board members will be offered or receive gifts or donations when acting in their capacity as individual members. Should such offers be made or any gifts be received they should be discussed with the board chair (or in the case of the board chair, the chair of the Finance Risk and Audit Committee) who will determine how to respond.

Gifts or donations to the DHB, accepted on the board's behalf by individual board members, are the property of the DHB.

The only exceptions are small gifts (eg bottle of wine; a diary) worth less than \$50.00.

Board members are governed by HBDHB's policy on Koha. Board members should not provide gifts or donations except when acting on behalf of and expressly authorised by the board.

Board members and staff should note that under section 135 of the CE Act they are "officials" for the purpose of sections 105 and 105A of the Crimes Act 1961 relating to bribery and corruption.

For further information please refer to State Services Commissioner Memorandum to all Chief Executives – <http://www.ssc.govt.nz/guidance-acceptance-of-gifts>.

**“Company” Credit Card**

Under no circumstances will any board member or the board chair be provided with or have personal use of a HBDHB credit card.

**PROCESS FOR CLAIMING PAYMENT OF FEES AND EXPENSES****1. Standard Payment**

Base remuneration is paid monthly (one twelfth) by automatic direct credit into individual board member’s bank accounts. Payments for newly elected members commence with a full month’s payment in December of the year they are elected.

Additional meeting fees and mileage allowance for meetings in Hawke’s Bay are regarded as standard payments to be claimed monthly using the *Board and Committee Members’ Attendance and Expenses Claim Form*. Fees for statutory advisory committee meetings are based on attendance and a form will be circulated to attendees at each meeting for signature. Attendance is also checked against the minutes of the meeting. A register of attendance is maintained by the Board Administrator and in April each year there will be a check to ensure that no members receive payment for more than ten (10) meetings for each committee for that year (i.e. more than \$2,500 pa).

Standard payments (covering base remuneration, meeting fees and local mileage) are made each month by direct credit into individual board member’s bank accounts. A remittance advice is sent to members showing the calculation of the net amount lodged into their account each month.

The board chair will review the standard payments made to members each month, including mileage claims. **Note:** this may be on a retrospective basis.

**2. Non-standard items**

For other, non-standard items (travel outside Hawke’s Bay, meals, accommodation, courses etc) the standard HBDHB forms should be used: the form for Approval of Travel and Accommodation, and the *Board and Committee Members’ Meeting and Travelling Expenses Claim Form*. Original receipts should accompany all claims for reimbursement of expenses (credit card receipts are not sufficient). For board members, reimbursement of such expense claims require the approval of the board chair and should be discussed with the board chair before they are incurred. For the board chair, reimbursements for non-standard expense claims are to be signed off by the chair of the Finance Risk and Audit Committee.

**BUDGET AND MONITORING OF BOARD EXPENDITURE**

A separate budget will be set for all board expenditure. This will be reviewed and subsequently monitored against actual expenses by the Finance Risk and Audit Committee at least every six (6) months.

**TAX TREATMENT OF FEES AND ALLOWANCES**

In November 2010, advice was received from Audit New Zealand, now attached as Appendix 2 to this Schedule.

In summary this advice states:

- “In general, payments for work or services performed by members of boards, councils and committees are subject to withholding tax at the rate of 33%”; and
- No tax is deducted from mileage allowance payments.



## Office of Hon Tony Ryall

Minister of Health  
Minister for State Owned Enterprises

### APPENDIX 1 to Schedule 4

Kevin Atkinson  
Chair  
Hawke's Bay District Health Board  
Private Bag 9014  
HASTINGS 4156

26 JUL 2013

Dear Kevin

In December 2012, Cabinet approved an updated *Fees framework for members appointed to bodies in which the Crown has an interest* CO (12) 6. The new Fees Framework brought district health boards (DHBs) within the general classification for all governance boards, altering the mechanism by which fees are set and reducing the anticipated time requirements.

All DHBs have been reassessed under the new Fees Framework, and I have used this opportunity to review the fees payable to the DHB boards. Fees for DHB members have not been amended since 2006. Since that time inflation has increased by 16.4 percent, the median salary for resident medical officers has risen by 15.3 percent and nurses by 17.6 percent.

With agreement from the Minister of State Services, I have decided to increase the annual fees payable to DHB Chairs by 5 percent, and for members and Deputy Chairs by 2 percent. This increase is effective as of 1 July 2013. This represents an annualised increase since 2006 of 0.28 percent for members and 0.7 percent for the Chair.

For Hawke's Bay DHB, the new annual rates will be \$42,000 for the Chair, \$25,500 for the Deputy Chair and \$20,400 for members.

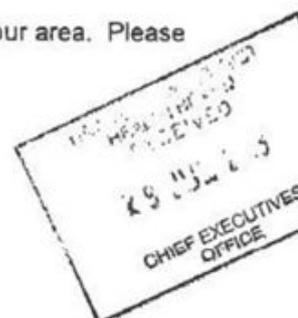
This fee increase is made in recognition of the increased responsibilities DHBs have taken on since the last time DHB fees were reviewed, both in the budget and assets they are required to manage, and the level of services they are required to oversee. DHB budgets have increased by approximately 50 percent and staff numbers by 16.7 percent.

It should be noted that DHB boards are now remunerated for an expected annual workload of 30 days for members and 50 days for Chairs, excluding work relating to the three statutory advisory committees and the DHB's Audit Risk and Finance committee (or its equivalent). The rates for these committees are not affected by this increase.

Thank you for your ongoing contribution to improving health services in your area. Please advise the members of your Board about this change.

Yours sincerely

Hon Tony Ryall  
Minister of Health



Cc Dr Kevin Snee, CEO, Hawke's Bay District Health Board

## APPENDIX 2 to Schedule 4

## Tax treatment of allowances paid to members of boards, councils, and committees

Jason Biggins, Director, Tax - November 2010

The Income Tax Act 2007 has recently been amended to provide further clarity regarding the taxation of payments to members of boards, councils, and committees. The list of schedular payments has been expanded to include the following:

*A payment has a 0.33 rate of tax for each dollar of the payment, if it is for work or services performed by—*

- a. *a local government elected representative:*
- b. *an official of a community organisation, society, or club:*
- c. *a chair or member of a committee, board, or council:*
- d. *an official, chair, or member of a body or organisation similar to one described in paragraph (b) or (c).*

In general, payments for work or services performed by members of boards, councils, and committees are subject to withholding tax at the rate of 33%, unless Inland Revenue has issued an exemption certificate or special rate certificate.

Payments to members of board, councils, and committees were previously included in the honoraria category. The honoraria category of the withholding tax regulations referred to payments made to members of statutory boards, councils, committees, and other similar bodies. This amendment removes payments made to these individuals from the honoraria category and creates a new payment category.

As the new category refers to payments for work or services (rather than all payments), allowances and reimbursements paid to members of boards, councils, and committees are no longer subject to

tax deduction. A significant number of public sector entities have previously deducted tax from mileage allowances paid to members of boards, councils, and committees. These entities can now stop deducting tax from these payments.

It is important to note that mileage allowances paid to members of boards, councils, and committees are still regarded as taxable income. However, in most cases, this income would be offset by a deduction for motor vehicle expenses. As a result, any tax deducted from the allowances in the past will generally be refunded or credited against other tax liabilities when the board, council, or committee members file their tax returns.

Fiona

### Fiona Elkington

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## Schedule 7: Templates

- [Governance Work Plan](#)
- [Board Induction and Training Register](#)
- [Interests Register](#)
- [Gifts and Hospitality Register](#)

Governance Manual 2019 - Schedule Seven: Templates

GOVERNANCE WORKPLAN PAPERS									
26-Oct-21									
BOARD MEETING 30 OCTOBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Sept)		Carriann Hall	Chris	15-Oct-19				30-Oct-19	30-Oct-19
Shareholder representatives for Allied Laundry and TAS meetings each year		Ken Foote		15-Oct-19					30-Oct-19
Te Ara Whakawaiaora - Access Rates 45 -64 years (local indicators) ADULT HEALTH		Chris Ash	Kate Rawstron	1-Oct-19	10-Oct-19				30-Oct-19
Quarterly Report to the Minister of Health (July 19-Sept 19) October 19 Board		Carriann Hall							30-Oct-19
Management Workplan		Craig Climo							30-Oct-19
Induction Package for New Board members		Ken Foote							30-Oct-19
2020/21 Planning Process & Timetable		Craig Climo							30-Oct-19
Cost Savings		Craig Climo							30-Oct-19
BOARD MEETING 27 NOVEMBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Oct)		Carriann Hall	Chris	19-Nov-19				27-Nov-19	27-Nov-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept) last one in cycle	E	Wayne Woolrich	Jill Garrett						30-Oct-19
HBDHB Non-Financial Performance Framework Dashboard Q1 - EMT/Board	E	Chris Ash	Peter MacKenzie	19-Nov-19					27-Nov-19
HBDHB Performance Framework Exceptions Q1 Feb19 /May/Aug/Nov (Just in time for MRB Mtg then to EMT)	E	Chris Ash	Peter McKenzie	12-Nov-19					27-Nov-19
People Safety & Wellbeing report	E	Kate Coley						27-Nov-19	27-Nov-19
BOARD MEETING 18 DECEMBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Nov)		Carriann Hall	Chris	10-Dec-19				18-Dec-19	18-Dec-19
VIP/Family Harm report		Bernard Te Paa	Patrick le Geyt	3-Dec-19	11-Dec-19				18-Dec-19
Electives - Status to public & referers		Craig Climo							18-Dec-19
Laboratory Negotiations update		Chris Ash	Di Vicary						18-Dec-19
BOARD MEETING 26 FEBRUARY 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Alcohol Harm Reduction Strategy (6 monthly update) Feb - Aug		Bernard TePaa	Rachel Eyre	28-Jan-20	12-Feb-20	12-Feb-20	13-Feb-20		26-Feb-20
Finance Report (Dec)		Carriann Hall	Chris	18-Feb-20				26-Feb-20	26-Feb-20
HBDHB Non-Financial Performance Framework Dashboard Q2 - EMT/Board	E	Chris Ash	Peter MacKenzie	18-Feb-20					26-Feb-20
HBDHB Performance Framework Exceptions Q2 Nov 18 Feb 19 /May/Aug 19 (just in time for MRB mtg then to EMT)	E	Chris Ash	Peter McKenzie	11-Feb-20					26-Feb-20
Ngatahi Vulnerable Children's Workforce Development - annual progress Feb 20 (annual update)		John Burns	Russell / Bernice Gabriel	24-Mar-20	8-Apr-20	8-Apr-20	9-Apr-20		26-Feb-20
People Safety & Wellbeing report	E	Kate Coley		18-Feb-20				26-Feb-20	26-Feb-20
Quarterly Report to the Minister of Health (Oct 19-Dec 19) Feb 20 Board		Carriann Hall							26-Feb-20

**Board Induction and Training Register - Sample**

Board Member Name	Date came into office	Familiarity with: ✓ / x				Training:					
		Obligations and Duties of a board member	Maori health issues	Treaty of Waitangi issues	Maori groups/ organisations in the district	Training Required	Training undertaken	Date training expected to start	Date training started	Date training expected to be completed	Date training completed

**HBDHB Employee and Agent Declaration of Interests / Conflicts of Interest**

**Name:** \_\_\_\_\_

Refer to [I:\HBDHB Interests and Conflicts of Interest Register](#)

Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to HBDHB	Mitigation Actions - To be completed by relevant Manager or leader

**1. I declare the above information to be complete and correct**

**2. Mitigation Actions discussed / agreed by:**

**Name/Signed** \_\_\_\_\_

**Name/Signed** \_\_\_\_\_

Name Signed

Name Signed

**Date** \_\_\_\_\_

**Date** \_\_\_\_\_

**3.** Entered into the Interests / Conflicts of Interest Register by \_\_\_\_\_ Date \_\_\_\_\_

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**Board Gifts and Hospitality Register - Sample**

Board Member Name	Current Status	Description of Gift/Hospitality	Estimated Value (\$)	Name of Donor (offered by)	Name of Recipient (offered to)	Date of Donation/ Receipt	Receipt/ Donation Approved By	Means of Disposal (decision regarding gift)



## **Schedule 8: Board Forms and Documents**

- [Board and Committee Member Declaration of Interest/Conflict of Interest](#)
- [Gifts and Hospitality Disclosure Form](#)
- [Board - CEO Linkage](#)

## **BOARD AND COMMITTEE MEMBERS DECLARATION OF INTEREST/ CONFLICTS OF INTEREST**

**This form is to be used by all persons who are to be (or have been) appointed to Hawke's Bay District Health Board (HBDHB) Board or Governance Committees.**

The New Zealand Health and Disability sector is an inherently close community, where people with specialist skills and knowledge are in high demand. Conflicts of Interest, both actual and potential are an inevitable result of this environment. The existence of conflicts is not itself a cause for concern, provided that they are managed in an appropriate manner.

This declaration is required to enable conflicts to be managed within HBDHB in such a way that reflects the key public service principles of impartiality and transparency. Full and open disclosure will also ensure compliance with all legal, ethical and good practice requirements.

**PLEASE COMPLETE THE ATTACHED DECLARATION FORM WITHIN THIS CONTEXT, USING THE DEFINITIONS AND EXPLANATORY NOTES BELOW.**

### **INTEREST**

Identify any interests (public, private or personal) from which you gain real, potential or perceived benefit, either financial or non financial, that have the potential to overlap with your DHB role.

- An advisor, employee, director, trustee or office holder of another business or organisation
- A major shareholder in a company, or owner of a business
- A member of a professional body, industry forum, trade association etc
- Close family affiliations with anyone working in the health sector.

### **CONFLICTS OF INTEREST**

**A Conflict of Interest exists** if the answer is YES to any one of the following questions:

- Could your duties or responsibilities to HBDHB be affected by any duty to (or involvement in) any of your other interests?
- Could your other interests create an incentive for you to act in a way that may not be in the best interests of HBDHB?
- Might an outside person reasonably perceive that in carrying out your duties or responsibilities to HBDHB, you could be influenced or could be perceived to be influenced by your other interests?

**A Conflict does not exist if:**

- Your interest is so remote or insignificant that it cannot be regarded as likely to influence you in carrying out your duties.

**If in Doubt:**

- Err on the side of caution and declare it, or seek guidance from HBDHB Company Secretary

### **AMENDMENTS TO INTERESTS**

This form should be used for declaring any amendments to existing interests at any time. The cessation or expiry of any recorded interests or conflicts of interest must be advised:

- In writing to the Company Secretary; or
- Raised verbally at a meeting of the Board or Committee and recorded in the minutes.

**Declaration of Interests / Conflicts of Interest**

**Name:** \_\_\_\_\_

Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to HBDHB

**I declare the above information to be complete and correct**

**Signed** \_\_\_\_\_

**Date** \_\_\_\_\_

**Appendix 1**

**Gifts and Hospitality, Other Benefits Disclosure**

I confirm the offer/acceptance of a gift or hospitality set out below

1. NATURE .....

2. ESTIMATED VALUE .....

3. PERSON OR COMPANY NAME PROVIDING GIFT/HOSPITALITY .....

4. CIRCUMSTANCE OF THE OFFER .....

5. REASON FOR ACCEPTANCE .....

6. ANY OTHER INFORMATION WHICH THE RECEIVER OF GIFT, HOSPITALITY OR OTHER BENEFIT FEELS IT APPROPRIATE TO PROVIDE .....

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

NAME \_\_\_\_\_

STAFF ID: \_\_\_\_\_

DATE HOSPITALITY/GIFT RECEIVED: \_\_\_\_\_

<p><b>Office Use:</b></p> <p>APPROVING MANAGER SIGNATURE _____ NAME: _____</p> <p>DATE _____</p> <p><b>Note: Please forward this completed form to the HBDHB Company Secretary for entering into the Register.</b></p> <p>COMPANY SECRETARY SIGNATURE _____ DATE: _____</p> <p>DISCLOSURE NUMBER _____</p>
--

## Board – CEO Linkage

### HAWKE'S BAY DISTRICT HEALTH BOARD

The board's linkage to the operations of the organisation is through the CEO.

Only decisions of the board are binding on the CEO. Accordingly:

- Decisions or instructions of individual board members or committees are not binding on the CEO unless the board has specifically delegated such authority.
- Recognising the right of individual board members to access information relevant to their governance responsibilities, the CEO can defer requests that, in the CEO's opinion, require a material amount of staff time or funds, or are disruptive. The CEO will immediately notify the chair of the use of this provision.

The board delegates to the CEO responsibility for implementation of its policies and decisions while complying with the boundaries and constraints imposed by the Delegation of Board Authorities Policy. Accordingly:

- The board will develop policies and make decisions that make clear the results/outcomes to be achieved.
- The board will develop a Delegation of Board Authorities Policy that limits the latitude of the CEO in choosing organisational means, offering boundaries of prudence and ethics.
- The CEO is responsible for the employment, management and performance evaluation of all staff employed/contracted to the organisation.
- Neither the board nor individual board members will 'instruct' staff in any matters relating to their work.
- The board's performance evaluation responsibilities are restricted to the CEO. The board will refrain from evaluating, either formally or informally, any staff other than the CEO.
- Always with the proviso that the CEO's decisions must be consistent with and not defeat the stated intent and the spirit of the board's policies, he/she is authorised to establish all operational policies, decisions, practices, and activities.
- The board may change its policies, thereby shifting the boundary between board and CEO domains. By doing so, the board may change the latitude of choice given to the CEO. But as long as any particular delegation is in place and the CEO can demonstrate compliance with the intent and spirit of the board's policies, the board will respect and support the CEO's choices.
- The expert knowledge and experience of individual board members is available to the CEO.

**CEO Performance**

The CEO's performance will be continuously, systematically and rigorously assessed by the board against achievement of its policies and compliance with the Delegation of Board Authorities Policy. The board will provide regular performance feedback to the CEO.

The purpose of monitoring the CEO's performance is to determine the extent to which the board's policies are being met. Only information relevant to the board's policies will be considered to be monitoring data.

The board will acquire monitoring data by one or more of three methods:

- (a) by direct CEO reporting to the board;
- (b) from an external, disinterested third party selected by the board to assess compliance with board policies, and/or
- (c) by direct board inspection, in which a designated board member or board members assess compliance with the appropriate policy criteria.

In every case, the standard for compliance shall be that the CEO has met or can demonstrate compliance with the intent or spirit of the board policy being monitored.

There will be an annual formal appraisal of the performance of the CEO. The timing, format and process for this meeting will be negotiated between the CEO and the board at the beginning of the performance monitoring period.

A board committee may assist the board in this process which may make recommendations to the board.

All policies that instruct the CEO will be monitored at a frequency and by a method chosen by the board. The board may monitor any policy at any time by any method, but will ordinarily depend on a routine schedule.

If at any time the board engages an outside evaluator to assist the board to conduct an assessment of the CEO's performance, the process must be consistent with this policy. Any such evaluator is a contractor to the board, not the CEO.

## **Schedule 9: HBDHB Board Policies**

- [Communications Policy – Board and Board Members](#)
- [Delegation of Board Authority \(Nov 2015\)](#)
- [Gifts, Hospitality and Other Benefits \(Nov 2015\)](#)
- [Sensitive Expenditure Policy \(Aug 2016\), for all staff](#)
- [Payment of Fees and Expenses \(Dec 2013\)](#)
- [Health & Safety Policy \(September 2018\)](#)
  - [Board Health & Safety Champion – Role Description](#)

## Communications Policy – Board and Board Members

### PURPOSE

Communications encompasses all forms of communication and interactions. This policy applies to the board of Hawke's Bay District Health Board. It encompasses the following:

1. The strategic purpose of the board's communications
2. The board's communications principles and process
3. The formal Delegations that underpin the policy.

Communications is the process by which the board and communities can share information, knowledge and experience in the development of health and disability services within the District. This policy outlines the key principles and process that will underpin an effective communications process.

