Waitematā
District Health Board
Best Care for Everyone

BOARD MEETING

Wednesday 21 August 2019

9.45am*

***Note:**

- **Public Excluded Session 9.45am to 12 noon**
- **Open meeting from 12 noon**

AGENDA

Items to be considered in public meeting

VENUE

Waitematā DHB Boardroom
Level 1, 15 Shea Terrace
Takapuna

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of Life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

MEETING OF THE BOARD
21 August 2019

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Tce, Takapuna **Time: 9.45am**

WDHB BOARD MEMBERS	WDHB MANAGEMENT
Judy McGregor - WDHB Board Chair	Dale Bramley - Chief Executive Officer
Max Abbott - WDHB Board Member	Robert Paine - Chief Financial Officer and Head of Corporate Services
Edward Benson-Cooper - WDHB Board Member	Andrew Brant - Deputy Chief Executive Officer
Kylie Clegg - WDHB Board Deputy Chair	Dr Jonathan Christiansen - Chief Medical Officer
Sandra Coney - WDHB Board Member	Debbie Holdsworth - Director Funding
Warren Flaunty - WDHB Board Member	Jocelyn Peach - Director of Nursing and Midwifery
James Le Fevre - WDHB Board Member	Cath Cronin - Director of Hospital Services
Matire Harwood - WDHB Board Member	Tamzin Brott - Director of Allied Health
Brian Neeson - WDHB Board Member	Fiona McCarthy - Director Human Resources
Morris Pita - WDHB Board Member	Peta Molloy - Acting Board Secretary
Allison Roe - WDHB Board Member	

APOLOGIES:

REGISTER OF INTERESTS

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

PART 1 – Items to be considered in public meeting

AGENDA

TIME **9.45am -** *please note agenda item times are estimates only and that the public excluded session is from 9.45am- 12noon*

	1.	**AGENDA ORDER AND TIMING**
9.45am	**2.**	**RESOLUTION TO EXCLUDE THE PUBLIC**
	3.	**BOARD & COMMITTEE MINUTES**
12noon	3.1	Minutes of the Meeting of the Board (10/07/19) Actions arising from previous meetings
	3.2	Minutes of the Hospital Advisory Committee Meeting (31/07/19)
	4.	**EXECUTIVE REPORTS**
12.05pm	4.1	Chief Executive Officer's Report
12.15pm	4.2	Health and Safety Performance Report
12.20pm	4.3	Communications Report
12.30pm	**LUNCH**	
	5.	**DECISION ITEMS**
1.00pm	5.1.	Adoption of Waitematā DHB Governance Manual (including review of Code of Conduct and Standing Orders)
1.20pm	5.2.	Power of Attorney for the Board Chair
	6.	**PERFORMANCE REPORT**
1.30pm	6.1	Financial Performance - June 2019
	7.	**INFORMATION PAPERS**
1.45pm	7.1	The Wai 2575 - Health Services and Outcomes Waitangi Tribunal Inquiry Update
1.55pm	7.2	Patient Reported Outcomes Measures (PROMs) Programme Presentation

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Judy McGregor (Chair)	Associate Dean Post Graduate - Faculty of Culture and Society, AUT Member - AUT's Academic board New Zealand Law Foundation Fund Recipient Consultant - Asia Pacific Forum of National Human Rights Institutions Media Commentator - NZ Herald Patron - Auckland Women's Centre Life Member - Hauturu Little Barrier Island Supporters' Trust	28/03/19
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology Patron - Raeburn House Advisor - Health Workforce New Zealand Board Member - AUT Millennium Ownership Trust Chair - Social Services Online Trust Board member - Rotary National Science and Technology Forum Trust	19/03/14
Edward Benson-Cooper	Chiropractor - Milford, Auckland (with private practice commitments) Edward has three (different) family members who hold the following positions: Family member; FRANZCR. Specialist at Mercy Radiology. Chairman for Intra Limited. Director of Mercy Radiology Group. Director of Mercy Breast Clinic. Family member; Radiology registrar in Auckland Radiology Regional Training Scheme. Family member; FANZCA FCICM. Intensive Care specialist at the Department of Critical Care Medicine and Anaesthetist at Mercy Hospital.	25/03/19
Kylie Clegg (Deputy Chair)	Trustee - Well Foundation Director - Auckland Transport Director - Sport New Zealand Trustee and Beneficiary - Mickyla Trust Trustee and Beneficiary, M&K Investments Trust (includes shareholdings in a number of listed companies, but less than 1% of shares of these companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, Next Minute Holdings Limited). Orion Health has commercial contracts with Waitematā District Health Board and healthAlliance. Director of High Performance Sport New Zealand Limited Board member, Counties Manukau District Health Board Shareholder – Genesis Energy Ltd	10/07/19
Sandra Coney	Member - Waitakere Ranges Local Board, Auckland Council Patron - Women's Health Action Trust Member - Portage Licensing Trust Member - West Auckland Trusts Services	15/12/16
Warren Flaunty	Member - Henderson–Massey Local Board Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder - Green Cross Health Director - Life Pharmacy Northwest Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd Trustee – Hospice West Auckland (past role) Shareholder - Genesis Energy	12/09/18

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Dr Matire Harwood	Senior Lecturer - Auckland University Director - Ngarongoa Limited, which is contractor providing services to National Hauora Coalition GP at Papakura Marae Health Clinic Advisory Committee Member - State Foundation NZ (Māori Health) Member Te Ora, Māori Medical Practitioners Step-daughter is a surgical registrar at Waitematā DHB	10/05/18
James Le Fevre	Emergency Physician - Auckland Adults Emergency Department Trustee - Three Harbours Foundation Member - Medical Protection Society Member - Northern Regional Clinical Practice Committee Shareholder - Pacific Edge Ltd DHB Representative (Auckland and Waitematā DHBs) - Air Ambulance Co-design Procurement Governance Board (past role) James' wife is an employee of the Waitematā DHB, Department of Anaesthesia and Perioperative Medicine and a Medico-Legal Advisor for the Medical Protection Society Board Member - Auckland District Health Board (past role) Shareholder - Genesis Energy	21/11/18
Brian Neeson	Member - Upper Harbour Local Board Member - Human Rights Review Tribunal Member - Auckland District Licensing Committee Managing Director - BK & VS Neeson Limited Managing Director - Apollo Property Investments Limited Property Development Consultant Chair – Wilson Home Committee of Management (past role)	19/12/18
Morris Pita	Owner/operator - Shea Pita and Associates Limited. Shareholder - Turuki Pharmacy Limited Shareholder and Director of Healthcare Applications Limited. In December 2018 this company won an RFP with Waitematā DHB for provision of the Emergency Q software service to reduce overcrowding in the ED and the company is currently (as at 27 March 2019) in the final stages of negotiation for a potential contract for service at both North Shore and Waitakere EDs. Morris' wife is a: Board member - Northland District Health Board Board member - Auckland District Health Board Director - Healthcare Applications Limited Director - Shea Pita & Associates	10/07/19
Allison Roe	Chairperson - Matakana Coast Trail Trust Member - Rodney Local Board, Auckland Council Member - Wilson Home Committee of Management (past role)	22/08/18

2. Resolution to Exclude the Public

Resolution:

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1.	**Minutes of Meeting of the Board - Public Excluded (10/07/19)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
3.	**Minutes of the Audit and Finance Committee – Public Excluded (31/07/19)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
4.	**Minutes of the Hospital Advisory Committee – Public Excluded (31/07/19)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
5.	**Board Chair's Report**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would	**Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
		be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)] **Improper gain or advantage** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or improper advantage. [Official Information Act 1982 S.9(2)(k)]
6.	**Infrastructure Services Programme – Tranche 1 Business Case**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
7.	**Elective Capacity Inpatient Beds – Infrastructure and related works**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
8.	**Special Care Baby Unit – Waitakere Hospital**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
		Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
9.	**New Lease – 46 Taharoto Road, Takapuna**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
10.	**New Zealand Health Partnership**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
11.	**Holidays Act – Memorandum of Understanding**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Conduct of Public Affairs** The disclosure of information would not be in the public interest because of the greater need to maintain the effective conduct of public affairs through the protection of members, officers and employees from improper pressure or harassment. [Official Information Act 1982 S.9 (2) (g)(ii)]
12.	**Safe Transfer of Patients to Urgent Care Clinics**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
		exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	[Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
13.	**Chief Executive Remuneration Review and KPIs**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
14.	**Adult Acute Inpatient Mental Health Quality Improvement Programme – Progress Summary**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
15.	**Legal Updates**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Legal Professional Privilege** The withholding of the information is necessary to maintain legal professional privilege. [Official Information Act 1982 S.9 (2) (h)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
			information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
16.	**E-notes presentation**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]

3.1 Confirmation of Minutes of the Board meeting held on 10 July 2019

Recommendation:

That the Minutes of the Board meeting held on 10 July 2019 be approved.