### PRINCIPLES

Board members will respect their role in providing a community voice to the activities of the District Health Board. Equally, however, board members will recognise that the organisation through the mandate of the board will have processes in place to seek public consultation, prioritise resources, establish waiting lists and times and respond to consumer complaints etc. To this end:

- The board's communications will be consistent with government policy and national health and disability strategies.
- Views communicated by the board will support the principle of a politically neutral public sector.
- Information provided to the community by the board will reflect the collective view and responsibility of the board.
- Board members will refrain from acting in public in a manner that undermines other board members and will not act for self-promotion purposes at the expense of the image of the DHB itself.
- The board will be proactive in keeping the population within the District informed on issues relevant to their health and disability services.
- The communications process will recognise and value the knowledge and contribution that the community can bring to the development of health and disability services.
- Communications will be responsive to public concerns and work in support of the public interest.
- The Community, and all interested parties, should be able to place reliance on the accuracy of the information provided, and to derive clarity and assurance from the information and the integrity of the process for engagement.
- Communications will be adapted to the needs of the audiences within the District and will recognise and respond to the different cultural perspectives within the community.
- Communications will give particular attention to hard to reach groups and to those groups who have the most ability to benefit from better access to and engagement with services
- Communications will draw on the board's own community networks and experience to inform communications planning and understanding.
- The communications process will underpin community engagement with the District Annual Plan and the priorities outlined in the plan.
- Communications will be consistent with the obligations to respect personal and patient privacy, and commercial confidence.
- The board will exercise care and judgement when commenting on unresolved policy or matters of public debate.
- Board members will distinguish clearly to their audience whether they are speaking personally and communicating their own views, or whether they are speaking on behalf of the board and conveying policy decisions taken by the board.

**PROCESS**

The board's communication process will provide an opportunity at regular intervals for the board to reflect on the major issues that are likely to be priorities for the community and to consider the communications process for best meeting the needs of the community.

The board will identify the major communications priorities for the 12 month period based on the priorities in the District Annual Plan. The priorities will be reviewed regularly, most likely on a quarterly basis.

The board will be supported by the Communications and Media Manager.

**DELEGATIONS**

The Chair of the board is the spokesperson for the board. The Chair may at their discretion, delegate the authority to act as spokesperson to another member of the board on a specific issue or in certain circumstances, for a defined period of time, or ongoing. The Chair will specify the extent and scope of the delegation at the time of making the delegation.

**COMMUNITY AND STAKEHOLDER COMMUNICATIONS**

Board members are actively encouraged as part of the work of the board to be part of a two way process in which the board can provide information to and get feedback from the community.

Board members may participate in and accept invitations to speak at a wide range of public forums on matters where there is an agreed policy. However, board members will consult the Chair and seek approval prior to making public comment on an issue where the board either does not yet have an agreed policy or where the issue is of significant public concern that the board needs prior opportunity to consider its collective view.

Board members will endeavour to comment publicly only on policy and governance matters for which they are responsible, and to leave public comment on operational and management matters to the Chief Executive and management according to HBDHB's Media Relations Policy.

The board and board members will consult the Communications and Media Manager to ensure that communications on major issues are co-ordinated with other DHB communications activity.

**MEDIA COMMUNICATIONS**

The DHB recognises the freedom of board members to communicate with the media, but board members agree that in doing so they should do so in a manner consistent with the principles of the board's Code of Conduct and Ethics and HBDHB's Media Relations Policy.

All communications with or through the media will be in accordance with HBDHB's Media Relations Policy. This Policy covers public speaking where media may be present. Board members and Advisory Committee Members may only speak on behalf of the DHB if authorised to do so in accordance with the Media Relations Policy. The Communications and Media Manager should be consulted before any approach or response is made to the media.

**PATIENT COMMUNICATIONS**

Board members will respect the DHB's processes in place to respond to consumer feedback and complaints. To that end board members will:

- Advise residents/health consumers, who desire personal matters to be brought to the attention of the District Health Board, to follow the proper procedure for raising issues and registering complaints;
- Not advocate on behalf of an individual beyond advising them of the complaints procedure and later checking that the matter has been addressed satisfactorily by the organisation. ('Satisfactorily' refers to the procedures followed by the organisation in addressing the matter, not necessarily whether the outcome is as the individual would wish.); and
- Not make commitments for board related work or expenditure which have not been previously approved by the DHB, nor create any liability for the DHB beyond authorised delegations.

#### **STAFF COMMUNICATIONS**

Board members will have access to the Chief Executive on DHB activities, and will interface with management at Board and Committee meetings. Any meetings or communications with management and other staff outside board and Committee meetings should be with the consent of the Chair and the Chief Executive.

Board members will:

- Be supportive of employees of the DHB, and will criticise neither employees nor the service provided by the DHB in public. Any concerns board members might have will be raised with the Board and/or Chief Executive, as appropriate;
- Exercise judgement and courtesy in respecting the protocol of communicating through the Chair and Chief Executive, (as appropriate), in raising matters with the Chief Executive and/or senior staff;
- Not attempt to influence any employee of the DHB to present material in a particular way, such that it might affect the outcome of a decision to be made by the board; and
- Exercise care in communicating privately with employees of the DHB, and will refer any staff with complaints or concerns back to the Chief Executive.



## Board Delegations Policy (Oct 2015)

<b>HAWKE'S BAY DISTRICT HEALTH BOARD</b>	Manual:	Operational Policy Manual
	Doc No:	HBDHB/OPM/024
	Date Issued:	November 2001
	Date Reviewed:	October 2015
<b>Board Delegations Policy</b>	Approved:	Ministry of Health
	Signature:	N/A
	Page:	1 of 15

### PURPOSE

The purpose of this Board Delegations Policy (the BDP) is to:

- provide guidelines regarding the appropriate use of delegated authority;
- raise awareness of the actions (and responsibilities) that are expected of a person who holds a delegated authority; and
- outline the delegated authority control framework and the consequences of exceeding delegations.

### What is Delegated Authority?

Delegated authority refers to the transfer of the right or power to make binding decisions on behalf of Hawke's Bay District Health Board (the DHB) in defined circumstances and within certain limits

### SCOPE

The BDP has been widened in scope from the National Delegated Financial Authority Policy. The following are included in this BDP that would be excluded from the National Delegated Financial Authority Policy:

1. Human Resources – including, but is not limited to, the following processes:
  - Staff recruitment and appointments;
  - Salary increases covering Multi-Employer Collective Agreements and Individual Employment Agreements;
  - Service reviews and restructuring; and
  - Grievance and termination payments.
2. Communications and media – delegations to staff to determine who may discuss issues with the media or other external parties.
3. Statutory delegations – this policy identifies the statutes and regulations that include functions and powers that may be delegated by the Board.

### EXCLUSIONS

The following areas are specifically excluded from the scope of this BDP. However, it is important to note that any expenditure arising from decisions made in these areas come within the scope of the BDP:

1. Board and Committees – the Board of the DHB (the Board) may delegate any of its responsibilities to an advisory committee;
2. Contract management – the establishment of sound contract management practices within the DHB;

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3. Financial governance – activities associated with financial management at a governance level;
4. Sub-delegations and processes set out in other DHB policies.

## PRINCIPLES

The following principles apply to the BDP.

### *DHB and DHB Board functions, duties and powers*

The DHB is a body corporate owned by the Crown and established under section 19 of the New Zealand Public Health and Disability Act 2000 ("the NZPHD Act"). Under the NZPHD Act and the Crown Entities Act 2004 ("the CE Act") the DHB and the Board have a number of functions, duties and powers. The NZPHD Act:

- a. requires the Board to delegate to the DHB's chief executive the power to make decisions on management matters relating to the DHB (section 26(3) );
- b. requires the Board to formulate, keep under review and amend or replace (as it considers appropriate) a policy for the exercise of its powers of delegation (clause 39(1) of Schedule 3); and
- c. expressly authorises the Board to, by written notice, delegate any of the functions, duties or powers of the Board or of the DHB (clause 39(5) of Schedule 3)

Every exercise by the Board of a power of delegation must comply with the BDP (clause 39 (3) of Schedule 3 of the NZPHD Act).

### *Matters not to be delegated by the Board*

The Board reserves all its powers with the exception of those specifically delegated under the BDP.

The Board may, by written notice to any member of the board or employee of the DHB, or person or class of persons approved by the Minister of Health for the purpose, delegate to that member, employee, person, or class of persons any of the functions, duties, or powers, of the Board.

## APPLICATION OF BOARD DELEGATIONS POLICY

### *Public Expenditure*

- a. All expenditure by a public entity is the spending of public money. Consequently, the expenditure should be:
  - i. subject to the standards of probity and financial prudence that are to be expected of a public entity, including value for money; and
  - ii. able to withstand Parliamentary and public scrutiny.
- b. The delegations in the BDP must be exercised in accordance with all other DHB policies.
- c. When exercising their Delegated Authority, delegates are responsible for ensuring that:
  - i. They can justify the business reason for the transaction;

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- ii. The transaction is of a type permitted under their Delegated Authority;
- iii. Payments are only for amounts the DHB has committed to pay and that the balance due is known or can be reasonably estimated; and
- iv. The expenditure is actual, reasonable and within approved budget expenditure limits.

#### ***Sub delegations***

- a. The Chief Executive Officer is authorised to:
  - i. sub delegate his or her powers, duties or functions; and
  - ii. make changes to delegation levels within his or her operational control.
- b. General Managers may sub-delegate their authority where it is permitted in the appendices to this policy.

#### ***Temporary Delegations***

- a. Wherever authority delegate takes leave or is going to be absent for a significant period of time they should decide whether another person requires temporary delegated authority to ensure continuation of the service.
- b. Such temporary delegation must be recorded in writing and detail:
  - i. The length of time the delegation authority is to be in force; and
  - ii. The position it applies to.
- c. The temporary delegation granted by the manager must be approved by the General Manager or, in the case of a General Managers' delegation, the Chief Executive Officer.

#### ***One up Principle***

- a. The one up principle must apply in all circumstances. This principle means that no person may approve timesheets, leave, expenditure, benefits etc. that relates to themselves. In all such instance, the person's manager must give approval.

#### ***Matters of Urgency***

- a. If a decision is required urgently on a matter not covered by the BDP, the matter should be discussion should be referred to the General Manager Planning, Informatics and Finance or Chief Executive Officer. They may refer the matter to the Board Chairperson. The Chairperson will have the Board's delegated authority to make decisions in such circumstances and will subsequently report any such decision to the Board.

#### ***Approval Limits***

- a. The approval limits stated in the BDP are in New Zealand Dollars and are exclusive of GST or any other such taxes or levies, as may be imposed.

#### ***Conflict of Interest***

- a. Those exercising delegations under the BDP must be aware of the Conflict of Interest Policy (PPM070.)

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**CONSEQUENCES OF NON-COMPLIANCE**

- a. Any person who exercises any of the delegated authorities set out within the BDP must do so in accordance with the BDP. Any action taken to circumvent the delegated authorities specified within the BDP is not acceptable and the DHB may take further action, including any disciplinary action considered necessary in the circumstances.
- b. Any transactions identified must be reported to the General Manager Planning, Informatics and Finance or Chief Executive Officer as appropriate, who must in turn report any substantiated serious breaches to the Board.

**STATUTORY DELEGATIONS**

- a. The Board has functions and powers under various statutes and regulations, in addition to its functions and powers under the New Zealand Public Health and Disability Act 2000.
- b. Such functions and powers may be delegated by the Board in accordance with this policy.
- c. The notice of delegation of such functions or powers will refer to the statutory power or function being delegated. The statutes and regulations that contain such powers and functions include:
  - Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999
  - Archives Act 1957
  - Charitable Trusts Act 1957
  - Children, Young Persons and Their Families Act 1989
  - Civil Defence Emergency Management Act 2002
  - Contraception, Sterilisation and Abortion Act 1977
  - Cremation Regulations 1973
  - Crown Entities Act 2004
  - Disabled Persons Community Welfare Act 1975
  - Education Act 1989
  - Electoral Act 1993
  - Food Act 1993
  - Health (Burial) Regulations 1946
  - Health (Infectious and Notifiable Diseases) Regulation 1996
  - Health (Infirm and Neglected Persons) Regulations 1958
  - Health (Needles and Syringes) Regulations 1998
  - Health (Retention of Health Information) Regulations 1996
  - Health Act 1956
  - Health and Disability Services (Safety) Act 2001
  - Health Entitlement Card Regulations 1993
  - Health Information Privacy Code 1994
  - Health Practitioners Competency Assurance Act 2003
  - Health Sector (Transfers) Act 1993
  - Injury Prevention, Rehabilitation and Compensation Act 2001
  - Land Transport Act 1998
  - Local Government (rating) Act 2002
  - Medicines Act 1981
  - Medicines Regulations 1984
  - Mental Health (Compulsory Assessment and Treatment) Act 1992
  - Mental Health Commission Act 1998

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- Misuse of Drugs Act 1975
- NZ Public Health and Disability Act 2000
- NZPHD (Archives) Regulations 2001
- Ombudsman Act 1975
- Privacy Act 1993
- Public Finance Act 1977
- Public Health and Disability Act 2000
- Public Records Act 2005
- Public Records Act 2005
- Smoke Free Environments Act 1990
- Social Security Act 1964
- Subordinate Legislation (Confirmation and Validation) Act 1991
- Tuberculosis Act 1948
- Venereal Diseases Regulations 1982
- Water Supplies Protection Regulations 1961

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### SCHEDULE OF DELEGATION LEVELS

These are the maximum delegations that can be allocated to each sub delegation group.

#### Schedule of Delegated Authority Levels - Budgeting

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM PI&F	GMs	List A	List B	List C	List D	List E
Approval of Virement:									
<ul style="list-style-type: none"> <li>Within annual operational budget <i>(Transfer of operational budget amounts between cost centres)</i></li> </ul>	Unlimited	\$1M	\$500K	\$250K	\$100k				
<ul style="list-style-type: none"> <li>Outside annual operational budget (i.e. Using contingency or surplus) <i>(Access to the Chief Executive Officers' operational budget to transfer amounts between cost centres)</i></li> </ul>	Unlimited	\$250K	\$100K						

#### Schedule of Delegated Authority Levels - Public Relations

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM PI&F	GMs	List A	List B	List C	List D	List E
Set and change public relations policy <i>(Set and change formal written public relations policy)</i>	Yes	Yes	No						
Comment to media on policy issues and governance <i>(Comments to the media relating in part or full to issues of DHB policy direction or governance)</i>	Yes	No	No						
Comment to media on operational issues <i>(Comments to the media relating in part on operational aspects of the DHB, including implementation of Ministry of Health policy)</i>	No	Yes	Yes	Yes					

Schedule of Delegated Authority Levels - Human Resources

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM P&F	GMs	List A	List B	List C	List D	List E
Approve remuneration or employment terms (including reviews and annual IEA remuneration strategy remits) <i>(Approve employment terms, changes in terms and reviews in collective agreements and Individual Elective Agreements)</i>	No	Yes							
Annual salary increase above budget and remuneration strategy <i>(Approval of salary increases above budget and remuneration strategy levels)</i>	No	Yes							
New, replacement and temporary appointments unplanned <i>(Approval of the appointment of new, replacement and temporary staff)</i>	No	Yes							
Relocation expenses outside Human Resources Policy (within General Expenditure section of this policy) <i>(Approval of relocation expenses outside Human Resource Policy, provided these align with the General Expenditure Section of this policy)</i>	No	Yes	Yes	Yes					
Approval of Senior Medical Officer / Registered Medical Officer expenditure (including locums and medical consultants) (within General Expenditure section of this policy)	No	Yes	Yes	Yes					
Ex-gratia payments (including redundancy and other payments outside collective agreement)	Yes	100K	\$50k						

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Schedule of Delegated Authority Levels – Revenue

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM P&F	GMs	List A	List B	List C	List D	List E
Revenue and Revenue Contracts:									
<ul style="list-style-type: none"> <li>Government funded services (\$ per annum) <i>(Approval of the proposal to receive government funded service revenue. Government funded services revenue includes revenue from government departments such as ACC, Ministry of Social Development and the Ministry of Health)</i></li> </ul>	Unlimited	\$5M	\$3M	\$1M	\$500K				
<ul style="list-style-type: none"> <li>Non-Government funded services (\$ per annum) <i>(Approval of the proposal to receive non-government funded service revenue. Non-government funded services revenue includes revenue from other district health boards, local authorities and other source)</i></li> </ul>	Unlimited	\$3M	\$1M	\$500K	\$250K				
<ul style="list-style-type: none"> <li>Invoices for revenue (not covered by a specific contract) (per annum) <i>(Approval of invoices to receive other revenue where a contract is not appropriate or necessary as determined by policy. This would include incidental claiming, meals on wheels invoicing, non-resident invoicing, pharmacy sales, warehouse sales, course attendance and reimbursement to the DHB)</i></li> </ul>	Unlimited	\$200K	\$100K	\$20K	\$10K				\$10K
Issue of credit notes (other than reissued invoices) <i>(Issuing of credit notes for revenue invoices raised. This is other than in the case where an invoice is then reissued. This does not include where a debt is considered not recoverable)</i>		Unlimited	\$500K	\$250K	\$100K	\$50K	\$10K		\$2K
Write off of bad debt <i>(Writing off of debts that are considered not to be recoverable)</i>	Unlimited	\$250K	\$150K	\$80K	\$50K	\$25K			\$5K

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Schedule of Delegated Authority Levels – General Expenditure

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM P&F	GMs	List A	List B	List C	List D	List E
General operating expenditure, including approval of requisitions/purchase orders/invoices <i>(Approval for all operational expenditure not covered in other categories. Expenditure must be exercised within budget. This includes purchase orders and requisitions. It excludes contracts, employment salaries and wages, and capital expenditure)</i>		>\$500k	\$500k	\$250K	\$100K	\$50K	\$10K	\$2K	
Capital charge <i>(Approval for payment of the capital charge as)</i>	Yes	Yes	Yes		Yes (Head of Finance only)				
Interest expenses & bank charges relating to the national banking & treasury services arrangements <i>(Relating to investment of surplus cash. Additional controls regarding investment are in the Crown Funding Agreement)</i>	Yes	Yes	Yes		Yes (Head of Finance only)				
Consultants - Non-clinical (within approved limits prescribed in this policy) <i>(Approval of the engagement of a consultant. A consultant is defined as a person (or organisation) that provides expert advice professionally. This includes service review/evaluation, accounting advice and legal costs)</i>	Yes	Yes	Yes						

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Schedule of Delegated Authority Levels – General Expenditure

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM PI&F	GMs	List A	List B	List C	List D	List E
Specific expenditures:									
• Electricity, gas, coal, other energy, water <i>(Approval of costs relating to facility utilities.)</i>	Yes	Yes	Yes	Yes (COO Only)	Yes (Facilities Manager Only)				
• Telecommunications <i>(Approval of all operational costs relating to all telecommunication, electronic IT devices and networking.)</i>	Yes	Yes	Yes		Yes (HoIS)				
• NASC packages of care (within limits prescribed in this policy) <i>(Approval of packages of care as determined through an assessment process. Ministry of Health approval may be required for some disability packages of care)</i>	Yes	Yes	Yes	Yes	Yes (Appropriate Service Director)	Yes (NASC Manager only)	Yes (NASC staff only)		
• Litigation settlement costs (within limits prescribed in this policy) <i>(Approval of costs relating to litigation include personal grievances, punitive and cost settlements)</i>	Yes	Yes							
• Write-off of stock/inventory <i>(Approval of changes in the value of cost of stock/ inventory due to impairment or revaluation)</i>	Yes	Yes	Yes		Yes (Head of Finance only)				
Trust funds (within approved trust purposes & limits prescribed in this policy by individual Trust fund Leads)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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Schedule of Delegated Authority Levels – Contract Management