DRAFT Minutes of the meeting of the Waitematā District Health Board

Wednesday, 10 July 2019

held at the Boardroom, Level 1, 15 Shea Tce, Takapuna,
commencing at 9.51am

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT:

Judy McGregor (Board Chair)
Max Abbott
Edward Benson Cooper
Kylie Clegg (Deputy Board Chair)
Sandra Coney
Warren Flaunty
James Le Fevre
Matire Harwood
Brian Neeson
Morris Pita
Allison Roe

ALSO PRESENT:

Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer)
Debbie Holdsworth (Director Funding)
Jocelyn Peach (Director Nursing and Emergency Planning)
Cath Cronin (Director of Hospital Services) (from 10.18am, item 4.1)
Tamzin Brott (Director of Allied Health, Scientific and Technical Professions)
Fiona McCarthy (Director Human Resources)
Peta Molloy (Acting Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

There were no media representatives present.

WELCOME:

The Board Chair welcomed everyone to the meeting.

APOLOGIES:

Apologies were received from the Chief Executive Officer and Chief Financial Officer.

DISCLOSURE OF INTERESTS

There were no additions or other amendments to the Interests Register.

With regard to item Morris Pita 5.1 Financial Update, Morris noted his EmergencyQ interest with regard to section 7.2 'Highlighted this month: ED Presentations'. He advised that he would step out of the meeting for the discussion of this update.

Kylie Clegg noted that after a query from Audit NZ she would provide the Board Secretary with an updated interest register listing specific companies for her registered interest M+K Investments Trust.

1 AGENDA ORDER AND TIMING

For the open meeting, items were taken in same order as listed in the agenda.

2 BOARD AND COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Board Meeting held on 29 May 2019 (agenda pages 7-17)

Resolution (Moved James Le Fevre/Seconded Warren Flaunty)

That the minutes of the Board meeting held on 29 May 2019 be approved.

Carried

Actions arising from previous meetings (agenda pages 18)

Noted. Max Abbott noted that a strategic session had been suggested around digital innovation.

2.2 Draft Minutes of the Special Meeting of the Board held on 26 June 2019 (agenda pages 19-21)

Resolution (Moved Edward Benson-Cooper/Seconded Kylie Clegg)

That the minutes of the Special Meeting of the Board meeting held on 26 June 2019 be approved.

Carried

2.3 Draft Minutes of the Hospital Advisory Committee Meeting held on 19 June 2019 (agenda pages 22-30)

Resolution (Moved James Le Fevre/Seconded Allison Roe)

That the draft minutes of the Hospital Advisory Committee meeting held on 19 June 2019 be received.

Carried

3 CHAIR REPORT

3.1 Board Chair's Report (agenda pages 31-61)

The Chair noted the correspondence received (agenda pages 31-61) from the Ministry of Health regarding 'Board decision-making and communications in the district health board election period'. She noted the key areas of the letter to be addressed, including observer status, removing profiles from the DHB's website, use of promotional material between now and the end of the election period and the use of DHB facilities by elected members is prohibited (stationery, postage, email or phone).

In response to a question about political neutrality in the public sector, the Board Chair noted that she had raised this matter as political neutrality is not possible with appointed members. It is suggested this be changed to political impartiality.

4 EXECUTIVE REPORTS

4.1 Chief Executive's Report (agenda pages 62-83)

A video clip on the opening of the refurbished Waitakere Hospital Spiritual Centre was shown.

Andrew Brant (Acting Chief Executive) summarised the report; in introduced the reported outcomes discussion 'Māori lung cancer screening research programme'. Karen Bartholomew (director Health Outcomes) further summarised the outcomes discussion noted that it is an exciting programme of work. Ethics approval is underway. The programme has strong Māori leadership.

Matters covered in discussion and response to questions included:

- In response to a question about vaping, it was noted that a regional meeting had recently been held on this topic to look at a range of views. A video produced by the Health Promotion Agency on Māori women's perspectives and experiences with smoking and vaping is available on its website; the website link will be sent to Board members. The region is developing a statement around vaping. The Board will have the opportunity to review any submission from the DHB on this matter. In response to a question, it was noted that a paper about vaping will be presented to the Board soon.
- In response to a query about low dose CT screening (in the 'Māori lung cancer screening research programme' outcomes discussion – page 70 of the agenda), it was noted that technology related to radiation doses continues to improve.
- With regard to costs for population screening, it was noted this is a research programme and research funding will be sought. The financial modelling indicates it is more viable to have population based screening.

The report was received.

4.2 Health and Safety Performance Report (agenda pages 84-94)

Michael Field (Group Manager, Occupational Health and Safety Service) and Fiona McCarthy (Director, Human Resources) presented this item.

Michael Field said that the DHB has reached a staff flu vaccination rate of 65%. Due to vaccine availability nationwide, the DHB is following the Ministry of Health guidelines for the use of remaining vaccine with high risk staff (such as pregnant or have a health risk) and high risk patients being prioritised. The DHB has ordered more vaccine, but it is not yet known if it will be received. It was also noted that the DHB had introduced an opt-in form for staff to complete, which has captured additional information.

Matters covered in discussion and response to questions included:

- That the shortage of flu vaccine had encouraged people to seek a vaccination to not miss out.
- Australian media were reporting on the influenza outbreak in Australia.

- The month-on-month reduction of injuries associated with aggressive incidents was highlighted. In response to a query about what the DHB was doing to improve this area of safety, it was noted that: a review of community services was undertaken to look at the types of injuries received, the security team was provided with impact resistant and stab proof vests, sturdy boots with ankle support and 'bite proof' gloves. It was also noted that when members of the public are cognitively aware of the camera in a security vest it reduces the number of aggressive incidents.
- It was noted that 'Managing Aggression and Potential Aggression' training is being arranged across the DHB.
- The DHB is organising a presentation from the NZ Police on being safe at night. This follows the presentation given at Counties Manukau DHB, which was well received.
- In reference to the book 'Beyond the Stethoscope' and managing wellbeing, it was noted that the DHB, in conjunction with the Mental Health Foundation, has developed a pilot on the 5 ways of wellbeing and creating positive work environments. Each of the 5 ways has key actions to improve wellbeing; one of this is being connected. The training provides those attending the 5 ways of wellbeing, strategies to use and how to apply these to the work environment. The intention is to teach a group of people the 5 ways and for them to take it back to their areas of work and pass on the knowledge. Two sessions are planned (one in August and one in September) for the pilot programme. If the pilot programme shows that in-team training is successful it will be rolled out further.
- It was confirmed that the additional security door access at North Shore Hospital is due for completion in August 2019.
- That the definition of a 'lone worker' (page 93 of the agenda) relates to people who work alone, such as community nurses or someone who is in a building on their own. The DHB is undertaking a project in this area to review organisational policies and procedures covering lone worker emergency response plans. The Board requested a more detailed update on this project.

The report was received.

4.3 Communications Report (agenda pages 95-104)

Matthew Rogers (Director Communications) and Ruth Dryfhout (Communications Advisor) were in attendance for this item.

Matthew Rogers introduced Ruth Dryfhout to the Board. He noted the work she did in preparing the videos to be viewed at the meeting. The two short videos are related to the DHB's campaign work on promoting MRR vaccinations. Six short videos were produced in total. The most viewed post reached 68,500 viewers and was shared 245 times. Matthew Rogers also acknowledged the work of the Planning and Funding immunisation team in this area.