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM P&LF	GMs	List A	List B	List C	List D	List E
<p>Contract Planning Approvals, including extension/rollovers, for supply of goods &amp; services:</p> <ul style="list-style-type: none"> <li>Total contract value (contract terms less than 5 years) (\$ Per annum) <i>(Approval of Budget Funding Proposals from both operational and funder cost centres. This relates to the decision on the nature and impact deliverables of the service.)</i></li> </ul>	Unlimited	\$5m	\$3m	\$1m	\$500k (Head of Strategic Services.)				
<p>Signing of service contracts:</p> <ul style="list-style-type: none"> <li>Approval of Funder/ Provider Purchasing Plans to expend approved contract planning approvals. <i>(Approval of plan to approach the market including contestable processes and providers.)</i></li> </ul>	Unlimited	\$5m	\$3m	\$1m	\$500k (Head of Contracts only.) \$50k others.				
<ul style="list-style-type: none"> <li>Local contracts and services arrangements for operational expenditure. <i>(Approval of contracts and signing.)</i></li> </ul>	Yes	Yes	Yes		Yes (Head of Contracts only)				
<ul style="list-style-type: none"> <li>National service contracts (e.g. Pharmacy, ARC)</li> </ul>	Yes	Yes	Yes		Yes (Head of Contracts only)				
<ul style="list-style-type: none"> <li>Contract terms greater than 5 years</li> </ul>	Yes								
<p>Leases (total value):</p> <ul style="list-style-type: none"> <li>Operating leases (within limits prescribed under this policy)</li> </ul>	Yes	Yes	Yes	Yes	Yes (Facilities Manager)				
<ul style="list-style-type: none"> <li>Finance leases (within General Operational Expenditure Policy.)</li> </ul>	Yes	Yes	Yes		Yes (Head of Finance only)				

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**Schedule of Delegated Authority Levels – Capital Expenditure**

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM P&F	GMs	List A	List B	List C	List D	List E
Value within approved capital budget (subject to the requirements of the Capital Investment Committee and the National IT Board) <i>(Approval of capital budget documentation subject to appropriate approvals)</i>	Unlimited	\$1M	\$500K	\$100k	\$80k				
Value with agreed capital budget swap <i>(Approval of reallocation of capital budget within existing total capital budget)</i>	Unlimited	\$500K	\$250k	\$100k					
Disposal of capital asset (excluding land which requires Ministerial approval) <i>(Disposal of plant, property and other equipment or assets)</i>	Unlimited	\$1M	\$500K						
Value within approved business case for capital expenditure (as specified within the business case) <i>(Approval of capital costs within an approved capital budget document for capital expenditure. This includes construction costs and major capital projects)</i>	Yes	Yes	Yes	Yes	Yes	Yes			

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Schedule of Delegated Authority Levels – Treasury Management

Delegation Descriptor	Board Delegations			Sub Delegations					
	Board	Chief Executive	GM PI&F	GMs	List A	List B	List C	List D	List E
Banking arrangements:									
• Determine bank accounts	Yes	Yes	Yes						
• Determine overdraft/working capital facilities	Yes	Yes	Yes						
• Determine banking/cheque signatories	Yes	Yes	Yes						
Core Term Debt:									
• New facility draw down	Yes	Yes	Yes						
• Existing facility draw down	Yes	Yes	Yes						
• Rollover of existing debt	Yes	Yes	Yes						
• Repayment of core debt	Yes	Yes	Yes						
• Change of debt terms (including interest rate rollovers)	Yes	Yes	Yes						
• Interest rate hedging	Yes	Yes	Yes						
Foreign exchange hedging	Yes	Yes	Yes						
Credit and purchasing cards issuance	Yes	Yes	Yes		Yes (Head of Finance Only)				

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**IDENTIFIED POSITIONS WITH GENERIC DELEGATIONS**

These sub-delegations may be amended by agreement of the Chief Executive Officer.

Department	GM	List A	List B	List C	List D	List E	
Health Services	Chief Operating Officer	Service Director Woman, Children and Youth	Cost Centre Managers	Delegated staff within cost centres	Executive Assistant	Nil.	
		Service Director Older Persons Health					
		Service Director – Oral, Rural and Community					
		Service Director Surgical					
		Service Director – Acute and Medicine Laboratory Manager Pharmacy Manager					
Maori Health	GM Maori Health	Programme Manager	Manager Maori Health	Senior Clinical Workforce Coordinator	Kaumatua	Nil	
Population Health	Director of Population Health		Team Leader/ Population Health Advisor	Delegated staff within cost centres	Executive Assistant	Nil	
			Manager Population Health Programme				Medical Officer of Health
			Population Health Strategist				Pacific Health Development Manager
Human Resources	GM Human Resources			Recruitment Team Leader	Executive Assistant		
			Drs Unit Manager	Education and Development Manager	Payroll Manager		

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Department	GM	List A	List B	List C	List D	List E
Planning, Informatics and Finance	<i>(Already included in table)</i>	Head of Finance  Head of Strategic Services Head of Information Services Procurement and Supply Chain Manager Head of Contracts	Head of Business Intelligence	Head of Planning	Executive Assistant  Chief Pharmacist	Finance Office Manager Finance Administrator
Company Secretary	Company Secretary			Emergency Response Advisor Communications Manager	Board Administrator	

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HBDHB

Board

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## Gifts Hospitality and Other Benefits Policy (Nov 2015)

<b>HAWKE'S BAY DISTRICT HEALTH BOARD</b>	<b>Manual:</b>	Operational Policy Manual
<b>Gifts, Hospitality and Other Benefits Policy</b>	<b>Doc No:</b>	HBDHB/OPM/114
	<b>Date Issued:</b>	November 2015
	<b>Date Reviewed:</b>	
	<b>Approved:</b>	Company Secretary for Executive Management Team
	<b>Signature:</b>	Ken Foote
	<b>Page:</b>	1 of 3

### PRINCIPLE

Hawke's Bay District Health Board (HBDHB) operates as part of the public sector, so the organisation itself, and all employees, must be very careful about accepting favours where there could be perceptions of influence or personal benefit. Staff therefore must not seek or accept favours, gifts, hospitality or other benefits from anyone, or on behalf of anyone, who could benefit from influencing them and HBDHB. Equally, perceptions of personal gain from third parties for 'just doing your job' must be avoided. Such perceptions have the potential to undermine trust in the public sector.

### DEFINITIONS

- A gift is money, service, or product offered to, or received by HBDHB, HBDHB departments/teams or individual employees, for any reason, whilst employed by HBDHB for which no money is paid or service of any kind provided (other than those provided generally to consumers/patients), to the person making the gift.
- Hospitality is the friendly generous reception and entertainment of guests, visitors, delegates etc at events and functions, normally at no cost to the guest.
- Other benefits cover any other gratuitous gesture of a tangible nature, similar to (but not being) a gift or hospitality.

### LAW

It is illegal for HBDHB employees to receive any inducement or bribe as part of any tender, contract, case or other business dealing. If any employee receives such an inducement or bribe, then that employee must refuse the request immediately, and then inform their manager (who shall provide whatever notification to the police as appropriate).

### POLICY STATEMENT

- In general any gifts, hospitality or other benefits must be declined where:
  - it places HBDHB or any employee of HBDHB, under any obligation or perceived influence;
  - the value or nature of a gifts is inappropriate or excessive to the occasion or the reason for it being given;
  - the gift is given in substitution for legitimate payment or remuneration; or
  - a personal benefit or gratuity is offered by a third party for carrying out the HBDHB's functions, participating in activities as an HBDHB representative or undertaking work-related speaking engagements.

*However*

- Gifts, hospitality and other benefits may be accepted in the following circumstances:
  - HBDHB (or an employee on behalf of HBDHB) is presented with a ceremonial gift reflecting a special relationship.
  - infrequent (less than annually) and inexpensive gifts (less than \$50), given to individuals or teams, that are openly distributed by suppliers or patients (for example, pens calendars, boxes of chocolates);

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- genuine offers of appreciation or gratitude; or
- as part of accepted business practices for a public sector organisation.

### CONDITIONS / PROCESS

- Employee shall discuss the acceptance or any gift, hospitality or other benefit with their immediate manager, and managers have the responsibility of ensuring that such gifts, hospitality or other benefits are being declined or accepted in accordance with this policy.
- If it is agreed that a gift over the value of \$50 is to be accepted then the receiver must complete a Gifts, Hospitality and Other Benefits Disclosure Form (**Appendix 1**) and provide it to a higher level manager, who will then sign and forward the Form to the HBDHB Company Secretary who will enter it into the Gifts, Hospitality and other Benefits Register (**Appendix 2**).
- If a manager is unsure about approving the acceptance of any gift, they may refer approval to their General Manager or CEO (as appropriate).

### OWNERSHIP / DISTRIBUTION

The following conditions shall apply to any gifts, hospitality or other benefits accepted:

- Any ceremonial gift presented to HBDHB shall remain the property of HBDHB.
- Any inexpensive gifts received by any individual or team may be retained by the individual or team.
- Any other gift, hospitality or other benefit accepted by an individual due to their position within HBDHB, shall be allocated in a transparent, fair and equitable manner.

### RESPONSIBILITIES

- All staff need to be aware of this policy, and the potential risks associated with accepting gifts, hospitality and other benefits.
- All managers need to be familiar with the principles and processes within this policy, and generally be able to interpret the policy statement when approached by a staff member.
- Service Directors and General Managers need to be fully aware of this policy, and ensure that all staff under their direct management are complying with it.

*The HBDHB Company Secretary:*

- Provides advice on the interpretation of this policy
- Receives all 'Gifts, Hospitality and Other Benefits Disclosure' Forms and enters the relevant details into the 'Gifts, Hospitality and Other Benefits Register'.
- Maintains the Register and makes it available as appropriate.
- Maintains this Policy, and its availability on the HBDHB Intranet.
- Communicates the requirements of this policy through staff notices.
- Annually issues a letter to all staff from the CEO, reminding them of their responsibility as a public sector employee to declare any gifts, hospitality or other benefits received in the past 12 months, if not already done so.

*The Chief Executive Officer:*

- Has ultimate responsibility for declining, or approving any offers of gifts, hospitality or other benefits.

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## Sensitive Expenditure Policy (Aug 16)

<b>HAWKE'S BAY DISTRICT HEALTH BOARD</b>	<b>Manual:</b>	Operational Policy Manual
	<b>Doc No:</b>	HBDHB/OPM/015
	<b>Date Issued:</b>	September 2008
	<b>Date Reviewed:</b>	August 2016
	<b>Approved:</b>	Chief Executive Officer
	<b>Signature:</b>	Dr Kevin Snee
	<b>Page:</b>	1 of 9
<b>Sensitive Expenditure Policy</b>		

### POLICY STATEMENT

This policy is to help HBDHB to make sensitive expenditure decisions which consistently meet the test of Parliamentary and public scrutiny. This will be achieved through:

- a principles-based approach supported by specific policies and procedures
- leading proper and prudent practices by example
- developing procedures that consistently support employees to follow proper and prudent practices and providing appropriate training
- monitoring activities to ensure effective control of sensitive expenditure

All HBDHB expenditure is public spending. It should therefore be subject to standards of probity and financial prudence that are to be expected of any public entity; and able to be justifiable under Parliamentary and public scrutiny. These standards apply the principles that expenditure decisions:

- have a justifiable business purpose;
- preserve impartiality;
- are made with integrity;
- are moderate and conservative, having regard to the circumstances;
- are made transparently; and
- are appropriate in all respects.

This policy is based on good practice guidelines issued in February 2007 by the Office of the Auditor General to control sensitive expenditure, and as such may be used when carrying out performance audits or inquiries under section 16 or section 18 respectively of the Public Audit Act 2001, or in annual financial audits.

### DEFINITIONS

Sensitive expenditure is expenditure that provides, has the potential to provide, or has the perceived potential to provide a private benefit to an employee, that is additional to the HBDHB benefit of the expenditure. It also includes expenditure by HBDHB that could be considered unusual for its purpose and/or functions.

### SCOPE

This policy applies to all employees and those contracted to supply services for Hawke's Bay District Health Board ("HBDHB").

### PRINCIPLES APPLICABLE TO SENSITIVE EXPENDITURE

The most fundamental fact applicable to all expenditure by a public entity is that the entity is spending public money – it is not the property of staff (including members, office holders, managers, and employees) of the entity to do with as they please. Consequently, the expenditure should be:

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- subject to the standards of probity and financial prudence that are to be expected of a public entity; and
- able to withstand Parliamentary and public scrutiny.

## APPROVAL AND DOCUMENTATION

Approval of sensitive expenditure will be given only when the person approving the expenditure is:

- satisfied that a justified business purpose and other principles have been adequately met;
- given before the expenditure is incurred, wherever practical;
- made within the statutory limits on HBDHB delegations and
- satisfied that budgetary provision exists.

*(Refer to Board Delegations Policy– HBDHB/OPM/024)*

Approval is to be given by a person senior to the person who will benefit, or who might be perceived to benefit from the sensitive expenditure.

Even when sensitive expenditure decisions can be justified at the item level, the combined amount spend on a category of expenditure may be such that, when viewed in total, the entity could be criticised for extravagance and waste.

Reimbursement of sensitive expenditure will:

- clearly state the business purpose of the expenditure. In instances where the business purpose is not clear from the supplier documentation supporting the claim, a written statement of the purpose should be included as part of the claim
- be accompanied by adequate original (not photocopied) itemised receipt (or original invoice and accompanying receipt as proof of payment). Credit card statements do not constitute adequate documentation for reimbursement
- be submitted promptly when the expenditure is incurred, or within one month of invoice. HBDHB reserves the right not to pay claims for reimbursements that are received later than six months from invoice date

## CREDIT CARD USE

Using credit cards is not a type of sensitive expenditure, but is a common method of payment for such expenditure. HBDHB has specific policies and procedures to minimise risks. e.g. HBDHB credit cards cannot be used for cash advances.

Credit cards offer convenience, but this needs to be balanced with appropriate use. Credit cards should only be used to incur costs that the DHB would approve if made by other payment methods.

*(Refer to Purchasing Credit Card Policy – HBDHB/OPM/096)*

### Internet purchases using credit cards

Credit card payments over the Internet need to reflect good security practice, such as purchasing from only established reputable companies known to the entity. The card holder needs to keep a copy of any online order forms completed when purchasing, and purchasing by credit card over the internet needs to be consistent with the entity's normal purchasing controls.

*(Refer to Procurement Policy – HBDHB/OPM/061)*

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**Cash advances**

In instances where an individual does not have an HBDHB credit card, but is required to travel overseas to undertake HBDHB business, it may be necessary to provide the individual with a cash advance. In these instances, expenditure of the cash advance will be properly documented and accounted for.

**TRAVEL AND ACCOMMODATION EXPENDITURE**

Expenditure on travel and accommodation is one of the highest sensitive expenditure risk areas. The principles of a justified business purpose and moderate expenditure are particularly relevant. Travel and accommodation expenditure must be economical and efficient, having regard to purpose, distance, time, urgency, personal health, security, and safety considerations. The principles and terms of this policy apply except where a favoured condition applies in either an IEA or a MECA.

**Procedure to arrange Travel and Accommodation**

Employees must have permission to travel from the employees' line manager before bookings are made.

**Air Travel**

- domestic flights must be booked via the Air NZ Portal well ahead of the actual travel where possible so the expenditure is the most economic possible
- discounted economy or economy class is to be used for journeys of up to seven hours of uninterrupted flight duration, except where, work schedule on arrival, personal health, safety, or security reasons make business class preferable. Employees will not manipulate work schedules to increase access to preferential levels of travel
- a clearly explained rationale must be provided whenever HBDHB pays for non-economy class travel

**Private Travel Linked with Official Travel**

Employees may be allowed to undertake private travel before, during, or at the end of travel paid for by the DHB, provided that there is no additional cost to the DHB and the private travel is only incidental to the business purpose of the travel.

**Air Points**

Where an employee is a member of an air points frequent flyer programme, the air points earned on organisation paid flights will be the property of the employee as the earning of air points arises from a direct contract between the employee and the airline. HBDHB is unable as an entity to claim air points for business flights and therefore air points may be retained by the employee member flying on business or work related travel.

**Koru club membership**

- requires prior approval of the Chief Executive Officer (CEO)
- is restricted to employees who fly frequently
- membership to be reviewed annually

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**Accommodation and Reimbursement while Travelling**

A list of HBDHB's preferred supplier(s) of accommodation can be obtained from Logistics and Purchasing. Alternative accommodation if required should be sought at a competitive price.

Accommodation should be prearranged either via company purchase order or credit card.

Reimbursement must be based on actual and reasonable expense accompanied by an original tax invoice/receipt. Any costs incurred without receipts will not be considered.

Alcohol and mini-bar expenses are prohibited.

The following expenses may be claimed for reimbursement where fees and expenses have been agreed prior to the expense being incurred, as specified in applicable employee contracts:

- airport bus/shuttle transfers, however it is preferred that employees take bus/shuttle transportation to and from airports to destinations and not taxis

**Meals**

Separate meal expenses may not be claimed if a meal is provided as part of another package paid for by the DHB.

Reimbursement of meals while travelling on HBDHB business will be as follows:

- Breakfast - Maximum \$25
- Lunch (if not provided) - Maximum \$15
- Dinner Maximum - \$50

Morning/afternoon tea are at employees own cost.

**Motor Vehicles**

The HBDHB central pool vehicle system must be used in the first instance  
(Refer to *Safe Driving and Motor Vehicle Policy – HBDHB/OPM/034*)

- HBDHB vehicles (provided outside remuneration arrangements) should not be used for private purposes
- HBDHB requires the driver, to pay any fines (parking or traffic offences) incurred while using a HBDHB vehicle (unless the fines relate to an aspect of the condition of the vehicle outside the driver's control, rental vehicle or private vehicle on HBDHB business)
- where practicable, a central pool vehicle will be sought in the first instance and where available the pool vehicle will be used. Where not available a staff member will be entitled to use their private motor vehicle or a rental vehicle after confirmation from the Fleet Coordinator and approval from the respective Service Director/Manager
- pre-approval to use a private motor vehicle for HBDHB business must be obtained
- rental vehicle use should generally only be external to Hawke's Bay
- rental vehicles must be refuelled before returning to the supplier. This is more cost efficient for the organisation
- rental cars if used, will be the most economical type and size, consistent with the requirements (including the distance and number of people) of the trip

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Private use of a rental car is not permitted except in exceptional circumstances (such as reasonable weekend use when the driver is away from home and undertaking work for the entity before and after the weekend) and the employee reimburses the entity for any additional cost.

HBDHB will require a completed and signed claim based on distance travelled when reimbursing employees for use of a private vehicle, and the rates of reimbursement for private motor vehicle use will be in line with public sector rates.

Bus/rail should be the preferred option and any taxi use should be moderate, conservative, and cost-effective relative to other forms of transport available to the entity. Entity-funded taxis should not be used for travel between home and office, unless the reason for the travel is because of work past a reasonable hour, a safety concern, or similar justification, and prior approval for the travel has been given where practicable (including to and from airports).

HBDHB expects employees to use the chit system or HBDHB purchase cards for all taxis fares. This decreases the amount of administration required in reimbursing employees. The chits are to be issued in an individual's name to support transparency about who used a taxi and for what purpose.

## ENTERTAINMENT AND OFFERING HOSPITALITY

Expenditure on entertainment and offered hospitality is sensitive because of the range of purposes it can serve, the opportunities for private benefit, and a range of opinions as to what is appropriate.

HBDHB does not consider the provision of alcohol appropriate.

There are limited accepted business purposes for expenditure on entertainment and hospitality for public entities including DHBs:

- building relationships
- representing the organisation
- reciprocity of hospitality where this has a clear business purpose and is within normal bounds where acceptance of hospitality is expected to be consistent with the principles and guidance for provision of hospitality
- recognising significant business achievement or building revenue, however, building revenue is unlikely to be a legitimate purpose for HBDHB, given that most of its revenue is obtained directly or indirectly from the Government
- supporting internal organisational development may, in occasional circumstances, also be a legitimate business purpose for moderate expenditure.