The first video viewed by the Board was of Kaylee, who spent her first birthday in Waitakere Hospital with measles. The second video was of Max, who is a young transplant patient, this video was shared 159 times. It was noted that the Communications team monitors and manages comments posted on the DHB's social media page.

Matters covered in discussion and response to questions included:

- There are further videos to be uploaded to reach wider audiences, a link will be sent to the Board on these videos.
- The Planning and Funding team are working with Māori general practitioners to promote immunisation.
- The DHB's campaign videos [content] have been shared with Auckland and Counties Manukau DHBs.
- The Communications team is active regarding media/social media seven-days a week for the DHB. Any 'trolling' on social media is actively monitored.
- In response to a question about the immunisation videos posted, it was noted that the DHB includes a link with each video the Ministry of Health website which provides immunisation facts.

The Board thanked Ruth for her work on the compelling stories and on social media for the DHB.

Matthew Rogers said that for the year ended 30 June 2019, the DHB received 500 unique media enquiries and produced 47 proactive media releases. In addition, the DHB has received 115 OIA requests to-date (compared to 96 at the same time in the previous year); the six-month statistics for the year show 93 OIA responses to-date, with no breaches.

The report was received.

5 PERFORMANCE REPORTS

5.1 Financial Performance (agenda pages 105-118)

Morris Pita noted his registered interests for EmergencyQ as it relates to an update provided in the Financial Performance report for 'ED Presentations' (pages 117-118 of the agenda). Before stepping out of the meeting for the discussion of this item, Morris Pita tabled an observation related to section 1.1 of the report, under key financial impacts for the Funder Arm including 'lower than planned demand, especially in pharmaceuticals' (page 106 of the agenda) and queried whether this reflected a softening in growth of the population. In response Debbie Holdsworth (Director Funding) advised that it is not related to population, but that it is difficult to understand the lower demand as it is forecast at a national level not a DHB level. Morris Pita stepped out of the meeting.

Simon Watts (Acting Chief Financial Officer) summarised this report. Matters covered in discussion and response to questions included:

- That the EY Sustainability Implementation Plan will commence with weekly reporting to the Executive Leadership team. The status report will progress through to the Board.
- Noting the amendment to capital charge going forward. The capital charge changes will apply going forward and that at this time there is no guidance around retrospective removal.
- That the ED voucher system is paid for by the DHB and each voucher provides one doctor's visit.

The report was received.

6.1 Statement of Performance Expectations (SPE) Performance Report: Quarter Three 2018/19 (agenda pages 119-129)

Wendy Bennett (Manager, Planning and Health Intelligence) was present for and introduced this item.

Matters covered in discussion and response to questions included:

- The first draft of the Annual Plan will be presented to the Board at its September meeting.
- With regard to update provided on ED admissions 'unknown' to be alcohol related (page 127 of the agenda), it was noted that historically it had not been required to report alcohol related information in ED. Going forward better data quality will be available.
- In response to a query about 'PHO-enrolled population with login access to a portal' (page 127 of the agenda) that there are a number of issues to work through to ensure the data is usable, but it is ground-breaking and evolving. Primary Care is progressing in the area of IT; reference to the data collected around diabetes was noted, and the time it took to develop a system to match data.

The report was received.

8. RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages130-134)

Resolution (Moved Warren Flaunty/Seconded Kylie Clegg)

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1.	Minutes of Meeting of the Board - Public Excluded (29/05/19)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
2.	Minutes of the Special Meeting of the Board - Public Excluded (26/06/19)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
3.	Minutes of the Audit and Finance Committee – Public Excluded (19/06/19)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
4.	Minutes of the Hospital Advisory Committee – Public Excluded (19/06/19)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
5.	Chair's Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
6.	healthAlliance C Class Share Issue	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
7.	Living Wage	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)] **Commercial Sensitivity** The disclosure of information would not be in the public interest because of the greater need to protect information where the making available of the information would be likely unreasonably to prejudice the commercial position of the person who supplied or who is the subject of the information. [Official Information Act 1982 S.9 (2) (b)
8.	KARE Project	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
9.	Funding for ARPHS	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
10.	Wilson Centre - New Lease and Development Agreement	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
11.	Cash Flow	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
12.	Elective Capacity and Inpatient Beds (ECIB) Initiation Works	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
13.	Interventional Radiology Update	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
14.	Procurement Update	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
15.	Legal Update	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Legal Professional Privilege** The withholding of the information is necessary to maintain legal professional privilege. [Official Information Act 1982 S.9 (2) (h)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]

The open meeting concluded at 11.10 a.m.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD - BOARD MEETING HELD ON 10 JULY 2019

_____CHAIR

Actions Arising and Carried Forward from Previous Board Meetings as at 15 August 2019

Meeting Date	Agenda Ref	Topic	Person Responsible	Expected Report back	Comment
10/07/19	4.2	Health and Safety Update A further update to be provided on the review being undertaken on organisational policies and procedures covering lone worker emergency response plans.	Michael Field		Report updated on this agenda. The review has commenced and a further update will be provided when available.

3.2 Minutes of the Hospital Advisory Committee meeting held on 31 July 2019

Recommendation:

That the Draft Minutes of the Hospital Advisory Committee meeting held on 31 July 2019 be received.

Draft Minutes of the meeting of the Waitematā District Health Board

Hospital Advisory Committee

Wednesday 31 July 2019

held at Waitematā District Health Board Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.00 p.m.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

James Le Fevre (Committee Chair)
Judy McGregor (Board Chair)
Max Abbott
Edward Benson-Cooper
Kylie Clegg (Deputy Board Chair)
Sandra Coney
Warren Flaunty
Matire Harwood
Brian Neeson

ALSO PRESENT

Dale Bramley (Chief Executive Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Cath Cronin (Director of Hospital Services)
Jocelyn Peach (Director of Nursing and Midwifery)
Fiona McCarthy (Director Human Resources)
Tamzin Brott (Director of Allied Health)
Lorraine Bailey (IDF Performance Manager)
Peta Molloy (Acting Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

Jodi Yeats, The Rangitoto Observer

WELCOME

The Committee Chair welcomed those present.

APOLOGIES

Apologies were received and accepted from Morris Pita and Allison Roe and for early departure from Sandra Coney.

DISCLOSURE OF INTERESTS

There were no additions to the Interests Register.

There were no interests declared that might give conflict with a matter on the open agenda.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed in the agenda, except item 4.3 was considered before item 4.2.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Hospital Advisory Committee Meeting held on 19 June 2019 (agenda pages 7-15)

Resolution (Moved Kylie Clegg/Seconded Max Abbott)

That the Minutes of the Hospital Advisory Committee meeting held on 19 June 2019 be approved.

Carried

Actions Arising (agenda pages 16-17)

The actions were noted. No issues were raised.

3. PROVIDER ARM PERFORMANCE REPORT

3.1 Provider Arm Performance Report – May 2019 (agenda pages 18-83)

Executive Summary/Overview

Cath Cronin (Director Hospital Services) summarised this section of the report.

With regard to SOS "Self-referral on Symptom" for outpatient follow up (page 22 of the agenda) it was noted that i3 is closely involved with the initiative, which provides opportunities in the management of waiting lists.

Human Resources

Fiona McCarthy (Director Human Resources) introduced this section of the report. She acknowledged the vaccination rate and advised that remaining vaccine supplies were being offered to staff.

Acute and Emergency Medicine Division

John Scott (Head of Division, Specialty Medicine and Health of Older People), Alex Boersma (General Manager) and Melody-Rose Mitchell (Associate Director Nursing, Medicine) were present for this section of the report.

Alex Boersma introduced the report, summarising the reported highlights and key issues.