Expense must be substantiated, approved by the CEO, or a member of the Executive Management Team, or the Chair of the Board if the CEO is a beneficiary. Claims must include tax invoices/receipts, and identify who has been entertained.

## GOODS AND SERVICES EXPENDITURE

### Sale of HBDHB surplus assets to employees

As part of normal business, HBDHB will from time to time dispose of assets. Typically, this is when the assets have become obsolete, worn out, or surplus to requirements. HBDHB expect employees disposing of assets not to benefit as individuals from the disposal. HBDHB disposal

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processes have therefore been designed not to compromise employee's personal judgement or integrity, neither will HBDHB sell assets at a discounted rate to employees, if a greater value could be realised by an alternative method of disposal.

*(Refer to Asset Disposal Policy, Plant and Equipment – HBDHB/OPM/016)*

#### **Loyalty Reward Scheme Benefits**

Prizes received from a free competition entry obtained as part of HBDHB business are considered in the same way as a loyalty or reward scheme. In situations where receiving a prize or loyalty reward could be perceived as inappropriate, even if the entity rather than the individual would benefit from it, HBDHB expects the prize or reward to be declined if the value is greater than \$50.

#### **Private use of HBDHB Assets**

Any physical item owned, leased, or borrowed by HBDHB is considered an asset. This includes photocopiers, telephones, cell phones, means of accessing the Internet, and stationery. Generally, costs of private use should be recovered, unless it is impractical or uneconomic to separately identify those costs. The use of HBDHB assets in any private business that any employee may operate is prohibited.

#### **Private use of an entity's suppliers**

Any private use of official procurement processes could give HBDHB employees access to suppliers on the same basis as the DHB at a preferential price that is not available to the general public. There is therefore a risk that the availability of the discount could influence the choice of suppliers to the DHB where private use of suppliers should not be taken into account when selecting suppliers. HBDHB employees should be moderate in their use of any preferential access to goods or services through a DHB supplier and must not use purchasing privileges on behalf of any third party, such as family members or friends. Employees must pay in full and HBDHB must not be used as a source of credit by employees.

#### **Financing the Activities of a Social Club**

HBDHB does not financially support social clubs.

#### **Retirements**

Expenditure on retirements includes spending on function, gifts, and other items when employees are retiring from HBDHB. Expenditure on retirements should be aligned to the Retirement Guidance. Please refer to Nettie for further information.

#### **Farewells**

The same general principles as for retirements apply, and will be at the discretion of the Service Director/Manager. Costs should be limited to \$50 per year of service to a maximum of \$1,000.

#### **GIFTS, HOSPITALITY and Other Benefits**

Refer OPM HBDHB/OPM/114

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## DONATIONS AND SPONSORSHIP

The DHB is not empowered to offer public resource with no exchange of goods or services in return. This is not an appropriate use of tax payers' money as it does not represent Value for Money. The DHB will not therefore make donations nor provide sponsorships.

HBDHB will only solicit donations from others for the purposes of enhancing patient comfort or for the support of services not covered or supported by the Crown Funding Agreement and no employee may solicit for donations without the approval of the CEO. Before any prospective donor is approached for any reason related to a donation, the relevant General Manager's written authority, or the CEO's if appropriate, must be requested in writing. Such requests should detail the intended purpose of soliciting funds and the benefit to the HBDHB.

Seeking donations shall not distract employee's energies or divert HBDHB operating resources from planned objectives and contractual responsibilities.

Offers of any donations or gifts, shall be advised to the relevant Service Director/Manager.

All donations should be receipted, acknowledged and deposited into an appropriate HBDHB account. Making a donation should not result in any counterpart obligation on individuals or entities, other than to apply the donation to the purposes of the recipient.

### Koha

The need for koha is to be determined by the HBDHB Service Director/Manager advised by their Kaumatua/Maori Advisor.

Koha should reflect the circumstance and should not exceed two hundred dollars (\$200).

All services that request koha must:

- consult with service kaumatua/Maori Advisor
- justify the amount of koha to be given in advance of the occasion and submit the request to their manager
- complete a koha request form (appendix one) and forward to Finance. Finance will then prepare a cheque and advise when this will be available to uplift
- where possible obtain a receipt from the organisation or parties where the koha was presented

### Fundraising

No fundraising or concessionary activity shall be undertaken on HBDHB premises without the prior written consent of the CEO or delegate.

Any approved fundraising or concessionary activities shall be conducted in a discreet and professional manner, in strict compliance with all statutory requirements. In no circumstances should any employee, patient, visitor, or other person be subjected to any pressure, nor should any employee be distracted from carrying out their work duties.

If employees are carrying out approved fundraising activities these are usually to be undertaken outside of working hours, unless approval has been given for these activities to occur during working hours.

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### Communications technology

Communications technology – (such as cell phones, telephones, and e-mail and access to the Internet) – is widely used in the workplace. While some level of personal use of this HBDHB based technology is unavoidable (such as for dealing with a family emergency during work hours), excessive use incurs costs that are a diversion of public money from the business purposes of the DHB. Such costs include lost productivity (including dealing with incoming personal e-mails and phone calls) and the direct cost of the technology. The risk associated with personal use of an entity's communications technology is the cost to the entity of it being used excessively. Please note that access to an external wireless network (Spark Hotspot) is now available and can be utilised for personal purposes during assigned breaks.

A further risk includes the HBDHB technology being used for purposes that are not consistent with DHB goals. An example would be use of Internet access for downloading or e-mailing unacceptable material. Even with access to an external wireless network the use of HBDHB devices to download unacceptable material is not permitted.

Any personal use of communications technology must be well managed through adequate controls and regular monitoring and reporting. HBDHB has a policy on personal use of communications technology. Refer to Internet Acceptable Use Form.

Where it is administratively possible, cost-effective and appropriate to do so, HBDHB may require reimbursement for personal use of communications technology.

### REFERENCES

Controlling sensitive expenditure: Guidelines for public entities  
Office of the Auditor-General (February 2007)  
Retirement Guidance  
Safe Driving and Motor Vehicle Policy – HBDHB/OPM/034  
Special Funds Policy – HBDHB/OPM/092  
Asset Disposal Policy, Plan and Equipment – HBDHB/OPM/016  
Board Delegations Policy – HBDHB/OPM/024

### KEY WORDS

Accommodation  
Donations  
Entertainment  
Expenditure  
Finance  
Koha  
Money  
Travel

*For further information please contact the Head of Finance - Finance Department.*

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Appendix 1

## Koha Request Form

HBDHB Department: \_\_\_\_\_

Nature of Event: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Event Host/Provider/Supplier (to whom cheque will be made out):

\_\_\_\_\_

The cheque will be uplifted by: \_\_\_\_\_  
*Please print*

Date required: \_\_\_\_\_

Service Manager: \_\_\_\_\_  
*Please print*

Cost Centre and Code: \_\_\_\_\_

Approved by: \_\_\_\_\_  
*Please print*

Designation: \_\_\_\_\_

Date: \_\_\_\_\_

**Accounts Department Use:**

Cheque No: \_\_\_\_\_ Date: \_\_\_\_\_

Uplifted by: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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## Payment of Fees and Expenses (Dec 13)

<b>HAWKE'S BAY DISTRICT HEALTH BOARD</b>	<b>Manual:</b>	Operational Policy Manual
	<b>Doc No:</b>	HBDHB/OPM/108
	<b>Issue Date:</b>	July 2012
	<b>Date Reviewed:</b>	December 2013
	<b>Approved:</b>	Company Secretary
	<b>Signature:</b>	Ken Foote
	<b>Pages :</b>	1 of 4
<b>Payment of Fees and Expenses</b>		

### PURPOSE

This policy sets out the basis for the payment (or non payment) of fees and expenses to members of HBDHB committees, advisory groups, stakeholder groups and project teams.

### SCOPE

This policy will apply to everyone who attends meetings or who otherwise provides input into any governance, clinical or management committee, advisory group, stakeholder group or project team (as defined below) regardless of whether they are appointed, co-opted or otherwise asked to be involved.

### PRINCIPLES

The fundamental intent of this policy is to set out very clearly HBDHB's position on the payment (and non payment) of fees and expenses in such a way that the expectations of any person contemplating getting involved in such activities, can be managed at the outset.

Significant principles on which the policy is based include:

1. HBDHB will pay remuneration, fees and expenses (as appropriate) to all those individuals who have (either individually or collectively) been formally appointed to a role that has delegated authority or a contractual responsibility to make decisions and/or recommendations, provide services or otherwise act on behalf of HBDHB. Such payment recognises not only the value of the input or service provided but also the legal responsibility and accountability attached to it.

Such individuals include:

- HBDHB Board and Board Committee Members
  - Hawke's Bay Clinical Council Members
  - Hawke's Bay Health Consumer Council
  - HBDHB Staff and Contactors
  - Contracted Professional and Specialist Advisors
2. For these individuals, such involvement in relevant committees, advisory groups, stakeholder groups and project teams is usually required as part of their appointment responsibilities (either directly or indirectly), or because HBDHB requires their advice based on their particular clinical knowledge, skills or experience.
  3. HBDHB significantly appreciates and values the time, commitment and input of other stakeholders and advisors (as defined below) into various committees, advisory groups, stakeholder groups and project teams.
  4. Such appreciation does not however, extend to the payment of fees and expenses to these individuals due to:
    - Participation is purely voluntary.

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- There is no responsibility or accountability expected or required.
  - With technical, clinical, professional and community representational input being provided by those appointed and accountable members identified above, participation of other stakeholders and advisors is normally invited to provide additional views, perspectives, opinions and experience to add balance and depth to the discussions and recommendations.
  - There is no objective basis for putting a dollar value on such input that would be fair and equitable to the range of stakeholders and advisors involved.
5. Genuine appreciation for the input of other stakeholders and advisors will be expressed and demonstrated on an ongoing basis.
6. The non-payment of "other stakeholders and advisors" will be taken into account in the setting of the timing, frequency, location etc., of meetings and the means of maintaining communications.
- A key consideration will be minimising the disruption and potential costs and/or losses incurred by such members.
7. Applications for justifiable reimbursement of expenses from other stakeholders and advisors may be considered and approved in exceptional circumstances.

## POLICY

In relation to the payment of fees and expenses for involvement in HBDHB committees, advisory groups, stakeholder groups and project teams:

HBDHB will pay for:

- HBDHB Board and Board Committee Members:
  - Paid under the provisions of the Crown Entities Act as set out in Schedule 4 of the HBDHB Governance Manual. (Cabinet Fees Framework)
- Hawke's Bay Clinical Council:
  - Paid as part of HBDHB employment agreement (if HBDHB employee) or through individual contract/agreement.
- Hawke's Bay Health Consumer Council
  - Paid in accordance with the Cabinet Fees Framework applicable to HBDHB statutory Committees. Additional fees and allowances may be paid to the Independent Chair depending on the level of commitment involved in addition to Consumer Council meetings.
- HBDHB Staff and Contractors:
  - Paid in accordance with employment agreement or (direct or indirect) contract for services.
- Contracted Professional and Specialist Advisors:
  - For primary care clinician advisors (where appropriate), paid an agreed fee as partial compensation for lost earnings as a result of attending relevant meetings
  - For all others, paid in accordance with contracted terms and conditions.

HBDHB will not pay for:

- Other stakeholders and advisors.

The above seven principles shall be applied as part of this policy.

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**DEFINITIONS*****“HBDHB Committees, Advisory Groups, Stakeholder Groups and Project Teams”***

Includes all those committees, groups and teams established from time to time (whether formally in accordance with specific terms of reference or not), for a specific HBDHB purpose requiring the provision of information, discussion, analysis, opinions, perspectives, advice, experience etc., into the decision making and performance monitoring structures and processes of HBDHB.

***“HBDHB Board Committee Members”***

Includes the members formally appointed by the Board to those committees established by HBDHB under the provisions of the New Zealand Public Health and Disability Act 2000 i.e.:

- Community and Public Health Advisory Committee (CPHAC)
- Disability Support Advisory Committee (DSAC)
- Hospital Advisory Committee (HAC)
- Finance Risk and Audit Committee (FRAC)
- Maori Relationship Board (MRB)
- Pacific Health Leadership Group (PHLG)
- Appointments and Remuneration Advisory Committee (ARAC)

***“Hawke’s Bay Clinical Council”***

Includes only those individual members formally appointed by the Board to the HBDHB Clinical Council i.e., does not include those clinicians invited to attend all/or part of the Clinical Council meetings from time to time, or those non-Clinical Council members invited to participate in Clinical Council Committees or Sub-Committees.

***“Hawke’s Bay Health Consumer Council”***

Includes only those (15) individual members and the independent Chair formally appointed to the Consumer Council. It does not include those consumers invited to participate in Consumer Council sub-committees or as consumer representatives on other HBDHB advisory groups or project teams.

***“HBDHB Staff and Contractors”***

Includes all those who are engaged full time, part time, temporarily or casually by HBDHB through either an employment contract or a (direct or indirect) contract for services.

***“Contracted Professional and Specialist Advisors”***

Includes those businesses and/or individuals who provide professional or specialist services or advice, not otherwise available to the DHB from any of the above, who are engaged by an authorised manager of HBDHB on a contracted fee for service basis for a designated purpose and/or fixed period of time. Includes also those primary care clinicians formally appointed from time to time to provide relevant clinical advice through a Hawke’s Bay Clinical Council Committee or an HBDHB Project Team.

***“Other Stakeholders and Advisors”***

Includes all those other health sector, business, public service, consumer and/or community members who have voluntarily become involved in the structured decision making, advisory, information gathering, monitoring or consultative processes of HBDHB.

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## MEASUREMENT CRITERIA

Measurement Criteria/Success indicators are measurable aspects which provide evidence of effective implementation of the policy e.g. staffs knowledge of policy content, staff's knowledge of how to access the policy, critical factors within the policy that can be audited. The measurement criteria describes how the policy compliance will be monitored that is; audit survey etc e.g. There is an annual audit undertaken to measure compliance with this policy.

This policy will be reviewed every three years.

## REFERENCES

Governance Manual for Hawke's Bay District Health Board, December 2013 (as amended).

## KEY WORDS

Advisor  
Advisory  
Board  
Committee  
Contracted  
Contractors  
Expenses  
Fees  
Payment  
Professional Advisor  
Reimbursement  
Specialist Advisors  
Stakeholder

*For further information please contact the Company Secretary.*





<b>HAWKE'S BAY DISTRICT HEALTH BOARD</b>	<b>Manual:</b>	Operational Policy Manual
	<b>Doc No:</b>	HBDHB/OPM/019
	<b>Date issued:</b>	July 2002
	<b>Date Reviewed:</b>	September 2018
<b>Health and Safety Policy</b>	<b>Approved:</b>	Executive Management Team
	<b>Signature:</b>	Kate Coley
	<b>Page:</b>	1 of 7

## Health & Safety Charter

### Our health and safety vision

*'safe place, safe people, safe care'*

### We believe that...

- health and safety is everyone's business
- providing a safe place to work is the right thing to do for our staff
- everyone who works here should be supported to ensure they do their job safely
- staff whose health, safety, and well-being is valued, will then be ready and able to offer high quality care to our community

### To achieve this, we will...

- make sure everyone who works for the HBDHB understands our health and safety vision
- actively seek out hazards that could cause harm, and work to eliminate or minimise them so that everyone feels safe here
- consult with staff and anyone else affected by our activities, to make sure that we all have a say on health and safety matters
- work actively with unions and any other worker organisation to promote improvement in health & safety practices
- make sure that anyone doing work for the HBDHB has the knowledge, skills, supervision, and capability to do the job safely, every time
- make sure that our policies and procedures reflect our practice, and that staff health, safety and well-being is assured
- work actively with our staff to improve their health & wellbeing on a continuous basis
- ensure that healthy and safe practice is a regular part of performance review for all
- investigate all incidents, and change the way we do things when that is required
- support all injured workers in their safe return to work

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## PURPOSE

To ensure a safe environment that protects workers wellbeing and is without risk to health, HBDHB is committed to consultation, coordination and co-operation. Everyone at HBDHB needs to understand what their role is in assuring wellbeing and making the workplace safe.

To ensure that all workers are aware of their health, safety and wellbeing responsibilities, HBDHB will ensure that these are communicated to each worker through induction, training and consultation.

## SCOPE

This policy applies to all board members (governance), executives (officers), and staff (employees, contractors, sub-contractors, workers) and others (volunteers, general public) who work for HBDHB at any of the sites where activities take place, or who are affected by our activities.

## PRINCIPLES

Every board member, executive and staff member has a responsibility for their own health and safety and that of others in the workplace.

It is HBDHB's policy that each of our staff members shall be provided with a safe and healthy place in which to work, and that our work practices will not compromise the health or safety of people in the workplace.

To deliver on this policy, management will ensure that there is appropriate hazard and risk identification, risk assessment, control and review as well as health preservation and promotion. These aspects of setting and maintaining healthy working conditions will be embedded in our organisations' plans, procedures, programs and job instructions.

We are committed to continual improvement of health and safety of our staff and the elimination of workplace injury and illness.

Our commitment extends to supporting the safe return to work of injured workers.

## HEALTH AND SAFETY MANAGEMENT SYSTEM FRAMEWORK

The health and safety management system aligns with the Health & Safety at Work Act (2015) and all related Regulations, approved codes of practice and guidelines.

### The health and safety management system framework includes:

- An overarching health and safety policy
- A health and safety charter endorsed by the Board which is reviewed two yearly
- Policies, procedures, and other documents that describe how healthy and safe practice will be achieved
- Quarterly H&S key performance indicators and reports including staff related events, identified risks and corrective actions.

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**DEFINITIONS**

<b>Term</b>	<b>Definition</b>
The Health and Safety at Work Act 2015 (HSWA)	New Zealand's key work health and safety legislation is the Health and Safety at Work Act 2015 (HSWA) and regulations made under that Act. All work and workplaces are covered by HSWA unless specifically excluded.
WorkSafe New Zealand (WorkSafe)	WorkSafe is the government agency that is the workplace health and safety regulator.
Duty holders under HSWA	A duty holder is a person who has a duty under HSWA. There are four types of duty holders – PCBUs, officers, workers and others
PCBU	A PCBU is a 'person conducting a business or undertaking'. In general, the PCBU is the legal entity [such as the HBDHB], but a PCBU may be an individual. A PCBU must ensure, so far as is reasonably practicable, the health and safety of workers, and that other persons are not put at risk by its work. This is called the 'primary duty of care'.
Officer	An officer is a person who position that allows them to exercise significant influence over the management of the business or undertaking. Officers must exercise due diligence to ensure the PCBU meets its health and safety obligations.
Worker	A worker is an individual who carries out work in any capacity for a PCBU. A worker may be an employee, a contractor or sub-contractor, an employee of a contractor or sub-contractor, an employee of a labour hire company, an apprentice or a trainee, a person gaining work experience or on a work trial, or a volunteer worker. Workers can be at any level (eg managers are workers too). Workers have their own health and safety duty to take reasonable care to keep themselves and others healthy and safe when carrying out work.
Other person in the workplace	Examples of other people can include visitors and casual volunteers. Other people have their own health and safety duty to take reasonable care to keep themselves and others safe at a workplace.
Risk	Risks arise from people being exposed to a hazard (a source of harm).
Reasonably practicable	'reasonably practicable' means what is or was reasonably able to be done to ensure health and safety, taking into account and weighing up relevant matters including: <ul style="list-style-type: none"> <li>I. The likelihood of the risk concerned occurring, or workers being exposed to the hazard, and</li> <li>II. The degree of harm that might result, and</li> <li>III. What the person concerned knows, or ought to reasonably to know <ul style="list-style-type: none"> <li>a. about the hazard/risk</li> <li>b. ways of eliminating or minimising it, and then after assessing the extent of the risk, to</li> </ul> </li> <li>IV. review the cost associated with available ways of eliminating/minimising the risk, including whether or not the cost is grossly disproportionate to the risk.</li> </ul>

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**DUTY-HOLDERS and their obligations****PCBU**

The HBDHB is the PCBU; represented by the Board<sup>1</sup>

The **Board** must:

- provide and maintain a work environment that is without risks to health and safety
- provide and maintain safe plant and structures
- provide and maintain safe systems of work
- ensure the safe use, handling and storage of plant, structures and substances
- provide adequate facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities
- provide any information, training, instruction, or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking
- monitor the health of workers and the conditions at the workplace for the purpose of preventing injury or illness of workers arising from the conduct of the business or undertaking

**Officers** of the HBDHB include the Chief Executive Officer and all members of the EMT.

**Officers** must:

- Acquire, and keep up to date, knowledge of work health and safety matters; and
- Gain an understanding of the nature of the operations of the business or undertaking of the HBDHB and generally of the hazards and risks associated with those operations; and
- Ensure that the HBDHB has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking; and
- Ensure that the HBDHB has appropriate processes for receiving and considering information regarding incidents, hazards, and risks and for responding in a timely way to that information; and
- Ensure that the HBDHB has, and implements, processes for complying with any duty or obligation of the HBDHB under the Health and Safety at Work Act 2015; and to verify the provision and use of the resources and processes referred to in paragraphs (3) to (4) above

**Workers** include employees, contractors, subcontractors, labour hire workers, apprentices and trainees, and volunteer workers.

**Workers** must:

- take reasonable care for their own health and safety
- take reasonable care that what they do or do not do does not adversely affect the health and safety of other persons
- co-operate with any reasonable workplace health and safety policy or procedure that has been notified to workers
- comply, so far as is reasonably practicable, with any reasonable instruction given by the PCBU, so the PCBU can comply with HSWA and regulations.

<sup>1</sup> Certain officers have the due diligence duty but cannot be prosecuted if they fail to meet their due diligence duty. This includes members of the HBDHB Board

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**LEADERSHIP & WORKER PARTICIPATION**

<b>Role</b>	<b>Responsibilities/Accountabilities</b>
The <b>Board</b> is accountable to	<ul style="list-style-type: none"> <li>ensure that the health, safety and well-being of staff is an important element in all decision-making</li> <li>ensure that no business decision takes priority over the health, safety, and well-being of our staff</li> <li>ensure that our staff feel safe at work, and believe that they can raise any issues which could affect their health, safety, and well-being</li> <li>provide training, education, knowledge, and supervision to all staff, to help them make the right choices about their own and others' health, safety, and well-being</li> <li>manage the risks which work at the DHB creates; ensure that suitable and sufficient controls are in place to manage those risks</li> <li>support the safe and early return-to-work of staff who've been injured here</li> <li>to practice due diligence with respect to the health and safety of all HBDHB workers</li> </ul>
The <b>EMT</b> [as officers] is responsible and accountable for:	<ul style="list-style-type: none"> <li>The overall implementation of the health and safety management system.</li> <li>Supporting the day-to-day management and administration of the health and safety management system</li> <li>Providing adequate resources to ensure conformance to the management system.</li> <li>Ensuring all employees are aware of their responsibilities and are held accountable to their performance within the framework of the health and safety management system</li> <li>Ensuring the organisation complies with all relevant health &amp; safety legislation, regulations and other legislation that applies to the business</li> <li>Ensuring health and safety consideration when purchasing equipment and work practices</li> <li>Leading the investigation of accidents</li> <li>Ensuring that health and safety objectives are reported, reviewed and completed as stated</li> <li>Undertaking performance reviews of management positions against designated health and safety roles</li> <li>Reviewing the health and safety management system regularly</li> </ul>
Health & safety manager is responsible for:	<ul style="list-style-type: none"> <li>Development, implementation and monitoring of the Board's H&amp;S strategic &amp; annual planning</li> <li>development of a proactive working relationship with enforcement agencies</li> <li>Providing the necessary guidance to the EMT</li> <li>Maintaining an awareness of national, regional, local and other applicable health and safety laws and regulations to determine whether they affect the HBDHB</li> <li>Maintaining the health and safety manual</li> <li>Ensuring the management systems are reviewed/audited so that the systems remain consistent, adequate and effective</li> </ul>

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<b>Role</b>	<b>Responsibilities/Accountabilities</b>
	<ul style="list-style-type: none"> <li>Ensuring the risk management programme is well managed</li> <li>Ensuring the DHB complies with all relevant health &amp; safety legislation, regulation and other legislation that apply to the business</li> <li>Ensuring health and safety consideration when purchasing equipment and work practices</li> <li>Ensuring that health and safety objectives are being monitored and met</li> </ul>
Managers are responsible for:	<ul style="list-style-type: none"> <li>Ensuring all work tasks and activities are performed in a safe manner</li> <li>Ensuring the DHB complies with all relevant health &amp; safety legislation, regulation and other legislation that apply to the organisation</li> <li>Ensuring health and safety consideration when purchasing equipment and work practices</li> <li>Leading the risk management system</li> <li>Accurately reporting and recording all accidents and incidents</li> <li>Involved in ensuring employees are trained</li> <li>Conducting staff area health &amp; safety inductions</li> <li>Undertaking emergency training and practice drills</li> <li>Performing housekeeping and work place inspections</li> </ul>
Staff [ <b>workers</b> ] are responsible for:	<ul style="list-style-type: none"> <li>participating in hazard identification</li> <li>Accurately reporting and recording all accidents/incidents [events] and near misses</li> <li>Participating in emergency training and practice drills</li> <li>Performing housekeeping and work place inspections</li> <li>Participating at health and safety meetings</li> <li>Ensuring compliance with health and safety procedures</li> <li>Undertaking work tasks and activities in a safe manner</li> </ul>
<b>Contractors, subcontractors, and their workers</b> are responsible for the same duties listed immediately above, for staff. In addition, they are responsible for:	<ul style="list-style-type: none"> <li>Advising the HBDHB what hazards they will create while contracted to do work for us, and</li> <li>to meet the duty of consultation, cooperation and coordination</li> </ul>
<b>Health &amp; safety champions [HSCs]</b> are responsible for	<ul style="list-style-type: none"> <li>representing the health and safety concerns for those people whose work area they represent</li> <li>to participate in hazard identification and risk management</li> <li>to participate in incident investigation where they have the skills to do so</li> <li>to attend health and safety committee meetings, and feed back to their work areas</li> </ul>
<b>Health &amp; safety committees [HSCE]</b>	<ul style="list-style-type: none"> <li>to provide a formal forum for all staff to raise any concerns about the workplace which relate to worker health, safety and well-being</li> </ul>

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<b>Role</b>	<b>Responsibilities/Accountabilities</b>
	<ul style="list-style-type: none"> <li>to provide a forum where management can consult with workers about all matters relating to worker health, safety, and well-being</li> <li>to meet at least 8 times each calendar year, and provide quarterly reports to the Board</li> </ul>
<b>'Others'</b> [anyone else who is not an officer or a worker]	<ul style="list-style-type: none"> <li>Take reasonable care for his or her own health and safety and</li> <li>Take reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons; and</li> <li>Comply, as far as he or she is reasonably able, with any reasonable instruction that is given by the HBDHB to allow the HBDHB to comply with the Health and Safety at Work Act 2015 Act or regulations.</li> </ul>

## REFERENCES

- Health and Safety at Work Act 2015
- Health and Safety Regulations 2016 (General Risk and Workplace Management, Worker Engagement, Participation, and Representation)
- Health and Safety Guide: Good Governance for Directors March 2016 (Institute of Directors, WorkSafe New Zealand)

***For further information please contact the Health & Safety Manager.***

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## BOARD HEALTH & SAFETY CHAMPION

As the governors of HBDHB, the Board has the ultimate responsibility to provide organisational commitment and leadership by approving strategy, values and policy that sets the direction and expectations for health and safety management, and performance.

Providing effective leadership requires the Board to demonstrate:

- Commitment, clarity of vision and focus
- Consistency and authenticity
- Understanding that health and safety is an investment
- Personal involvement
- Engagement and encouragement
- Capability and knowledge

In addition to this, the Board as a whole, is responsible under the HSAW Act for a number of very specific issues. These are set out in the current HBDHB Health & Safety Policy

Many of the above requirements and responsibilities will be met by the Board as a whole through training, reporting, discussions and decision making at both Finance Risk and Audit Committee and Board Meetings. Some of the more detailed and personal involvement requirements however will be met by Board members rotating through a six month appointment as a H&S Board Champion. Two Board members will be Champions at any one time.

The role requirements of a Board Health & Safety Champion include:

- Meeting with Executive Director People and Quality and Health & Safety Manager
- Attending Health & Safety Committee meeting
- Conducting safety tours and conversations
- Conducting critical risk / hazard safety sample
- Presenting health and safety awards
- Providing 'informed' comment on H&S reports to FRAC / Board
- Forming and presenting an independent assessment to FRAC and/or the Board

Further detail and guidance on these duties are attached.

## **HBDHB HEALTH AND SAFETY BOARD CHAMPION ROLE REQUIREMENTS**

### **MEET WITH EXECUTIVE DIRECTOR PEOPLE & QUALITY and HEALTH & SAFETY MANAGER**

Discuss:

- Health & Safety Management System
  - How well is the system working?
  - How well were any significant issues addressed?
  - What were the outcomes of any audits/reviews
  - What changes have been made to the system – why?
  - What training has been undertaken?
  
- Health & Safety Performance Measures
  - What are the leading and lagging indicators telling us?
  - What are we doing about this?
  
- Safety Culture Maturity
  - Where are we?
  - Are we improving

### **ATTEND HEALTH & SAFETY COMMITTEE MEETINGS**

Observe / Ask:

- Are workers actively and positively engaged?
- Do they feel that they are listened to and that things are continuously improving?
- Do they understand / value the roles they have?
- Do they feel that senior management and the Board are actively committed to their health and safety
- Is there anything significant they would like to see changed?

### **CONDUCT SAFETY TOURS AND CONVERSATIONS**

- Report template attached

### **CONDUCT CRITICAL RISK / HAZARD SAFETY SAMPLE**

- Report template attached

**PROVIDE 'INFORMED' COMMENT ON H&S REPORTS TO FRAC / BOARD**

- Current detailed knowledge and experience provides an advantage with comments or questions

**FORM AN INDEPENDENT VIEW AND ADVISE THE BOARD ON:**

- How well is the overall strategy and system is working?
- How committed are manager, leaders and workers to achieving: “Safe place, safe people, safe care”?
- Are sufficient resources available for the development, implementation and maintenance of the system?
- Is there a need to obtain an external independent review?

**NOTE**

Key Reference for H&S Board Champion is the booklet:

**“Health & Safety Leadership and Governance”**  
published by IMPAC Training

**HBDHB HEALTH AND SAFETY BOARD CHAMPION  
SAFETY TOURS AND CONVERSATIONS**

Date: \_\_\_\_\_ Location \_\_\_\_\_

Observation team members Name(s) \_\_\_\_\_

**Suggestions of health & safety elements to look for on “safety tours”**

1. Does area appear calm with staff working efficiently and happily?
2. Are there any obvious hazards – how well have they been mitigated or minimised?
3. Are the work areas and passages clear, and free from materials being stored and any other unrequired equipment etc?
4. Are walls free from extraneous materials, old notices etc?
5. Is waste managed? No overflowing rubbish bins, paraphernalia left lying about etc?
6. If you were a patient, how would the work area and staff appear to you?

**Suggestions of questions to ask during ‘safety conversations’**

7. Tell me about your job. What do you do?
8. Is there anything slow, inconvenient, or uncomfortable about doing this job well and safety?
9. What could go wrong? What are the greatest hazards you face?
10. Do you think these hazards are sufficiently controlled?
11. How do you feel about how well health & safety issues generally are managed in your area?
12. If you could change anything for the better, what would that look like?

**What impresses/concerns you about the area?**

Comment: \_\_\_\_\_

**HBDHB HEALTH AND SAFETY BOARD CHAMPION  
CRITICAL RISK/HAZARD / HAZARD SAFETY SAMPLE**

Date: \_\_\_\_\_ Location \_\_\_\_\_

Observation team members Name(s) \_\_\_\_\_

Hazard or Risk to be sampled: \_\_\_\_\_

**Suggestions of questions to ask:**

1. How and why has this been identified as a hazard / risk?
2. What has analysis and evaluation of the risk identified?
3. What has been done to eliminate, mitigate or minimise the risk?
4. Do these controls meet the “so far as is reasonably practicable” test?

**Personal observation of hazard / controls:**

5. Does everything you have been told reflect the reality ‘on the ground’?
6. Are people working / visiting the area of the hazard aware of it, and /or the controls to mitigate it, and do they feel safe?
7. Does everything look safe to you?

**Overall assessment – Has this risk/hazard been well managed?**

Comment \_\_\_\_\_



## **Schedule 10: Audit Risk and Finance Committee Handbook for District Health Boards**

Citation: Ministry of Health. 2006. *Audit Risk and Finance Committee Handbook for District Health Boards*. Wellington: Ministry of Health.

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## Foreword

Audit, Risk and Finance (ARF) committees provide a cornerstone of good governance for District Health Boards (DHBs). Primary responsibility for financial governance rests with DHB boards but they may look to their ARF committees for much of their assurance.

ARF committees often tackle a significant and complex workload. The Ministry has put together this handbook to assist boards and ARF committee members in defining and planning that workload. Each DHB has developed its own allocation of roles between board and committees, and will therefore use this guidance to suit its own circumstances.

The handbook began as an adaptation of one developed in the UK for NHS trusts. We have deleted material not relevant to DHBs and incorporated other relevant material on best practice as appropriate. We would like to thank those who have commented on drafts, particularly the Office of the Auditor-General and the Audit and Risk Committee of Taranaki DHB – any remaining errors and omissions are our own.

I hope you find this handbook of value. I welcome your feedback on the handbook and on any other areas where guidance of this type may be helpful.



Karen O Poutasi (Dr)  
Director-General of Health

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## **Executive Summary**

### **Purpose of this handbook**

The purpose of this handbook is to maximise the effectiveness of District Health Board (DHB) Audit, Risk and Finance (ARF) committees by providing concise and practical guidance for board members. The material has been drawn largely from existing best practice guides (see Bibliography).

DHBs have different committee structures. Some of the roles and functions discussed here in relation to ARF committees may be allocated to the board and/or other committees, as appropriate to each DHB's needs. This handbook may therefore also be relevant to board members who are involved in other committees.

### **Structure**

The handbook is divided into five sections. Following this Executive Summary, Section 2 addresses audit related functions, Section 3 financial planning and reporting, Section 4 risk management oversight, and Section 5 practical aspects such as membership, authority, protocols, and meeting arrangements. The appendices provide specimen terms of reference for an ARF committee, a self-assessment checklist and a summary of characteristics of good financial management.

### **Roles of the DHB board and executive management**

The board of the DHB is responsible for governance of the entity. The ARF committee is a mechanism to assist the board to meet this responsibility.

The chief executive is employed by the board to deal with management and operational matters of the DHB, including its employees.

The chief financial officer's role is to maintain a sound system of internal financial control, manage financial risks, and produce management accounts and annual financial statements. The chief financial officer is a key contact for both internal and external auditors.

### **What is an ARF committee?**

Under clause 38 of Schedule 3 to the New Zealand Public Health and Disability Act 2000 (the NZPHD Act), DHB boards are entitled to establish committees. All DHBs currently have some form of ARF committee. The ARF functions discussed in this handbook may be distributed across more than one committee (for example where a DHB has a separate risk committee).

### **Objectives and functions**

ARF committees offer advice and recommendations to the board, independently of management, regarding the DHB's financial performance and major areas of risk.

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The overall objective of the ARF committee is to ensure that the DHB board complies with its financial accountabilities and responsibilities including, but not limited to, those set out in sections 39 and 41-42 of the NZPHD Act, section 51 and Part 4 of the Crown Entities Act 2004 (the CE Act) and related regulations.

To fulfil this objective, the ARF committee may undertake audit related functions, review financial planning and reporting, and oversee risk management. Each of these areas is discussed in its own chapter below.

The ARF committee contributes to the board's overall process for ensuring that an effective internal control system is maintained and that financial reporting is robust. An effective committee will not duplicate the work of DHB staff or auditors.

## Audit related functions

An independent and effective ARF committee provides internal and external auditors with a reporting line independent of management, giving effect to the principle that the auditors work “for” the board and “with” management.

The key audit related functions of an ARF committee are likely to be:

- liaising with the internal auditor and reviewing internal audit scope, planning and resourcing
- assisting the external auditor to identify risks and issues relevant to the external audit planning process
- receiving the reports of the internal and external auditors and reviewing their findings
- monitoring the progress made by management in implementing recommendations arising from audit.

## Internal audit

Internal auditors undertake detailed examination, evaluation and testing of financial and management systems in order to ensure the quality of the internal financial control system and proper application of processes. This systems focus may also be applied to non-financial control systems such as quality systems and clinical information systems.

The internal audit function may also review and report on key areas where risks may become apparent, such as complaints, DHB-funded providers, major projects and procurement issues. The internal auditors should also liaise closely with the ARF committee with regard to prevention and detection of fraud.

A large proportion of most DHBs’ funds is spent on non-DHB providers. Some DHBs use internal audit resources to provide a mechanism over and above normal contract monitoring for verifying the performance of contracts by outside providers and ensuring early warning of any problems.

For some DHBs, it may be practical for the ARF committee to receive and review all internal audit reports on behalf of the board. However, it is important that the committee does not duplicate the work of senior management or of any other committee. It may be more appropriate for the ARF committee to focus on financial control issues while ensuring that other assurance activities such as quality management are covered elsewhere. It is up to the board to decide on the extent of the ARF role and to ensure that all necessary aspects are covered in practice. The board as a whole is responsible for the integrity of the DHB’s financial (and other) reporting.

## Effectiveness of internal audit

The ARF committee must evaluate the scope, standard and effectiveness of work carried out by the internal audit service, and consider whether it is adequately resourced. It should do this by:

- seeking feedback from the external auditors and considering the extent of the reliance they place on work performed by internal audit in planning their own work
- obtaining feedback from executive management
- reviewing internal audit reports
- observing any apparent weaknesses in or failures of the internal audit programme when internal control issues arise.

## External audit

In relation to any body being audited, the external auditors review and report on:

- the financial aspects of its corporate governance arrangements, as they relate to:
  - financial standing
  - systems of internal financial control
  - standards of financial conduct, legality of significant transactions, and the prevention and detection of fraud and corruption
- its financial statements
- its other published reports or disclosures. In the case of DHBs, the external auditors must audit statements of service performance against the Statement of Intent.

The ARF committee's relationship with the external auditor provides an opportunity to secure an independent view of any major activity within the auditor's remit.

## Reviewing the external audit plan

Under the Public Audit Act 2001, the Auditor-General is the auditor for all DHBs. In practice, this means that the Office of the Auditor-General appoints the external auditor and issues specific audit standards, guidelines and briefs to reflect specific public sector audit requirements, which are in addition to general auditing standards.

Although a DHB ARF committee is therefore not responsible for the appointment of the external auditor, the Auditor-General expects the appointed auditor to meet regularly with the DHB's ARF committee. The ARF committee should discuss with the external auditor the annual audit plan and strategy. In planning their audit work, external auditors are expected to consider and assess the relevant significant operational and financial risks that apply to the DHB, the arrangements it has put in place to manage these risks and the extent of relevant internal audit work. This assessment enables the external auditors to plan their audit to direct effort to areas of greatest risk.