Matters covered in discussion and response to questions included:

- With regard to staff training associated with safety and security as reported (page 40), it was noted that the MAPA training engages staff in the initial stage of training. The next stage is sustainability. In addition, it was noted that the eCALM training module is mandatory with all staff in the emergency department completing the module.
- With regard to mandatory training, the time of year training is undertaken is taken into consideration, for example the months of June/July/August are busy from a service perspective. It is important to make sure staff have time to do training.
- The DHB monitors the number of aggressive incidents, and whether these are verbal. This data will be reported to the Committee; this will be linked to the HR update provided.

The Committee Chair acknowledged and thanked the service for the work they do.

Specialty Medicine and Health of Older People Division

John Scott (Head of Division, Specialty Medicine and Health of Older People), Brian Millen (General Manager) and Melody-Rose Mitchell (Associate Director Nursing, Medicine) were present for this section of the report.

John Scott introduced this section of the report. The reported highlight of the month, Implementing Electronic notes (E-notes) on Wards 15 and 14 and the key issue, Hospital Palliative Care Team were noted.

Matters covered in discussion and response to questions included:

- The Committee requested a presentation on E-notes.
- That there are options for palliative care in Waitakere, with an appointed SMO at Waitakere Hospital.

Child, Women and Family Services

Meia Schmidt-Uili (Head of Division Medical Child Women and Family), Stephanie Doe (General Manager) and Emma Farmer (Head of Division Midwifery) were present for this section of the paper.

Meia Schmidt-Uili introduced the report. The highlight of the month, Implementation of the Outreach Fluoride Varnish Programme was summarised.

Matters covered in discussion and response to questions included:

- With regard to topical fluoride application, it was noted that information on oral health status was collected, but that any influence over/or impact of was not likely to be seen for some time. There is a particular focus on improve care for Maori and Pacific children.
- That with regard to gynaecology targets in WEIS, how counting/coding is captured is being looked at. There is the potential that documentation associated with coding is incorrect (not coders). This matter is also being looked at in other services as well.

Specialist Mental Health and Addiction Services

Dr Susanna Galea-Singer (Director and Head of Division), Pam Lightbown (General

Manager), Alex Craig (Head of Division Nursing) and Derek Wright (Consultant) were present for this item.

The Chief Executive introduced Derek Wright to the Committee, noting that Derek will be providing support to the Mental Health Service over coming months.

Susanna Galea-Singer introduced the report.

Matters covered in discussion and response to questions included:

- The IPS update was noted. The commitment from the Ministry of Social Development in this area was acknowledged, the Board Chair suggested and it was agreed that a letter of thanks be sent from the DHB.
- The recent events in the service was noted, the safety of the ward is a priority with a number of actions being put in place.
- The service is currently recruiting; there is a vacancy rate of 7%. Work is also underway with NRA (Northern Region Alliance) on recruitment processes.
- A Ministry led session was held in Auckland prior to the meeting, which included discussion around workforce issues.

Surgical and Ambulatory Services

Charlie McFarlan (Clinical Director, Anaesthesia), Kate Gilmour (Associate Director of Nursing) and Karen Hellesoe (Operations Manager) were present for this item.

Kate Gilmour introduced the report, noting the highlight of the month 'Outreach 24/7 North Shore Hospital', which has been in place for eight weeks.

Information regarding the demand of surgical pathology laboratory staff will be reported back to the Committee.

Diagnostic and Clinical Support Services

Cath Cronin (Director Hospital Services) summarised these sections of the report.

The Committee Chair noted the data provided in the Provider Arm report and noted the need to see disaggregated data by ethnicity for each directorate in the area of DNA. He also said each service should have a number of strategic initiatives that have an equity focus, with at least on Maori equity focus.

The Committee received the report.

3.06pm – Matire Harwood retired from the meeting.

4. CORPORATE REPORTS

4.1 Clinical Leaders' Report (agenda pages 84 - 94)

Jocelyn Peach (Director of Nursing and Midwifery), Tamzin Brott (Director of Allied Health) and Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer), were present for this item.

Nursing and Midwifery and Emergency Planning Systems

Jocelyn Peach summarised this section of the report. The matter of workforce planning was noted; it is a nationwide issue and at present the DHB has 11 positions still to fill. Students are being engaged with to support and understand how they are progressing.

Allied Health, Scientific and Technical Professions

Tamzin Brott noted similar workplans to that of nursing and that there is also a link directly with the Ministry of Health's Deputy Director General for Health Workforce.

Tamzin summarised the remainder of this section. In response to a query, it was noted that the 'Get Up, Get Dressed, Get Moving' material is available online.

Medical Staff

Andrew Brant summarised this section of the report, acknowledging in particular the accreditation of PGY1.

The report was received.

4.2 Quality Report (agenda pages 95 - 201)

This item was considered after item 4.3.

Penny Andrew (Clinical Lead, Quality) and Jacky Bush (Quality and Risk Manager) were present for this item. An apology was received from David Price (Director of Patient Experience).

Jacky Bush introduced and summarised the report. Matters covered in discussion and response to questions included:

- The inaugural Consumer Council meeting was held; a website for the Consumer Council is being considered. If a Consumer Council member was elected to the Waitemata DHB Board, they would resign to take up their elected role on the Board.
- The good results in the national in patient surveys were noted.
- Statistics on the number of staff who have received the influenza vaccine and then contracted the flu year on year were requested if available.
- Noting the new measure around opioids.
- With regard to the document bowel function update, it was noted that it has taken time to develop measures. It is an iterative process with clinical input. There is the ability to measure this in eVitals, particularly with e-progress notes.

Penny Andrew summarised the section of the report related to i3, noting in particular the support being provided to the Mental Health Services team related to improvement programme, a new piece of work assisting the surgical team around informed consent and the sepsis improvement programme

Matters covered in discussion and response to questions related to the i3 update section of the report included:

- That the update provides a horizon scan of work being undertaken; it was suggested that deep dives on particular projects could be provided to the Committee to give a better understand on the potential of projects.
- Projects are linked to the financial sustainability programme and all projects have a clinical sponsor. If seed funding is required, it will be detailed in a business case. It was noted that innovation often happens in a constrained environment.

The report was received.

4.3 Human Resources Report (agenda pages 202-204)

This item was received before item 4.2.

Fiona McCarthy (Director Human Resources) introduced this item.

There were no matters raised.

6. RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 205)

Resolution (Moved Warren Flaunty/Seconded Max Abbott)

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 19/06/19	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Quality Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
3. Human Resources Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
	reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

Carried

The open session of the meeting concluded at 3.47 p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATA DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 31 JULY 2019

_____COMMITTEE CHAIR

4.1 Chief Executive's Report

Recommendation:

That the Chief Executive's Report be received.

Prepared by: Dr Dale Bramley (Chief Executive Officer)

1. News and events summary

A number of events of significance took place across the DHB over the past six weeks:

Executive appointments - Dr Jonathan Christiansen has been appointed Chief Medical Officer (CMO), replacing Dr Andrew Brant who, after nine years as CMO, remains as Deputy Chief Executive. Dr Christiansen first joined Waitematā DHB in 1991 as a fifth-year medical student and later became House Officer. He spent several years in the United States as a specialist and returned to North Shore Hospital in 2003 as a general physician, running a general medical team and working as a consultant cardiologist. He has held several leadership roles since then, including Head of Division for Medicine and Health of Older People Services and Associate CMO.

In other news, Stuart Bloomfield has been permanently appointed to the position of joint Chief Information Officer (CIO) Waitematā DHB and Counties Manukau DHB. Mr Bloomfield joined Waitematā DHB in 2003 as our Mental Health Services Information Manager, followed by Decision Support Group Information Manager before taking on the CIO role in 2013. For the past year he has been working across both the Waitematā and Counties Manukau DHBs as CIO, describing it as both challenging and invigorating.

Pictured are (left) incoming Chief Medical Officer Dr Jonathan Christiansen and (right) Chief Information Officer Stuart Bloomfield

Focus on the future - Minister of Health Rt. Hon. Dr David Clark has laid out his expectations to DHBs in an open letter to Board Chairs. In the letter, he encourages continued support of the Government's priorities: increased collaboration between sectors, reduction of inequities, and strong leadership from DHBs in priority wellbeing areas. The Minister also highlighted his expectations in a number of areas, including ongoing progress toward Smokefree 2025; closer integration between primary and secondary care; moving toward only selling water and milk as cold drink options, which is part of the Healthy Food and Drink Policy; improving mental health services

and strengthening support around emerging drug threats such as synthetic cannabis; and strong focus on developing the healthcare workforce and implementing Care Capacity Demand Management. We currently have a number of successful initiatives underway to support these areas, particularly within the Māori Health Pipeline, our recruitment processes and i3.

Progress toward our new hospital – This month, hoardings will be erected around the demolition site of the Pupuke and Taharoto buildings at North Shore Hospital. These works will help make way for our new hospital, set to be completed in 2023. This is an exciting project that will eventually cost over $240 million, the biggest construction project our DHB has seen since the construction of the main North Shore Hospital tower block more than 30 years ago. The safety hoardings will feature an artist's impression of what the new build will look like and more information about the project.

Artist's impression on the new hospital

Improving health outcomes for Māori – Our Matāriki Awards were held on 4 July at Whenua Pupuke. This was a chance for us to recognise individuals and teams who have made outstanding efforts to improve health outcomes for Māori. It was great to see our staff helping to reduce inequities for Māori by looking for innovations, driving initiatives, opening communication lines and breaking down barriers. The winners were: Everyone Matters – Te Rau Kamehameha Team for their work in raising the level of physical activity among Māori mental health patients; With Compassion – Te Kaunihera Kaumatua o He Kamaka Waiora for the work they do to support and advocate for Māori patients and their whānau; Connected – Whānau Ora Cancer Navigators from Te Whānau o Waipareira Trust for their work developing a digital diary to help families embarking on a cancer journey; and Better, Best, Brilliant – Karyn Thwaites-Valter from the Auckland Regional Dental Service for her helping patients overcome barriers to attending scheduled appointments.

New guardian for korowai - Registered nurse Stella Williams was announced as the winner of Waitematā DHB's Te Kauae Raro Māori Nursing and Midwifery Awards in July. In recognition of the award, she was given guardianship of a korowai, a traditional hand-made Māori cloak, for the year. Ms Williams, who is of Te Rarawa, Te Aupouri and Nga Puhi descent, graduated from Unitec in 2017 and works at the DHB's Whītiki Maurea - Māori Mental Health and Addiction Services in Henderson,

West Auckland. The award recognises the bicultural advisory work she is doing with new-graduate nurses, occupational therapists and social workers. Ms Williams is now completing her post-graduate diploma in nursing and will begin her Masters studies in 2020.

Registered Nurse Stella Williams is the recipient of the Te Kauae Raro Māori Nursing and Midwifery Award

Investing in the future of footcare – The Diabetes Podiatry Service and AUT's Department of Podiatry have launched a combined clinic within AUT Integrated Health (AIH) on Akoranga Drive – a five-minute car trip from North Shore Hospital. AIH is a state-of-the-art interprofessional learning environment for Bachelor of Health students, which gives patients access to a wide range of related services. DHB podiatrists aggressively treat active foot wounds or infections and work closely with patients and whānau to educate them about early warning signs and how to protect their feet from deterioration. It is important for patients to identify nerve damage and structural changes to their feet that would result in a loss of sensation and put them at-risk of further damage or wounds. We see great value in developing a future workforce in this essential area.

Everyone matters - The 'Hello My Name Is…' is campaign launched on 23 July to highlight the importance of staff introducing themselves to patients and whānau. A simple 'hello' and a quick introduction is often all it takes to help put someone at ease – particularly if it's accompanied by a warm and friendly smile. It's something we prescribe regularly in our hospitals, especially when patients, family and whānau need some reassurance in times of uncertainty. Our annual 'Hello My Name Is…' campaign serves as valuable reminder that no one should ever be too busy to say hi.

Here is a great video that explains the importance of this campaign, featuring some of our staff at Waitakere Hospital:
https://www.facebook.com/WaitemataDistrictHealthBoard/videos/626563821085989/

Collaboration in the Cook Islands – We have signed a Memorandum of Understanding (MOU) with the Cook Islands Ministry of Health, which formalises a partnership that will help enhance the professional development of healthcare workers based in the Pacific nation and create learning opportunities between our hospitals. Two staff members who have been instrumental in establishing this MOU are Clinical Director of Pacific Mental Health Dr Francis Agnew and Anaesthetist Dr Ted Hughes. Both doctors are of Cook Island descent and have spent years establishing strong connections abroad. Formalising this relationship will be beneficial to all staff

keen to improve health outcomes for Cook Islands patients coming to New Zealand. The MOU was signed at the Cook Islands Health Conference 2019 (10 -12 July) in Rarotonga. The conference was focused on the main theme of Smokefree 2025 as well as community health, traditional medicine, non-communicable diseases, mental health, vulnerable populations and workforce. I presented an overview of Waitematā DHB at the conference to demonstrate the progress we have made toward equitable outcomes for Māori, our values and the innovations coming out of i3.

Dale Bramley signed a Memorandum of Understanding with Dr Josephine Aumea Herman, Secretary of Health for Te Marae Ora: The Ministry of Health Cook Islands.

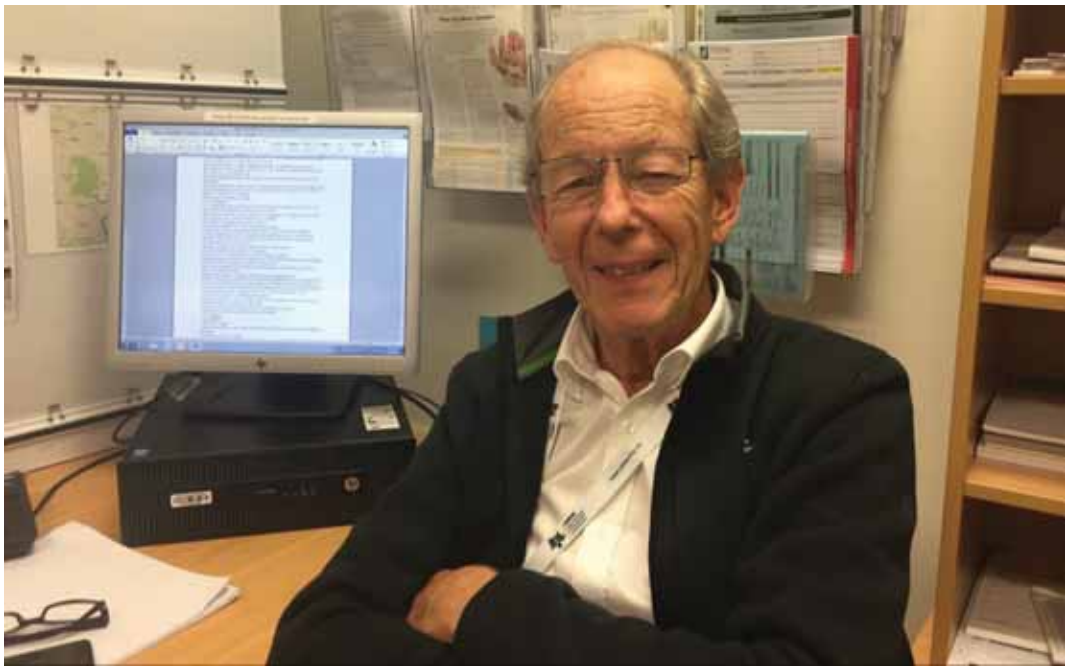
Health Hero - July's Health Hero Award went to Michelle Gordon, a dental therapist with Auckland Regional Dental Service. Ms Gordon is based in Papakura and has been instrumental in developing Qlik Sense for our dental service, a software tool that helps us analyse data in a more meaningful way that has helped engage more kids with the service.

Deputy CEO Dr Andrew Brant (right) presenting Michelle Gordon with her Health Hero Award.

Milestone for Elective Surgery Centre – The Elective Surgery Centre (ESC) at North Shore Hospital celebrated six years since opening on 19 July. During that time the team have treated 30,000 patients and completed 1,825 hip operations, 2,385 knee operations, 2,353 hernia repairs, 909 breast lump surgeries and 728 prostate surgeries.