## Involvement in finalising the financial statements

The ARF committee may be involved in the finalisation of the financial statements, subject to final board approval, before the audit opinion is given. The ARF committee can play a valuable role in resolving differences in judgements between external auditors and management.

## **Reporting arrangements**

The external auditor is required to provide an opinion on the accounts of the DHB. They also typically issue an audit letter or memorandum to the board, setting out their observations of issues and weaknesses identified during the audit and their recommendations to address these. Draft recommendations are usually discussed with management to determine their feasibility.

## **Monitoring implementation**

The ARF committee can play an active role in following up agreed actions contained in the internal and external auditors' reports and letters. The value of these reports is not in the acceptance of issues raised but in the implementation of agreed actions. The ARF committee should monitor these agreed actions until the benefits have been realised or circumstances have changed.

Typically this monitoring will involve the preparation of a summary of outstanding recommendations and receipt of progress reports from the managers responsible for their implementation. Lack of progress on important action points should be escalated to the board.

## **Co-operation between internal and external audit**

The ARF committee should ensure that a professional relationship between the internal and external auditors is maintained to maximise the effectiveness of each and minimise duplication of effort.

## **Private discussions**

Although the chief executive remains responsible for implementing actions agreed following audits, both internal and external auditors should have a reporting line independent of management. The ARF committee as a whole and/or its chairperson should meet periodically with each of the internal and external auditors without management being present. This will enable the ARF committee to obtain the frank views of the auditors, uninhibited by the presence of management.

## Planning and reporting

The ARF committee is likely to be involved in reviewing both external reporting issues and internal planning and reporting, both financial and non-financial, where they are relevant to the board's compliance with financial accountabilities and responsibilities.

The ARF committee may undertake any or all of the following roles in relation to planning and reporting:

- review and advise the board on its approval of the DHB's financial statements and disclosures
- review draft District Annual Plans, Statements of Intent and District Strategic Plans for their financial impact
- review and advise the board regarding finance-related policies and procedures requiring board approval, including delegation policies
- review management accounting and internal financial reporting practices and issues and alert the board to any areas which appear ineffective
- review capital expenditure and asset management planning and their relationship with service planning
- monitor the financial performance and position of the DHB against budget and forecast.

## Financial statements and disclosures

The committee should review the annual report and financial statements prior to approval by the board, focussing particularly on:

- any changes in accounting policies and practices
- major judgemental areas
- significant adjustments arising from the audit
- compliance with financial reporting and other applicable standards
- compliance with statutory requirements
- consistency with other reports prepared by management for release to stakeholders, such as statements of service performance and any summary reports.

The timeframe for the preparation of the annual financial statements is typically tight. If the ARF committee is to play an effective role in advising on issues of judgement, then a meeting needs to be planned before the agreement of the financial statements. The role of the ARF committee and the purpose of the meeting should be made clear.

If the ARF committee is to be involved in the resolution of significant accounting issues raised in the context of the annual audit, then meetings need to be scheduled prior to the signing of the audit report.

The ARF committee should pay particular attention to proposed changes in accounting policies and issues involving significant judgements as these may be subject to manipulation to meet key performance indicators or bank covenants. ARF committee members should ensure that they are familiar with the covenants, ratios etc which may affect the DHB's borrowings or position on the Monitoring and Intervention Framework.

## **Financial content of plans and SOIs**

As part of its overview role for financial documents issued by the board, the ARF committee should review the financial content of draft District Annual Plans, Statements of Intent and District Strategic Plans to ensure that these are consistent with each other and fall within required parameters (such as breakeven or agreed funding path).

## **Finance-related policies and procedures**

The board is required to approve changes in certain policies and procedures, including delegation policies (where approval is also required from the Minister). These will tend to affect how the internal controls of the organisation operate. The committee should therefore advise the board on whether to approve changes.

## **Management accounting/internal financial reporting**

The ARF committee is well-placed to have an overview of the various financial reports which are produced for internal use and for the various committees. It also receives feedback from auditors on apparent weaknesses in financial management of the DHB. It should therefore regularly review the form, content and timeliness of internal reports. If weaknesses are not addressed, it should alert the board to any areas in which current practice appears ineffective.

## **Capital expenditure/asset management**

The ARF committee should ensure that all plans take account of relevant capital expenditure and explain how it will be funded. Conversely, it should also obtain regular assurance that appropriate asset management planning is routinely undertaken by the DHB to ensure early identification, prioritisation and planning for capital items, and that such planning is based on robust analysis of health needs and service planning. The ARF committee should ensure that business cases for capital expenditure, joint ventures and other proposals, including those requiring Ministerial approval, are robustly developed within the DHB's overall strategy.

The detail of such plans and proposals may well be addressed elsewhere, for example by the Hospital Advisory Committee.

## **Monitoring the financial performance and position of the DHB against budget and forecast**

The ARF committee should always have a clear understanding of the current overall financial performance and position of the DHB, of its expected future performance and position and of the reasons for any significant variances from budget. The committee

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should also ensure that all board members are kept fully informed of the financial performance and position of the DHB.

The ARF committee should ensure that its time is not absorbed by detailed financial monitoring tasks if such monitoring would be more appropriately done by other committees (such as Hospital Advisory Committees for issues relating to the provider arm).

Where the DHB needs to determine a plan of action to address major issues relating to its financial performance and position, the full board should participate in the discussion.

## Risk management oversight

Although ultimate responsibility rests with the DHB board, risk management oversight is likely to be a key part of the ARF committee's role.

Strategic and operational risks – such as clinical, media, legislative, personnel and public health emergencies – may well result in financial consequences downstream if the DHB does not identify, manage and mitigate them effectively. Depending on the roles played by other committees and by management, the ARF committee's oversight role may need to include monitoring of certain non-financial reporting systems and processes. Standards New Zealand has developed guidelines for managing risk in healthcare, focusing mainly on operational risk, which the committee may find useful (see bibliography).

The key functions of risk management oversight for an ARF committee are likely to be:

- ensuring that the DHB complies with its obligations under key legislation
- keeping other legislative compliance arrangements under review (such as employment legislation)
- monitoring risk assessment and risk management mechanisms, including internal control
- receiving and investigating disclosures under the DHB's 'whistle-blowing' policy where it is not appropriate for these to be received and investigated by the chief executive
- monitoring and reviewing policies and procedures to minimise and manage conflicts of interest among DHB board members, management and staff
- monitoring and reviewing policies and procedures to minimise and manage risks in the contracting of health services
- other monitoring responsibilities as determined by the board, for example in relation to major contracts or construction projects.

The ARF committee should play a key role in the process of review, not only in respect of its internal financial control oversight activities, but also in contributing to the assessment of wider aspects of risk management control. Where not dealt with by separate committees, this might well involve the ARF committee in the consideration of aspects of the following:

- operational efficiency and effectiveness
- health and safety
- reputation and communication.

Where it has responsibility for oversight of a DHB's risk management programme, the ARF committee may need to assure itself that:

- the risk management policies and strategies reflect board views and priorities

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- the DHB's risk management structure is appropriate to support the strategy, and is coherent across the DHB
- there is adequate monitoring of critical risks and responsibility for risk management has been appropriately delegated within the organisation
- a robust risk identification and assessment process is in place
- appropriate early warning systems are in place and warnings are escalated appropriately
- risks and risk treatments are regularly reported to the board in a meaningful format
- risk reporting within management, to the board and to the Ministry of Health (where required) is consistent.

The committee may also need to consider risk management of particular issues as required by the board.

## How can ARF committees work most effectively?

### Membership

Effective oversight requires objectivity and relevant experience. These are among the attributes that board members bring to the committee. The ARF committee provides members with access to financial information, internal control systems, and to external and internal auditors. Members are thereby able to bring their skills and experience to bear on the financial, risk and control issues, and to do so independently of senior management.

The full board is responsible for appointing and removing committee members. For reasons of independence, best practice indicates that the board chairperson should not chair the ARF committee, although it may be helpful for them to be a member. In making its appointments, the board should consider the requirements of clause 38 of Schedule 3 to the NZPHD Act, including representation of Māori where appropriate and the need for disclosure of conflicts of interest by external committee members. The board should avoid appointing any individual whose full participation in the committee's work might be inhibited by conflicts of interest. No executive of the DHB should be a member of the committee, although the chief executive and chief financial officer may be asked to be in attendance at most meetings.

Although a limited number of DHB board members will be members of the ARF committee, most DHBs currently indicate that all board members are welcome to attend. The board should consider the balance between openness to the board as a whole and the risk that the committee might be swayed or distracted by non-committee members with a limited understanding of the committee's work. The NZ Stock Exchange, for example, requires that directors who are not audit committee members only attend audit committee meetings by specific invitation.

All members of the committee, whatever their background, should be able to participate fully. To be effective, committees need some members to have the necessary skills to familiarise themselves with the organisation's financial reporting processes and its system of internal control. At least one member of the committee should therefore have a financial background, although the board should be careful to avoid placing too much reliance on any one member's expertise. The board may decide to appoint external members with relevant expertise in finance or other necessary skill areas to the ARF committee. Alternatively, the committee may commission external advisers as required.

### Authority

The ARF committee must be invested with sufficient authority and resources to act with independence and to investigate any matters within its terms of reference. It should be constituted as a committee of the board and the terms of reference should be agreed by the board. Appendix 1 gives an example set of terms of reference.

The Minister of Health has authorised DHBs to pay fees consistent with the Fees Framework to members of an ARF committee, subject to membership of the committee and its terms of reference being regularly advised to the Ministry of Health.

## Access

The ARF committee should have direct contact with the internal and external auditors, as well as the DHB chief executive, chief financial officer and possibly other staff who make regular reports relevant to the committee's role (such as risk management).

Other contacts would be arranged as required, through the DHB chairperson or chief executive. The committee should have the ability to call for independent advice from consultants and to request the attendance of any employees of the DHB at committee meetings.

## Meetings

Thorough preparation of agendas can have a significant influence on the effectiveness of an ARF committee. Agenda and briefing papers should be prepared and circulated in sufficient time for the members to give them due consideration.

The timing of ARF committee meetings should be planned in advance, to address key deadlines in the DHB's year relating to the committee's remit (such as audit and District Annual Plan timetables). However, the ARF committee should also be able to call ad hoc meetings if required.

Instituting such a work programme gives the ARF committee the opportunity to provide timely and forward-looking recommendations to the board.

The timing of meetings needs to be discussed with all parties, including the internal and external auditors.

It is for each ARF committee to decide what will work in practice. In doing so, the committee will weigh up competing demands on board members' time against an assessment of local needs.

## Information

### Information required by the ARF committee

The minimum information required by the ARF committee is likely to include, as it arises:

#### Audit

- Draft and final internal and external audit plans and strategies
- External audit engagement letter
- Internal and external audit reports/letters (draft and final)
- Schedule of action points and management reporting of progress made.

#### Financial reporting and monitoring

- Draft and final financial statements of the DHB

- Details of any proposals to change accounting policies and their impact
- Draft and final District Annual Plans, District Strategic Plans and Statements of Intent
- Finance-related policies and procedures of the DHB and details of any planned amendments
- Management accounts and financial reports as supplied to the board and other board committees
- Capital expenditure proposals and draft asset management plans.

#### **Risk management oversight**

- Risk management policies, procedures and regular reports.

#### **Public availability of information**

Under clause 38(4) of Schedule 3 to the NZPHD Act, the board may regulate the procedure of any committee in any manner not inconsistent with the Act that it sees fit. Under clause 38(5), the same requirements for routine public access to meetings and related documents as apply to the full board (clauses 16-24, 28 and 31-35) also apply to a committee **if** its meetings involve making resolutions or decisions.

Most ARF terms of reference require all recommendations to be referred to the board for decision, allowing ARF meetings to be held in closed session. Conversely, minutes of ARF meetings should be promptly made available to the board, with the expectation that non-confidential minutes will also be available to the public as part of the board papers.

DHBs are subject to the Official Information Act 1982 (OI Act). Irrespective of whether routine public access to meetings and related documents is provided, ARF documents including meeting agendas, reports and minutes may be requested by members of the public under the OI Act. The general principle of the OI Act is that information should be made available on request. However, a request may be refused if any of the grounds described in the OI Act apply.

#### **Other matters**

Other aspects of the committee's conduct should be governed by the NZPHD Act and CE Act as regards meeting procedure, record-keeping, confidentiality and conflicts of interest, with specific points in the terms of reference. The process for dealing with declared interests in a board committee is set out in clauses 38-39 of Schedule 4 to the NZPHD Act.

Relevant training should be provided to committee members as required, consistent with the DHB's obligations to board members under clause 5 of Schedule 3 to the NZPHD Act.

The committee should undertake regular self-assessment of its performance and effectiveness in the same way as the full board. An example self-assessment checklist is attached at appendix 2.



## Appendix 1: Specimen Terms of Reference

The following specimen terms of reference expand upon the summary included in the Minister of Health's letter to DHBs of September 2003 and are for DHB boards and their ARF committees to adapt to suit their own circumstances. Individual DHBs operate different models for deriving assurance in relation to financial, risk and internal control issues, and the scope of work of the ARF committee will therefore vary (for example, some DHBs operate a separate risk committee). Each board will need to determine the role and functions of its ARF committee as part of the total governance structure of the DHB.

### Terms of Reference

#### Constitution

The board hereby establishes a committee of the board to be known as the [Audit, Risk and Finance committee (ARF committee)].

#### Membership

The ARF committee shall comprise [3-6 members] to be appointed by the DHB board from amongst the board members and/or other persons. Notes:

- The board must endeavour, where appropriate, to include Māori representation on the committee (clause 38(2), Schedule 3, NZPHD Act).
- Best practice indicates that the chairperson of the board should not chair the ARF committee.
- No executive of the DHB should be a member of the ARF committee (although the attendance of the chief executive and other senior staff may frequently be required).
- It may be desirable to appoint one or more external members with relevant professional experience, especially where board members on the committee have limited financial skills and experience. Alternatively, individuals with appropriate skills and experience could be appointed as advisors to, rather than members of, the committee. External committee members must disclose any conflicts of interest (clause 38(6) of Schedule 3, NZPHD Act)
- Board members serving on the committee may require training to be provided under clause 5 of Schedule 3, NZPHD Act.

#### Objective

The objective of the ARF committee is to ensure that the DHB board complies with its financial accountabilities and responsibilities including, but not limited to, those set out in sections 39 and 41-42 of the New Zealand Public Health and Disability Act 2000 (the NZPHD Act) and section 51 and part 4 of the Crown Entities Act 2004 (the CE Act) and related regulations.

## Functions/duties

### Audit

- liaise with the internal auditor and review internal audit scope, planning and resourcing
- assist the external auditor to identify risks and issues relevant to the external audit planning process
- receive the reports of the internal and external auditors and review their findings
- monitor the progress made by management in implementing recommendations arising from audit.

### Financial planning and reporting

- review and advise the board on its approval of the DHB's financial statements and disclosures
- review draft District Annual Plans, Statements of Intent and District Strategic Plans for their financial impact
- review and advise the board regarding finance-related policies and procedures requiring board approval, including delegation policies
- review management accounting and internal financial reporting practices and issues and alert the board to any areas which appear ineffective
- review capital expenditure and asset management planning and their relationship with service planning
- monitor the financial performance and position of the DHB against budget and forecast.

### Risk management oversight

- ensure that the DHB complies with its obligations under key legislation
- keep other legislative compliance arrangements under review (such as employment legislation)
- monitor risk assessment and risk management mechanisms, including internal control
- receive and investigate disclosures under the DHB's 'whistle-blowing' policy where it is not appropriate for these to be received and investigated by the chief executive
- monitor and review policies and procedures to minimise and manage conflicts of interest among DHB board members, management and staff
- monitor and review policies and procedures to minimise and manage risks in the contracting of health services
- other monitoring responsibilities as determined by the board, for example in relation to major contracts or construction projects.

**Quorum**

A quorum of the ARF committee shall be at least [two] members.

**Attendance**

The committee may invite the chief executive, chief financial officer, internal and external auditors and/or any other party to attend its meetings as required and when appropriate.

**Frequency**

Meetings shall be held at least [four] times a year. The number and timing of meetings may vary depending on board requirements. The external or internal auditors may request additional meetings if necessary.

**Authority**

The ARF committee is constituted by the board under clause 38 of Schedule 3 to the NZPHD Act and must operate in accordance with directions from the board.

The ARF committee is authorised by the board to investigate any activity within its terms of reference. It has no decision-making powers but makes recommendations to the board on the agenda items submitted to it. [Some ARF committees hold delegations from the board for some specific tasks, such as approval of the external audit plan].

**Access**

The ARF committee has free and confidential access to the internal and external auditors (and vice versa) as required to fulfil its objectives, roles and responsibilities. It also has access to the DHB's chief executive officer and chief financial officer and to any other staff through the chief executive officer.

**Reporting**

The ARF committee is authorised by the board to obtain outside legal or other independent professional advice if necessary to fulfil its role.

The minutes of ARF committee meetings will be submitted to the board. [Copies may also be forwarded to the chief executive, chief financial officer and internal and external auditors either routinely or where actions are required.]

All recommendations from the ARF committee will go to the DHB board for decision.

**Information**

The following information will be supplied to the ARF committee in accordance with deadlines set in its workplan for the year:

**Audit**

- Draft and final internal and external audit plans and strategies
- External audit engagement letter
- Internal and external audit reports/letters (draft and final)
- Schedule of action points and management reporting of progress made.

**Financial reporting and monitoring**

- Draft and final financial statements of the DHB
- Details of any proposals to change accounting policies and their impact
- Draft and final District Annual Plans, District Strategic Plans and Statements of Intent
- Finance-related policies and procedures of the DHB and details of any planned amendments
- Management accounts and financial reports as supplied to the board and other board committees
- Capital expenditure proposals and draft asset management plans.

**Risk management oversight**

- Risk management policies, procedures and regular reports.

## Appendix 2: Self Assessment Checklist<sup>1</sup>

Issue	Yes	No	N/A	Comments / Action
<b>COMPOSITION, ESTABLISHMENT AND DUTIES</b>				
Does the ARF committee have written terms of reference that adequately and realistically define the committee's role?				
Have the terms of reference been adopted by the DHB board?				
Are the terms of reference reviewed annually to take into account governance developments and the remit of other DHB board committees?				
Has the ARF committee been provided with sufficient membership, authority and resources to perform its role effectively and				
Are changes to the ARF committee's current and future workload discussed and approved at board level?				
Are ARF committee members independent of the management team?				
Does the ARF committee report regularly to the board?				
Are members, particularly those new to the ARF committee, provided with training?				
Does the board ensure that members have sufficient knowledge of the organisation to identify key risk areas and to challenge both line management and the auditors on critical and sensitive matters?				
Does at least one ARF committee member have a financial background?				
Does the ARF committee have the ability / authority to seek independent advice?				
Does the ARF committee have a mechanism to keep it aware of topical legal and regulatory issues?				

<sup>1</sup> This checklist has been adapted from the Department of Health (UK) 2001, *Audit Committee Handbook*.

<b>INTERNAL AUDIT</b>				
Do formal terms of reference exist, defining internal audit's objectives, responsibilities and reporting lines?				
Does the ARF committee review and approve the internal audit plan at the beginning of the financial year?				
Are audit plans derived from clear processes based on risk assessment?				
Does the ARF committee receive periodic reports from the internal auditors at the desired level of				
Does the ARF committee monitor follow up audits and the implementation of recommendations?				
Are the internal auditors able to report directly to the ARF committee and its chairperson?				
Does the ARF committee hold periodic private discussions with the internal auditors?				
Are any scope restrictions placed on internal audit and, if so, what are they and who establishes them?				
Is internal audit free from any operating responsibilities or conflicts of interest that could impair its objectivity?				
Does the ARF committee review the adequacy of staffing and resources within internal audit?				
Has the ARF committee agreed internal audit performance measures to be reported on a routine basis?				
Is there appropriate cooperation with the external auditors?				
Are there any quality assurance procedures to confirm whether the work of the internal auditors is properly planned, completed, supervised and reviewed?				
<b>EXTERNAL AUDIT</b>				
Do the external auditors present their audit plans and strategy to the ARF committee for discussion?				