The original team at the opening of the Elective Surgery Centre in 2013

Respected surgeon retires – Internationally renowned orthopaedic surgeon Mr Tim Astley retired on 2 August after an extraordinary 50-year career. Mr Astley, who helped create Waitematā DHB's orthopaedic service alongside Mr John Cullen in 2004, is globally recognised as an expert in shoulder surgery and has been a highly sought-after figure on the lecture and training circuit. The life-long Aucklander started his career as a house surgeon for the late Mr Ross Nicholson at Middlemore Hospital in 1969, the same year that Neil Armstrong and Buzz Aldrin landed on the moon. Mr Astley has contributed to an orthopaedics service that is second-to-none and he has made a huge difference in the lives of many thousands of patients. He is also a highly-respected teacher and mentor to many up-and-coming orthopaedic surgeons. We wish him all the best for a happy retirement.



Surgeon Tim Astley has retired after 50 years in medicine

Spirituality in palliative care - All staff were invited to attend a presentation by London-based Brunel University Professor Holly Nelson-Becker at North Shore Hospital's Whenua Pupuke auditorium (and via video link) on 6 August where she discussed hospitals, healing and spirituality in palliative care. Professor Nelson-Becker is the author of 'Spirituality, Religion and Ageing: Illuminations for

Therapuetic Practice', a book designed to help multi-professional groups better-understand and work with patients.

Expansion of baby unit – Preparation has started for the $6 million upgrade of our Special Care Baby Unit (SCBU) at Waitakere Hospital. Construction is due to start in October. The new unit will be designed to meet the needs of a growing West Auckland population and have room for a bed or recliner chair right next to premature babies and unwell infants who require specialised hospital care enabling parents or caregivers to stay overnight. Fundraising for the new unit has been carried out by Well Foundation.

Raising awareness - World Hepatitis Day on 28 July was an important opportunity to learn more about different types of viral hepatitis that impact thousands in New Zealand and what is being done to help eliminate them. In the Waitematā DHB catchment, about 8,000 people have chronic hepatitis C and only half of these people are aware they have it. We took the opportunity to remind people about the free checks offered by several pharmacies across Waitematā.

Enabling breastfeeding - Maternity staff at North Shore Hospital celebrated World Breastfeeding Week (1 August – 7 August) with some cakes for the new mothers on the ward. The staff, mums and new bubs enjoyed getting together, sharing some breastfeeding tips and offering support. World Breastfeeding Week aims to promote and support breastfeeding to both mothers and fathers, informing on its benefits and addressing some of the inequities that prevent breastfeeding.

Midwives at North Shore Hospital celebrating World Breastfeeding Week

Renovations at North Shore Hospital – Work is currently underway at North Shore Hospital to upgrade waiting rooms in Phlebotomy, Radiology and Outpatients. Making these spaces more modern, functional and comfortable contribute to patient experience and creates a nicer working environment for staff.

Leadership in healthy food - We are making great progress on the National Food and Drink Policy, having overhauled the cafes and snacks available to the public in recent years and installing more

water fountains. By making unhealthy options less-accessible, we are helping our community to make better choices about what they consume. It was also great to see the complaint, from Healthy Auckland Together (HAT) group involving the metro Auckland DHBs, Auckland Council and the Ministry of Health, recently upheld by the Advertising Standards Authority. The advert in question was promoting Cookie Time biscuits. It featured a bowl of cookies and milk as the "perfect breakfast" in an ad that ran on social media in January. HAT successfully argued the ad promoted unhealthy eating and large portion sizes.

Creating a culture of appreciation - A further **50 staff** have been recognised in the CEO Awards, launched in mid-2014 to celebrate those staff, nominated by their colleagues and patients, who demonstrate our organisational values through their work. Each staff member whose nomination is considered worthy of acknowledgement receives a personalised letter of thanks, a certificate of appreciation and a small gift. Staff acknowledged with a CEO Award since the last Board meeting are included as ***Appendix One.***

2. Upcoming events

Looking toward the upcoming months, we can expect to see:

- August – Preparation for demolition of the Taharoto-Pupuke buildings commences ahead of construction of the new hospital building.
- 12-16 August – Cystic Fibrosis Awareness Week
- 14 August – Nurse graduation at Whenua Pupuke
- 14 August – Second meeting of the Consumer Council at Waitakere Hospital
- 9-13 September - Asian Health Week
- 12 October – Local Body Elections
- 29 October – Health Excellence Awards at ASB Waterfront Theatre.

3. Future Focus

The Leapfrog programme was established as a means to support a focused, intensive burst to take a large leap in moving the DHB from where we are to where we want to be. The programme consists of a small number of strategic organisation-wide projects that are resourced to achieve significant change and impact on health outcomes and patient/family experience.

Leapfrog and i3 continue to receive enquiries from DHBs, across the country, looking for guidance on their own planning and implementations of systems and technologies in use at Waitematā DHB. Four Leapfrog projects have been completed this year-to-date (Qlik, Mobile Security, MEAP and PERSy) with two new Phase 3 projects added (Digital Clinical Academy and the Patient Experience System). ePrescribing/MedChart trial on a new test network has proven successful with noticeable speed improvements and planning is now underway to scale-up the test network to be production-ready for these systems.

The end-to-end Patient Reported Outcomes Measures (PROMS) system is complete, including a bespoke website (http://proms.waitematadhb.govt.nz) that features a resource library and an online checklist for clinicians. Surveys are integrated with the clinical portal so that the results can be viewed in a patient's clinical record within five minutes of them completing a survey. Clinicians have expressed their excitement at having real-time data available to discuss with patients and we have had international interest with organisations such as the Agency for Clinical Innovation in Australia asking to learn about our programme after seeing the website.

Our email validation service has resulted in the collection of over 340,000 validated emails across three systems since October. Deployment of the digital post service, which utilises our pool of validated emails, is in full swing and is now live across 82 ARDS clinics, physiotherapy, cardiology procedures and all PSC Referral Clerks. Our Transcription Service went live on 5 August and will increase volumes through the new service from 4,000 to 8,000 letters per week. Around 45% of letters are being sent via email (forecast was 30% after 12 months) and we realised our first OPEX savings in June.

4. Board performance priorities

The following provides a summary of the work underway to deliver on the DHB's priorities:
Relief of suffering

Progress: ✔

Patient Experience

Better Outcomes ✔
Progress: On track

National Inpatient Survey

HQSC weighted results			
Communication	**Partnership**	**Co-ordination**	**Needs**
8.4 WDHB	**8.5 WDHB**	**8.2 WDHB**	**8.5 WDHB**

National Survey Quarter One (January- March 2019)

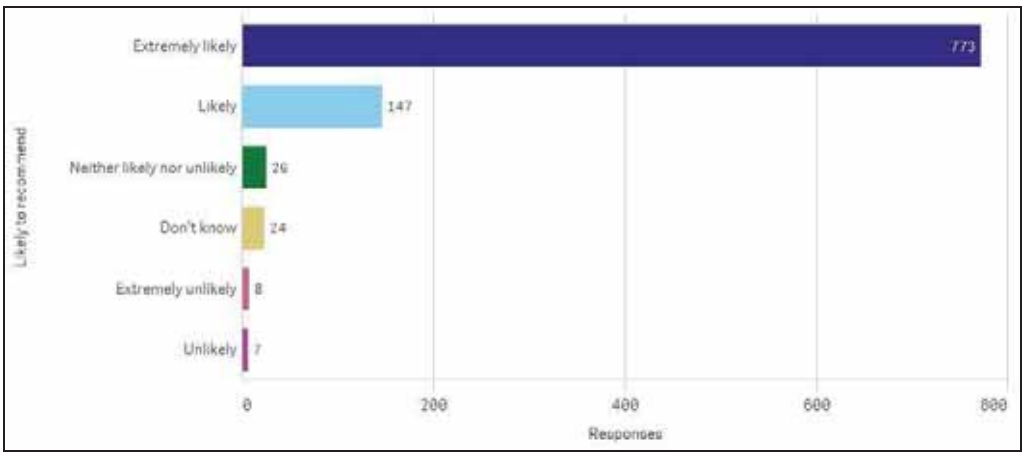
Following a similar trend from the previous quarter, all National Inpatient Surveys were sent electronically. The response rate for quarter one was 32%, which is an increase from last quarter (27%). National response rate for this quarter was 24%.

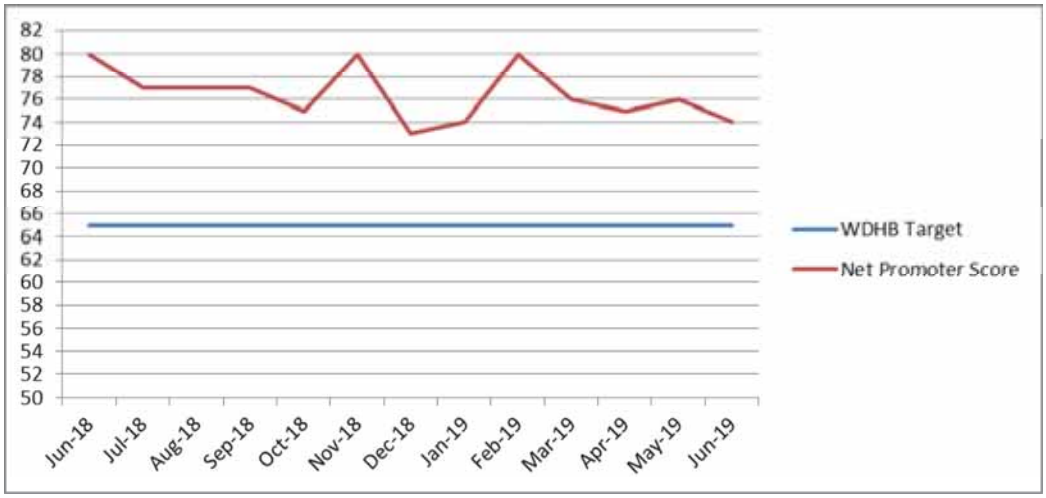
Waitematā DHB scores for communication and partnership were our highest scores ever achieved. All other domains are above our median score.

Friends and Family Test

In June 2019, our Net Promoter Score (NPS) decreased two points to 74 and we received feedback from 985 people, a decrease of 18% from the previous month. Despite this, the NPS continues to perform well and scores above the DHB target of 65.

The net promoter scores in June met the target for all Friends and Family Test questions. This month, all measures improved slightly or were on a par with the previous month. 'Welcoming and friendly' rated the highest with a score of 90 followed by 'showing care and respect' at 89.





Consumer Council Update

A pōwhiri was held on 3 July to welcome the 13 members of our new Consumer Council and hold the first meeting. Meetings will be six-weekly for the rest of the year and the next meeting is scheduled on 14 August at Waitakere Hospital.

Waitematā DHB's Consumer Council is pictured with Director of Patient Experience (far left) David Price, CEO Dr Dale Bramley and Board Chair Professor Judy McGregor.

Achieving the priority targets – June 2019

- Better help for smokers to quit (maternity) – 95% (target 90%)
- Improved access to elective surgery – 106% (target 100%)
- Shorter waits in ED – 95% (target 95%)
- Faster cancer treatment – 82% (target 90%)
- Increased immunisation – 93% (target 95%)
- Raising healthy kids – 100% (target 95%)

Health Quality and Safety markers

Falls

Falls risk assessment audits that inform the Health Quality and Safety Commission data continue and are conducted monthly. Overall, Acute & Emergency Medicine completed 99% of falls risk assessments, Specialist Medicine & Health of Older People completed 100% and Surgical and Ambulatory completed 100% on admission. Of those, Acute & Emergency Medicine completed 95% Specialist Medicine & Health of Older People 35%[*] and Surgical and Ambulatory completed 83% within eight hours of admission (against a target of 90%).

Hand Hygiene

Waitematā DHB's Hand Hygiene Compliance Audit result for June 2019 is 90%; this exceeds national target of 80% compliance and is equal to our highest-ever result. Well done to all of the staff involved.

[*] *An issue with information systems not recognising that AT & R ward patients are "Admitted" following transfer/discharge from an acute ward have impacted department results this month. This is being addressed*

Healthcare-Associated Infections

The CLAB insertion bundle was used in ICU on 100% of occasions in June 2019. The insertion bundle compliance also exceeds the national target of 90%.

Māori Health

Māori scorecard

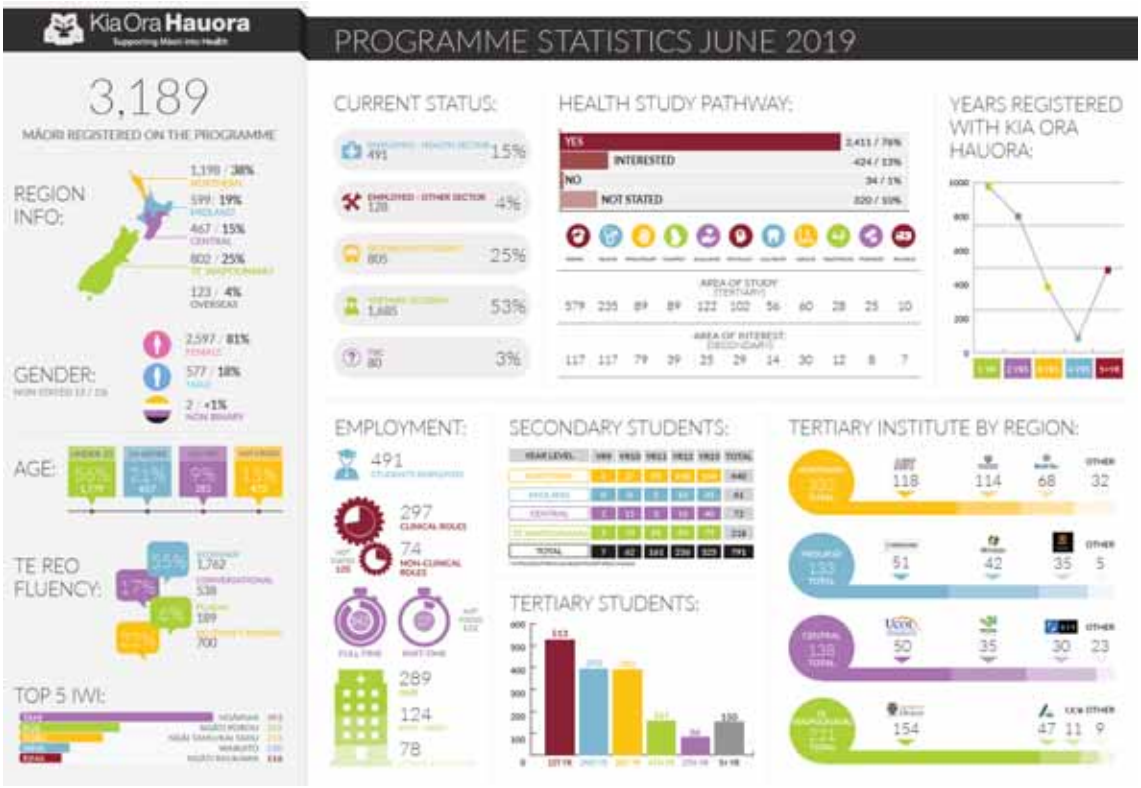
- Shorter waits in ED – 96% (target 95%)
- Helping smokers to quit (hospitalised) – 99% (target 95%)
- Older patients assessed for falling risk – 100% (target 90%)
- Raising healthy kids – 100% (target 95%)

Māori Patient and Whānau Experience Lead

A Māori Patient and Whānau Experience lead role for Waitematā DHB has been approved and will be jointly progressed by Patient Experience and Māori Health teams. The role will provide leadership and capability to strengthen our ability to collect, share and respond to feedback on Māori patient and whānau experiences within the healthcare sector.