Does the ARF committee review the external auditor's annual audit letter and monitor implementation of recommendations?				
Does the ARF committee hold periodic private discussions with the external auditor?				
Does the ARF committee assess the performance of external audit and provide feedback to the auditor and, where appropriate, the Office of the Auditor-General?				
<b>FINANCIAL REPORTING</b>				
Is the ARF committee's role in the approval of the annual financial statements clearly defined?				
Is a ARF committee meeting scheduled to discuss proposed adjustments to the financial statements and issues arising from the audit?				
Does the ARF committee annually review the accounting policies of the DHB?				
<b>RISK MANAGEMENT</b>				
Has the board considered how the ARF committee integrates with any other committees that are reviewing risk or financial issues?				
Has the ARF committee been briefed on its assurance responsibilities with regard to internal control and risk management?				
Has the ARF committee reviewed whether the reports it receives are timely and have the right format and content to ensure its risk management responsibilities are discharged?				
Is the ARF committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisation's responsibilities?				
<b>ADMINISTRATIVE ARRANGEMENTS</b>				
Does the ARF committee have a plan of matters to be dealt with over the coming year?				

Are papers distributed in sufficient time for members to give them due consideration and are minutes received as soon as possible after the meetings?				
Are the timing and frequency of ARF committee meetings appropriate to deal with planned matters?				
Is the timing of ARF committee meetings discussed with all the parties involved?				
<b>OTHER ISSUES</b>				
Does the ARF committee assess its own effectiveness periodically?				
Does the annual report and accounts of the DHB include a description of the ARF committee's establishment and activities?				

## Appendix 3: Text of Minister's letter authorising payment to ARF committees, September 2003

### Payment of fees to board members serving on DHB audit, risk and finance committees

Since I wrote to DHB chief executives on 9 April 2003 regarding payment of fees to committees, several DHB chairpersons have expressed their concern that board members serving on audit, risk and finance committees would no longer receive payment for their work.

I have noted these concerns and propose to allow DHBs to make additional fee payments to those board members who serve on board audit and finance committees. Audit, risk and finance committees make complex and time-consuming demands of their members and therefore the contributions to them by board members deserve financial recognition.

A decision to pay fees to a board committee in this fashion is an exception to the Cabinet Office Circular CO (01) 8, *Fees Framework for Members of Statutory and Other Bodies Appointed by the Crown* (the Fees Framework). Under paragraph 42 of the Framework I have therefore been required to consult with both the Minister of State Services and Cabinet before issuing this approval.<sup>2</sup>

My approval is subject to the following conditions:

- only one committee dealing with audit, risk and/or finance matters is to be paid. Some DHBs have more than one committee dealing with such issues and will need to select which committee is to receive payment
- the justification for the approval is to recognise the significant additional workload involved in audit, risk and finance (ARF) committees, the specialist nature of the work and the difficulty of recruiting and retaining high calibre individuals to serve on an ARF committee. It is therefore expected that a small number of board members will serve on the ARF committee
- I am to be advised of committee membership and terms of reference and future changes to these
- fees are to be based, as a maximum, on those established in the Fees Framework for board members serving on the advisory committees established under sections 34-36 of the Act
- as part of its normal processes for monitoring and reviewing board performance, the Ministry will monitor the performance and effectiveness of ARF committees and advise me of any issues arising.

<sup>2</sup> CO (01) 8 has been superseded by an updated version of the Fees Framework (CO (03) 4) but the approval given in this letter still applies.

To assist you in determining which committee of your board should be paid under this approval, I have attached to this letter an outline of the functions which an audit, risk and finance committee of a DHB might fulfil.

I look forward to receiving notification from you as to the committee membership and terms of reference of your audit, risk and/or finance committee.

#### **Typical functions of DHB audit, risk and finance committees**

Based on DHB experience to date and other examples of good governance practice, the functions of an audit, risk and finance committee would be as follows:

- to receive the reports of the internal and external auditors and monitor the progress made by management in implementing recommendations arising from those reports
- to provide a reporting line for the internal auditor independent of the chief executive
- to receive and investigate disclosures under the DHB's whistle-blowing policy where it is not appropriate for these to be received and investigated by the chief executive
- to review and advise the board on its approval of:
  - the DHB's financial statements and disclosures
  - the draft District Annual Plan
  - those finance-related policies and procedures which require board approval including delegation policies
- other monitoring responsibilities which may be delegated to it by the full board, for example in relation to major contracts or construction projects.

Such committees would be established pursuant to clause 38 of Schedule 3 to the Act.

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The Institute of Internal Auditors ([www.iianz.org.nz](http://www.iianz.org.nz)) and Institute of Chartered Accountants (<http://www.nzica.com/>) both carry a range of relevant material.

## Schedule 11: Governing for Quality



HEALTH QUALITY & SAFETY  
COMMISSION NEW ZEALAND  
*Kupu Taurangi Hauora o Aotearoa*



A QUALITY & SAFETY GUIDE FOR DISTRICT HEALTH BOARDS

# GOVERNING FOR QUALITY

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## About this guide

This guide will help district health boards (DHBs) put quality and safety at the centre of governance and drive improvement in their organisations. While the guide has been written with DHBs in mind, the principles and guidance are relevant and can be applied to all health care providers.

It includes:

- an outline of the role of boards as agents for quality and safety improvement
  - the seven essential steps boards can take to improve the quality and safety of health care services:
    1. Lead and set clear goals
    2. Gather information and seek out patient stories
    3. Establish system-wide measures and monitor them
    4. Put a high quality and safety culture in place
    5. Ensure the right mix of people and encourage discussion
    6. Commit to ongoing learning at all levels
    7. Define roles and establish clear accountability at all levels
  - a checklist to guide boards and assess progress. ●
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## Foreword



If we are serious about improving the quality of health and disability services and reducing avoidable or preventable harm to patients, boards must engage in this imperative – it is the board that sets the priorities for a DHB and culture begins at the top.

An increasing body of evidence points to board leadership as a critical

element for better, safer health care. Bader and O'Malley have made the point that boards 'can choose to be either active leaders or passive overseers in this process'.<sup>1</sup>

Leadership in this context requires a commitment to act, but it also requires an understanding of the issues. There is quite a lot to understanding the fundamentals of quality and safety in health care, much as there is to understanding the fundamentals of board responsibilities in respect of governance and finances. Many board members are already knowledgeable in all these areas, but for many more, education and training will be required – and for all who take on the responsibility of directorship, ongoing education is important.

The Health Quality & Safety Commission is responsible for driving improvement in the quality and safety of New Zealand's health and disability services. Our objectives have been captured in the New Zealand Triple Aim:

- Improving quality, safety and experience of care.
- Improving health and equity for all populations.
- Gaining best value from public health care resources.

Achieving these objectives requires, first, that we do the right things and, second, that we do these things right first time.

Ensuring the quality of health care is inextricably linked to ensuring the financial health of DHBs. It is

vital to ensure we do the right things. The health outcomes of a population are determined by many other factors as well as health care services. Continuing to increase the funding invested directly in health care can only be achieved at the cost of other essential social requirements, such as housing, employment and education. Health care is not just about increasing production, in the sense of more procedures and consultations. If patients in New Zealand are to receive effective care that meets their needs, we cannot waste money on treatments not supported by reasonable evidence. Nor can we waste money on the costs of avoidable or preventable patient harm.

Variation in accessed health care is recognised as a problem internationally. The discrepancies in outcomes between different population groups in New Zealand is evidence that we have not yet met the needs of all New Zealanders – although progress is being made.

Governing for quality has a critical role to play in furthering these goals and getting the best possible results out of available resources – for all our populations.

There is a great deal of impressive improvement work already underway across New Zealand DHBs, and many examples of good governance. However, if we want to have truly world class services, the pursuit of excellence must continue. I hope *Governing for quality* will be a catalyst for further discussion and action in this regard. I encourage board members to use this resource to help drive quality improvement even further – and to provide feedback on its value, and on ways to improve future editions of this publication.

**Professor Alan Merry ONZM FRSNZ**

Chair, Health Quality & Safety Commission

<sup>1</sup> Bader B, O'Malley S. 2006. *Great Boards. 7 things your board can do to improve quality and patient safety*. Bader and Associates Governance Consultants. 6(1). URL: [www.greatboards.org](http://www.greatboards.org) (accessed November 2015).

## Introduction – the role of governance in improving quality and safety

Improving quality and safety is fundamental to the DHB's governance role.

It is the board, with the senior leadership team, which sets the organisation's strategic quality direction and goals for improvement. It is the board and senior leaders that model desired attitudes and values that drive quality improvement. Their approach to governance will reflect the compassionate, patient-centred, high-quality care they expect of others.

That's why boards are so instrumental in setting and championing a culture within their organisations that puts the quality and safety of consumer care at the heart of everything they do.

The board, along with senior leaders, needs to put effective governance structures in place so teams can adapt to constantly changing health care environments.

The board environment should be safe, where honest and unfiltered discussion on patient safety and quality issues is encouraged.

Board members are responsible for putting in place systems that involve patients and families/whānau in quality-of-care discussions – listening to the consumer voice. This is also essential for ensuring equitable outcomes for all.

It is the role of the board and senior leaders to set clear expectations of staff and communicate compellingly about quality and safety. The aim is to create the right environment for organisational learning.

The board needs to drive a culture where education and training are valued and readily available to all staff. Such a culture will help to create an environment where all staff have the knowledge, skills and behaviours appropriate to their role. And board members themselves need to ensure they understand quality and safety issues to fulfill their responsibilities. This guide has been developed to improve understanding and encourage discussion about these issues. If you would like a two-hour workshop on quality and safety issues at your DHB, please contact the Health Quality & Safety Commission. ●

## Boards *do* affect quality

A growing body of international research into health organisations shows boards can make an enormous contribution to improving quality and patient safety. Effective governance and oversight by well-informed and skilled board members lies at the heart of improving quality and patient safety in health organisations.

In particular, evidence highlights the importance of strong and committed leadership. It is the board's role to make better quality of care their organisation's top priority, and to set clear and measurable goals for improvement.

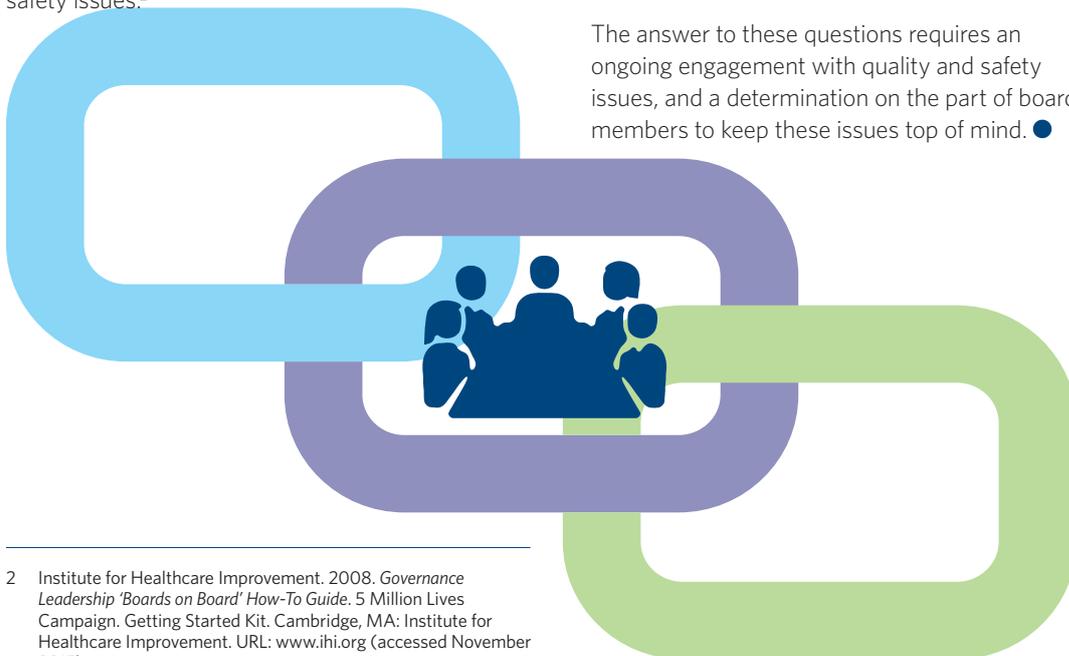
An effective board supports and expects a culture that continually strives to improve the quality and safety of care provided, and values experience, diversity and respect.

International studies recommend that boards need to allocate adequate meeting time to quality and safety issues.<sup>2</sup>

All board members should be able to answer these questions about quality and safety:

- How safe is your organisation?
- Is your organisation treating patients and families/whānau with respect and compassion?
- Is your organisation responsive to the cultural needs of all your patients, families/whānau and communities?
- Is patient safety improving year by year?
- Does your organisation collect robust data to measure quality and patient safety?
- Does your organisation achieve equitable outcomes for all patients, families/whānau and communities?
- Does your board report publicly against its quality and safety aims?
- How does your organisation compare with other similar organisations?

The answer to these questions requires an ongoing engagement with quality and safety issues, and a determination on the part of board members to keep these issues top of mind. ●



<sup>2</sup> Institute for Healthcare Improvement. 2008. *Governance Leadership 'Boards on Board' How-To Guide*. 5 Million Lives Campaign. Getting Started Kit. Cambridge, MA: Institute for Healthcare Improvement. URL: [www.ihl.org](http://www.ihl.org) (accessed November 2015).

## What the research tells us

Around the world, research is being conducted into the impact of board decision-making on patient safety. Evidence shows better outcomes are achieved in organisations where the focus on quality issues is paramount.

Recent research<sup>3</sup> involving nearly 4000 New Zealand health professionals established there is already an encouraging foundation on which to build a more robust quality and safety culture.

Key findings included:

- 77 percent agreed or strongly agreed health professionals in their DHB involved patients, families and whānau in efforts to improve family care
- 71 percent agreed or strongly agreed in their clinical area it was easy to speak up if they perceived a problem with patient care
- 71 percent agreed or strongly agreed there were people and processes in place to identify, analyse and act upon all adverse events to prevent future occurrences
- 74 percent agreed or strongly agreed their organisation had zero tolerance for patient harm anywhere in the organisation.

Overall the results of the survey provide a positive view of the existing quality and safety culture within DHBs. However, people saw room for improvement in the systems, structures and work processes across departments, work groups and with outside providers. A third of those surveyed agreed or strongly agreed 'there was little coordination of quality improvement efforts across departments and work groups.'<sup>4</sup>

The need for greater inspiration and leadership in these areas was also identified. Less than half of those surveyed agreed the organisation inspired them to do the best job they could every day. And nearly 60 percent of those surveyed thought there was further room for improvement in the quality of patient care.<sup>5</sup>

There is a challenge here for DHBs to advance quality and safety through their leadership, planning and system-level coordination.

Another three-year study<sup>6</sup> of New Zealand organisations highlighted that collective learning and continuous improvement are the central elements of an adaptive, resilient, high-performing organisation. The study describes organisational learning as 'a powerful and sophisticated competency' to help organisations 'adapt, survive and thrive in turbulent environments'. In this study, the specific characteristics of an adaptive organisation are identified as:

- an openness to learning, feedback and ongoing improvement
- an environment that encourages problem-solving, rather than handing out blame
- a safe culture where it is okay to admit mistakes and jointly learn from them
- an ability to pause and reflect as individuals and as a group
- an ability to listen to others and consider alternative options
- a willingness to explore untested new ideas.

3 Martin G, Mason D, Lovelock K, et al. 2015. *Health professionals' perceptions of quality survey. A report for the Health Quality & Safety Commission*. Wellington: Health Quality & Safety Commission. URL: [www.hqsc.govt.nz/assets/General-PR-files-images/Perceptions-of-quality-survey-Oct-2015.pdf](http://www.hqsc.govt.nz/assets/General-PR-files-images/Perceptions-of-quality-survey-Oct-2015.pdf) (accessed November 2015).

4 *Ibid.*

5 *Ibid.*

6 Nilakant V, Walker B. 2015. *Building Adaptive Resilience, high-performing today, agile tomorrow, thriving in the future. Key findings from the Building Resilient Infrastructure Organisations Project*. Christchurch: University of Canterbury.

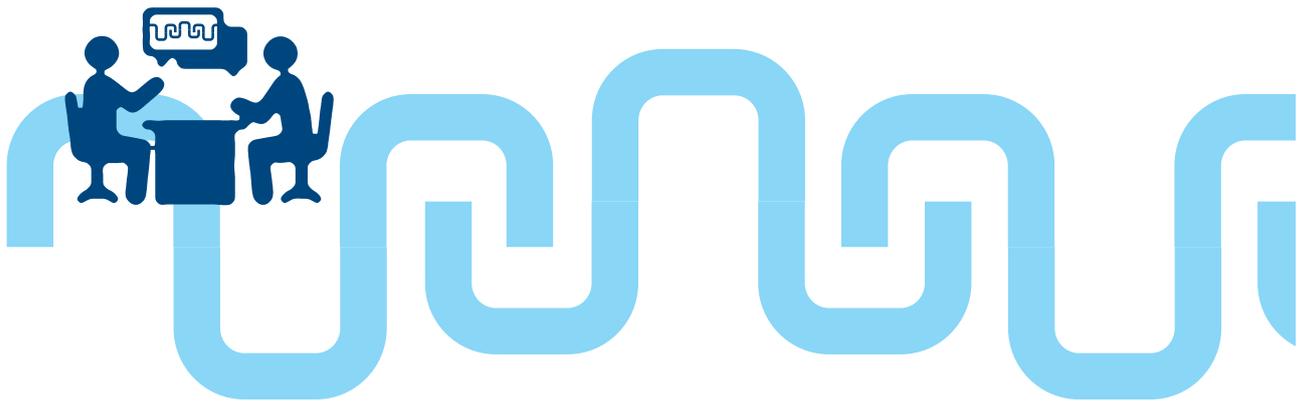
Other international research also demonstrates a strong correlation between high-performing health care organisations and boards that are actively engaged with quality assurance measures and issues. One US study showed 91 percent of high-performing health care organisations had boards that regularly reviewed quality data and information.<sup>7</sup>

Research also shows, however, that quality and patient safety is an area boards often neglect.

A study of over 5000 health care organisations in the USA described the state of health care governance as 'highly variable'.<sup>8</sup> Another survey of 1000 board chairs in US hospitals found 'fewer than half of the boards rated quality of care as one of their two top priorities, and only a minority reported receiving training in quality'.<sup>9</sup>

A national survey of health trust boards in the UK reached a similar conclusion. It found boards of governors were generally 'well-meaning but largely ineffective in helping to promote and deliver safer healthcare within their organisations'.<sup>10</sup> This was mainly due to a lack of awareness and understanding of the vital role of board members in assuring quality.

An Australian study<sup>11</sup> confirmed boards *are* key agents for change and reform in any health system. It identified the need for boards to elevate their vision beyond day-to-day processes, and give the organisation its direction, 'the purposes and values that define its actions'. The key message in this study was that board members were responsible for 'big-picture', strategic thinking that directly impacts on quality and patient safety. ●



7 Jha A, Epstein A. 2010. Hospital Governance and the quality of care. *Health Affairs* 29(1). URL: <http://content.healthaffairs.org/content/29/1/182.full.html> (accessed November 2015).

8 Institute for Healthcare Improvement 2008, *op. cit.*

9 Jha et al 2010, *op. cit.*

10 Mannion R, Freeman T, Millar R, et al. 2015. Effective board governance of safe care: A theoretically underpinned, cross-sectioned examination on the breadth and depth of relationships through local case studies and national surveys. *Health Services and Delivery Research* no 4.4. URL: [http://www.nets.nihr.ac.uk/\\_data/assets/pdf\\_file/0020/144821/FLS-10-1007-02.pdf](http://www.nets.nihr.ac.uk/_data/assets/pdf_file/0020/144821/FLS-10-1007-02.pdf).

11 Duckett S, Beaumont M, Bell G, et al. 2015. *Leading Change In Primary Care: Boards Of Primary Health Networks Can Help Improve The Australian Health Care System*. URL: [http://ahha.asn.au/sites/default/files/docs/policy-issue/leading\\_change\\_in\\_primary\\_care.pdf](http://ahha.asn.au/sites/default/files/docs/policy-issue/leading_change_in_primary_care.pdf) (accessed November 2015).

## The need to challenge outmoded views of governance

One of the main barriers to improving quality and safety is a narrow, outmoded view of governance. Too often boards are seen as only being responsible for an organisation's financial health and reputation.

As a consequence, little attention is given to establishing an organisational culture that will drive ongoing improvements in quality and patient safety.

Research in the USA has shown quality issues often receive significantly less attention at board level than financial issues. Ninety-three percent of US hospital boards put financial performance on the agenda at every board level compared with only 63 percent putting quality performance issues on the agenda at every board meeting.<sup>12</sup> Another telling statistic was that at low-performing hospitals, nearly half the boards did not regularly review quality measures.

Another barrier that can arise at board level is the perceived tension between financial considerations and quality improvement, as if a trade-off is required between the two. Enhancing quality does not necessarily cost more – in fact improved processes and workflows may use fewer resources and can reduce costs over the long term.

A study<sup>13</sup> of the link between quality improvement and health care financial performance, involving 1784 community hospitals in the USA, found quality programmes were a consistent predictor of positive financial performance. 'The longer a hospital's involved with QI (quality improvement), the higher the cash flow and the lower the cost per case.'<sup>14</sup>

'... [M]any of the arguments against quality improvement have been based on the premise that such programmes are expensive and divert scarce resources... This has proved not to be the case.'<sup>15</sup>

DHBs that effectively implement quality improvement programmes can expect to improve their financial performance. An integral part of quality improvement is therefore getting the chief financial officers of health organisations to view their role as chief quality enabler, rather than simply budget-keeper.

Board members will also be aware of the high costs of neglecting quality and safety. Examples include under-investment in regional/national electronic systems and adverse event review/investigation processes. An organisation's reputation is easily damaged by a serious failure in patient safety.

Just how damaging it can be, and the enormous costs involved, is vividly outlined in the Francis Report,<sup>16</sup> which many in the health sector will be familiar with. This report highlighted a whole-system failure at the Mid-Staffordshire NHS Foundation Trust. Its central message was that improving quality and safety requires the safety of the patient to be at the centre of service delivery, the first concern of professionals and the shared responsibility of all. ●

12 Jha et al 2010, *op. cit.*

13 Alexander JA, Weiner BJ, Griffith J. 2006. Quality Improvement and hospital financial performance. *Journal of Organizational Behavior* 27 (7): 1003–29.

14 *Ibid.*

15 *Ibid.*

16 [www.nhsemployers.org/your-workforce/need-to-know/the-francis-inquiry](http://www.nhsemployers.org/your-workforce/need-to-know/the-francis-inquiry)

## Modern view of governance

The modern view of governance is that boards have a significant responsibility to make better quality of care their organisation's first concern. This responsibility cannot just be delegated to medical staff and executive leadership – it is the boards' responsibility to ensure these delegations are acted on effectively. Ensuring patient care is safe and harm-free is at the very core of a board's legal and fiduciary responsibility.

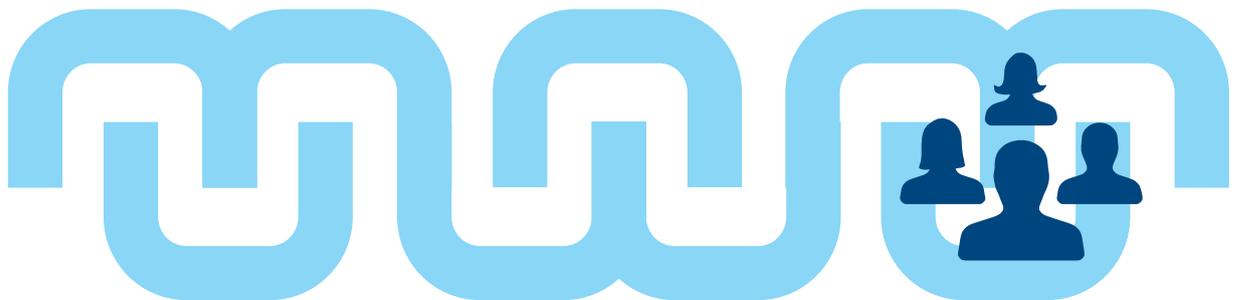
In practice, taking responsibility for improving patient quality care means boards will:

- spend an adequate amount of board time on quality issues
- hold the chief executive accountable for quality and safety goals, and see the chief executive as the person who has the greatest impact on quality
- base the chief executive's remuneration on quality and safety performance
- participate in the development of explicit quality criteria to guide clinical staff
- review patient and family/whānau satisfaction scores annually
- set the agenda for quality
- involve clinical staff in discussions around quality, with clinical staff taking the lead.<sup>17</sup>

A core role of the board is to improve how quality systems function. To achieve this, boards need to actively pursue change, innovation and reform. A board is not there to maintain the status quo. It has to think and act creatively.

A board must articulate its vision of change and strike the right balance between stability and innovation. The active pursuit of change is an evolutionary process that involves board members seeing themselves as enablers. They must have a clear vision and use all means at their disposal to achieve safer care.

Research highlights<sup>18</sup> a number of things all boards can do to improve quality and reduce avoidable or preventable harm. These are outlined in the next section. ●



<sup>17</sup> Institute for Healthcare Improvement 2008, *op. cit.*

<sup>18</sup> *Ibid.*

## What boards can do – the seven essentials

### 1. Lead and set clear goals

It is vital an organisation is unified around a clear mission, vision and strategy to improve quality and patient safety. This involves the board setting a clear direction and monitoring performance. The board's commitment to improving quality must be unwavering and visible to all who work in the organisation.

This vision must be communicated repeatedly to all stakeholders. Boards and chief executives will drive the right leadership culture and nurture people with the skills to lead the changes they desire.

Board members will demonstrate an energy and appetite for improvement. Studies have shown lack of will and commitment on the part of the board is a common cause of quality improvements stalling. A highly engaged board 'will be the source of will for the entire organisation'.<sup>19</sup>

Boards can set specific goals to reduce harm each year and make a public commitment to measurable quality improvement.

### 2. Gather information and seek out patient stories

Boards will review progress toward safer care as part of considering every agenda item at every board meeting. It is also important they put a 'human face' on harm data by hearing stories of patients and families/whānau who have experienced harm. Such story-telling is a powerful way of provoking fresh conversations and helps to guarantee a patient-centred approach at board discussions.

Boards will also receive detailed information from various sources to help establish patterns of harm. One idea is to report back to the board on a significant patient injury in the health care organisation. This will involve sharing the stories of the patient, family/whānau and staff involved. The aim is to illuminate the nature and source of hazards in a complex health care system.

Other potential sources of valuable information include:

- surveys of patient and family/whānau experience
- surveys of staff attitudes and perceptions towards organisational safety culture.

### 3. Establish system-wide measures and monitor them

Boards need to identify organisation-wide measures of patient safety, update the measures continually and make them transparent to the entire organisation and stakeholders.

A board must make sure it is getting the right information on quality of care and the reports it receives contain data that can help board members track quality improvement at the system level. These measures will also include benchmarks against comparable organisations as a way to monitor progress. An example is the rate of medical harm per 100 admissions or per 1000 patient days.

Boards should be educated to understand data in a range of formats. It is also recommended boards present their organisation's key safety data in an easily understood 'dashboard' format. Simple, visual displays are an important aspect of providing a high-level overview of performance against selected quality and safety indicators. Dashboards should be designed to include those areas that impact on quality and safety in an organisation.

<sup>19</sup> *Ibid.*

Boards will also consider establishing a quality and safety sub-committee, chaired by a board member, which analyse quality and safety issues in greater depth than is possible at a board meeting. This is common practice when dealing with financial issues.

#### 4. Put a high quality and safety culture in place

Boards will commit to establishing and maintaining an environment that is respectful, fair and just for all who experience pain and loss as a result of avoidable or preventable harm – patients, families/whānau and frontline staff.

Boards need to drive a culture of high quality and safety characterised by:

- respect
- transparent and open communication
- a commitment to full disclosure
- apology and support where needed
- resolution for patients and families/whānau where harm has occurred.

Boards will demonstrate the courage and commitment to confront these issues, and model expected attitudes and behaviours to the rest of the organisation. They will encourage staff members to proactively manage risk and maximise clinical safety.

In seeking a culture change, experience shows organisations should concentrate on identifying existing pockets of good practice that other groups can emulate. If people are doing good work, it's important for organisations to understand how they got there, and how staff leaders and clinicians worked together to achieve the results.

It is best to focus on delivering positive messages about change rather than negative ones. Every organisation will have examples of great culture and exceptional performance. The challenge is to replicate them. Usually it is not a matter of people not wanting to change, but not knowing how.

It is also important to celebrate learning and achievement, when quality milestones are achieved.

#### 5. Ensure the right mix of people and encourage discussion

To tackle quality and safety issues, boards need a diverse range of skills and experience. Traditionally, for their appointed members, boards have tended to include people with a narrow band of skills, ie, people with technical, professional or financial expertise.

A more modern view is that there needs to be a broad mix of board members including those who can think 'outside the square', challenge the status quo and come up with imaginative solutions. Research shows<sup>20</sup> including 'mavericks' who think and behave differently from others will help efforts to achieve change.

Boards members need to be capable of ranging across multiple areas and appointments to the board should reflect this. The overall aim is to create an environment which encourages robust analysis and debate.

20 Massie S. 2015. *Talent management. Developing leadership not just leaders*. London: The King's Fund. URL: [www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/talent-management-leadership-in-action-jun-2015.pdf?utm\\_source=The+King%27s+Fund+newsletters&utm\\_medium=email&utm\\_campaign=5770588\\_HMP+2015-06-05&dm\\_i=21A8,3FOM4,FLXAAH,CALXO,1](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/talent-management-leadership-in-action-jun-2015.pdf?utm_source=The+King%27s+Fund+newsletters&utm_medium=email&utm_campaign=5770588_HMP+2015-06-05&dm_i=21A8,3FOM4,FLXAAH,CALXO,1) (accessed November 2015).

An observational study<sup>21</sup> of four health boards in England revealed great variation in board members' level of engagement with patient safety. It described wide variation in how board debate was steered and influenced by chief executives and board chairs. The most effective discussions happened when there was reasoned and respectful questioning of management, and discussion was framed within the narrative of improving patient and family/whānau experience. This allowed improvements to be explored dispassionately in relation to culture change, rather than being seen as a personal challenge.

## 6. Commit to ongoing learning at all levels

A board needs to develop its own capabilities to engage effectively with quality and patient safety issues and work out the best strategies to drive continuous improvement. Boards need the skills and knowledge to lead effectively in this area.

On a practical level, board members will have the competence to:

- review quality and safety plans and reports
- evaluate their effectiveness
- consider recommendations for improvement.

Board competencies go to the heart of an organisation's health and safety culture. A recent study<sup>22</sup> found the competencies of board members 'appear to be linked to staff feeling safe to raise concerns about patient safety issues and also their confidence that their organisation would address their concerns'.

Keeping staff engaged and motivated is also crucial to an organisation's ability to provide high-quality care. Through senior management, the board will set an expectation for levels of education and training for all staff. It is easy to over-estimate the ability of frontline staff to improve without the right assistance. Some health care organisations develop their own programmes to build the specific skills staff require to deliver improvements.

A broader view of staff competencies is also required. In the safety and harm context, communication, consultation and relationship-development skills are as important as technical knowledge.

Leadership development is also vital to create an innovative culture. People with talent need to be nurtured so there is confident and empowered leadership at every level.

Boards will place a premium on accessing fresh ideas about improving clinical best practice. They must actively seek out new ideas that are superior to the status quo. The aim is for quality improvement to become part of business as usual.

## 7. Define roles and establish clear accountability at all levels

The roles of boards and senior leaders in the area of safety and quality are complementary.

A board sets the strategic leadership and direction. It drives an organisation's safety and quality culture. Senior leaders implement the strategic direction, manage operations, report on safety and quality, and implement a high quality and safety culture throughout the organisation.

21 Freeman T, Millar R, Mannion R, et al. 2015. Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England. *Sociology of Health and Illness* 38(2): 233-51.

22 Mannion et al 2015, *op. cit.*

As the diagram below illustrates, this relationship is two-way and dynamic.



More specifically, boards will set clear quality improvement targets for the executive team, and link improved performance in quality and safety to remuneration. Organisational managers will ensure quality and safety figure prominently in performance reviews and are part of day-to-day discussions.

It is the board's responsibility to ensure action is taken to address and remedy poor performance. ●

## Assess your progress – a high quality and safety checklist for boards

Here are some questions to help your board assess the robustness of its quality and safety processes and identify areas for improvement. Working through this checklist will help your board identify gaps and initiate discussion.

Please note a separate tool, *Improving quality and safety in the New Zealand health system: A framework for building capability*, is being developed and will be made available to all DHBs.

### Supporting a culture of care and compassion

**1.** *Supporting a culture of care and compassion will be the single most important factor in driving high quality and safety across health services.*

- What is the process for staff to raise concerns about high quality and safety? How do you ensure they can do this in a safe environment?
- What processes or systems are in place to enable referrers (eg, GPs) or other providers to provide input?
- How do you collect, monitor and analyse patient and family/whānau experience data? How do you use this data when making strategic and/or operational decisions?
- How do you ensure everyone in your organisation takes responsibility for high quality and safety in their role?
- How is high quality and safety reflected in the strategic vision of your organisation?
- How do you recognise the importance of care quality in your staff appraisal systems? What are your procedures for managing poor quality care?
- How do you ensure your staff are aware of and adhere to high quality standards and strategies in the health system?

### Promoting board responsibility for high quality and safety

**2.** *Quality and safety in a DHB is ultimately the responsibility of the board, and will be central to the strategic vision of the organisation. In addition to this, every staff member will be aware of their responsibility in ensuring high quality and safety, whatever their role.*

- What quality and safety information is provided to the board? What else does your board do to assure itself all patients and families/whānau are receiving quality care within your responsible population?
- What priority does the board give to high quality and safety? How is this reflected in the board's work and in the education and training provided to board members?
- How do you address high quality and safety issues with your contracted providers? Whose responsibility is it in your organisation?
- What information do you collect or receive to monitor quality and safety within your contracted providers?

### Communicating with and listening to patients and families/whānau

**3.** *Communicating with patients involves listening to them, and providing them and their families/whānau with the right information to be active participants in their own care. Communication will be respectful, understandable and caring. Patients should be able to answer several key questions to determine the quality of care they are receiving.*

**4.** *Listening to patients and families/whānau helps alert organisations to issues and sensitive events as well as enabling them to make improvements in the care of their patients.*

- ➔ What communication standards do you have to govern staff communication with patients and families/whānau?
- ➔ How do you encourage patients and families/whānau to give feedback (including complaints)? What proportion of your discharged patients and their families/whānau has provided feedback to you in the last year?
- ➔ How do you ensure patients and families/whānau are aware of the Code of Rights and of the role of the Health and Disability Commissioner if they do not feel they receive the appropriate standard of care?
- ➔ What is the role of the patient in their care while they are admitted? What information is given to the patients and their families/whānau to enable them to be active participants in their own care, during their time in hospital and post-discharge? How is this information given?
- ➔ How do you enable patients and families/whānau to participate in quality improvement in your organisation, and how do you share the results with them?
- ➔ How do you close the 'quality loop' and ensure lessons learnt are applied?



#### **Effective information and monitoring systems**

**5.** *Each organisation needs to collect data and build a comprehensive picture about quality and safety in the organisation, to enable issues and sensitive events to be identified before they escalate.*

**6.** *Data such as the standardised mortality ratio and clinical quality indicators, if analysed effectively, contribute to a robust data set to drive quality and safety.*

**7.** *The public reporting of key quality and safety data also ensures patients and families/whānau are informed about the quality of care in their DHB.*

- ➔ How do you collect, monitor and analyse patient experience data? How do you use this data when making strategic and/or operational decisions?
- ➔ How do you collect, monitor and analyse staff experience data? How do you use this data when making strategic and/or operational decisions?
- ➔ What is your early warning data set, to enable you to identify and monitor risks and pick up issues before they escalate?
- ➔ How do you collect, monitor and analyse data on adverse events?
- ➔ How do you collect, monitor and analyse data on mortality?
- ➔ Where is the information shared and discussed, and resulting actions agreed? How is progress against agreed actions measured and monitored?
- ➔ How do you ensure appropriate action is taken and is working?



#### **Maintenance of high professional standards and confidence**

**8.** *High quality and safety in the health system is also maintained through law and regulation. This includes auditing services, credentialing of clinicians and a range of standards staff working in the health sector are required to meet.*

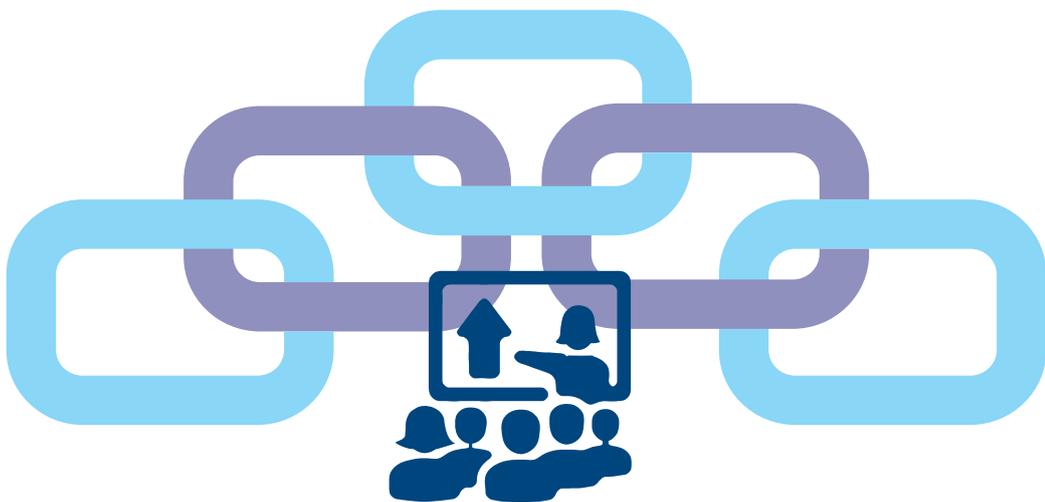
- ➔ How do you ensure recommendations from the Health and Disability Commissioner are put into practice? Whose responsibility is it to ensure this happens?
- ➔ How do you ensure your credentialing processes are robust? How often are senior clinical staff credentialed?
- ➔ How do you ensure issues raised in HealthCert and other audits are addressed? Whose responsibility is it to ensure this happens?



**Strengthening clinical governance and clinical leadership**

9. Clinicians are not only responsible for the provision of high quality patient care; their leadership is also important at all levels of the system. Clinical participation in the management and governance of DHB services is essential in creating the culture needed for high quality and safety.

- ➔ What clinical governance processes and structures do you have?
- ➔ How are clinicians represented at the board and executive leadership level?
- ➔ How does your board identify potential clinical leaders and what development processes do you have in place for them?
- ➔ What clinical audit processes do you have?
- ➔ How do you address deficiencies in practice and service, and how do you ensure your organisation learns from any issues that arise?
- ➔ How do you ensure the 'quality loop' is closed and lessons learnt are applied? ●



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