Kia Ora Hauora Māori Health Careers Program

The Kia Ora Hauora Maori health careers program continues to perform beyond contracted expectations. The Ministry of Health have recently provided some additional funding to enhance the programme in key areas: promoting health careers, supporting science achievement, supporting tertiary success, transition to employment and delivery of results. It is wonderful to see that 491 of the registered Kia Ora Hauora students have been employed.



Pacific Health

Pasifika Ball

The Moana Pasifika ball was held at the Maritime Museum on 3 August, celebrating the tireless work of the Pacific Health workforce. The event was a huge success, with attendance from The Fono, South Seas, Pacific Health and Welfare, Pacific Medical Association, Pacific Futures and DHB staff from across the region. The event is a celebration, as well as a chance for us to fundraise, for our charity partners and enable networking between people who are supporting Pacific Health across Waitematā and Auckland. The event was emceed by former Manu Samoa rugby player Filipo Levi.

MC and former Manu Samoa rugby player Filipo Levi, Warriors player Manu Vatuvei, boxer Joseph Parker and Pulotu Bruce Levi are pictured on-stage discussing issues related to Pacific communities as part of the Pacific Ball.

CEO Scorecard

Waitematā DHB Monthly Performance Scorecard

CEO Scorecard
June 2019

Health Targets

	Actual	Target		Trend
Better help for smokers to quit - maternity	95%	90%	●	▲
a. Better help for smokers to quit - primary care	*87%*	*90%*	●	▼
Improved Access to Elective Surgery - WDHB	106%	100%	●	▲
Shorter Waits in ED	95%	95%	●	--
Faster cancer treatment (62 days)	82%	90%	●	▼
Increased immunisation (8-month old)	93%	95%	●	▲
Raising Healthy kids	100%	95%	●	--

Provider Arm - Service Delivery

Waiting Times	Actual	Target		Trend
ESPI				
ESPI 1 - 90% OP Referrals processed w/n 10 days	*Compliant*			
ESPI 2 - % patients waiting > 4 months for FSA	*Non-Compliant*			
ESPI 5 - % patients not treated within 4 months	*Non-Compliant*			
Diagnostics				
% of CT scans done within 6 weeks	75%	95%	●	▲
% of MRI scans done within 6 weeks	92%	90%	●	▲
Urgent diagnostic colonoscopy (14 days)	96%	90%	●	▼
Diagnostic colonoscopy (42 days)	49%	70%	●	▲
Surveillance colonoscopy (84 days)	58%	70%	●	▲
Patient Flow				
Elective Surgical Discharges (YTD)				
Elective Discharges - Total	20,776	20,293	●	▼
Elective Discharges - Provider Arm	13,968	14,006	●	▼
Elective Discharges - IDF Outflow	6,808	6,287	●	▼
Efficiency				
Outpatient DNA rate (FSA + FUs)	7%	≤10%	●	--
a. Average Length of Stay - Electives	*1.42 days*	*≤1.49 days*	●	▲
a. Average Length of Stay - Acutes	*2.71 days*	*≤2.3 days*	●	▼

Best Care

Patient Experience	Actual	Target		Trend
Complaint Average Response Time	10 days	≤14 days	●	▲
Net Promoter Score FFT	74	65	●	▼
HQSC Quality and Safety Markers - Quarterly				
Older patients assessed for falling risk	97%	90%	●	--
Older patients assessed sig. fall risk with care plan	99%	90%	●	▲
Good hand hygiene practice	90%	80%	●	▲
Occasions insertion bundle used - ICU	100%	90%	●	▲
Occasions maintenance bundle used - ICU	96%	90%	●	▲
e. Surgical site infection rate per 100 procedures	*0.0*	*≤0.93*	●	▲
b. Antibiotic in the right time	*97%*	*100%*	●	--
Improving outcomes				
Better help for smokers to quit - hospitalised	99%	95%	●	--
a. Ambulatory Sensitive Hospitalisation rate (ASH) 0-4	*5724*	*≤5263*	●	
f. Annual amenable mortality rate (per 100 000)	*62.9*	*≤63*	●	▲
Population coverage/Access				
a. Cervical Screening	*71%*	*80%*	●	--
a. Breast screening	*65%*	*70%*	●	--
c. Bowel Screening				
% referred for colonoscopy (45 days) following +ve iFOBT	*96%*	*95%*	●	▲
Treatment				
a. HSMR (Source: Health Round Tables)	*0.82*	*≤1.01*	●	▼
a. Surgical intervention rates (per 10,000 pop)				
- Angioplasty	*15.7*	*12.5*	●	▼
- Angiography	*41.2*	*34.7*	●	▼
- Major joints	*23.2*	*21*	●	▲
- Cataract	*45.2*	*27*	●	▲
g. # NOF patients to theatre (48 hours)	*99%*	*85%*	●	▲
ST elevation MI receiving PCI (120 mins)	93%	80%	●	▲
AT&R referrals assessed (2 working days)	98%	90%	●	--

Managing our Business

Staff Experience	Actual	Target		Trend
Sick leave rate	3.3%	≤3.4%	●	--
d. Turnover rate - external	12%	≤14%	●	▲
Lost time injury frequency (12 mth rolling average)	18	≤10	●	▼
Financial Result				
Expense/Revenue (YTD Total)	1,850,157 k	1,840,192 k	●	▼

Major Capital Programmes	Time	Budget	Quality
Elective Capacity and Inpatient beds	●	●	●
Mason Clinic Tanekaha replacement	●	●	●

Maori Scorecard

k. Health Targets - Monthly	Actual	Target		Trend
Shorter Waits in ED	96%	95%	●	▲
Increased immunisation (8-month old)	85%	95%	●	▲
Better help for smokers to quit - hospitalised	99%	95%	●	--
Faster cancer treatment (62 days)	60%	90%	●	▼
Raising Healthy kids	100%	95%	●	--
k. Quality and Safety Markers - Monthly				
Older patients assessed for falling risk	100%	90%	●	--
Older patients assessed sig. fall risk with care plan	100%	90%	●	--
g. # NOF patients to theatre (48 hours)	*100%*	*85%*	●	--

Health Targets - Quarterly	Actual	Target		Trend
Better help for smokers to quit - maternity	94%	90%	●	▲
a. Better help for smokers to quit - primary care	*86%*	*90%*	●	▼
Quality and Safety Markers - Quarterly				
h. Surgical site infection rate per 100 procedures	*0*	*0.93*	●	
Maori Workforce - Quarterly				
Māori percentage of overall workforce	6.8%	7.0%	●	▲
Māori percentage of priority workforce group	5.8%	5.8%	●	▲
New employee ethnicity not specified	0%	≤5%	●	--
Existing employee ethnicity not specified	2%	≤5%	●	--

How to read

Performance indicators:

- ● Achieved/ On track
- ● Not Achieved but progress made
- ● Substantially Achieved but off target
- ● Not Achieved/ Off track

Trend indicators:

- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. Small data range may result small variations perceived to be large.

a. Reported quarterly - latest available Mar Q3 18/19
b. Dec Q2 2018/19 (latest HQSC data available).
c. Bowel Screening - New Indicator - % referred for colonscopy (within 45 days) following positive iFOBT (Sep 16 - Mar 19).
d. Employees taking positions outside of the hospital/DHB
Prelim Data Dec Q2 18/19
f. Annual data - latest available 2015
g. Coding dep, rolling 3 mths - May 19
h. Reported quarterly - latest available, Dec Q2 18/19
e.
k. Small volumes result in sensitivity to traffic light criteria

A question?

Contact: Victoria Child - victoria.child@waitematadhb.govt.nz - Reporting Analyst, Planning & Health Intelligence, Planning, Funding and Health Outcomes, Waitematā & Auckland DHBs Team

Appendix One - CEO Recognition

Nick Wiki - Charge Nurse Manager, Tanewhakapiripiri, Mason Clinic. Nominated by Shivika Singh.
"Thank you for all your hard work, commitment and invaluable contribution to Mason Clinic, especially in the kaupapa Māori stream. You manage multiple roles within the workplace and the community. Once again, thank you."
Janine Steenhuis - Charge Nurse Manager, Pohutukawa Unit and IDOLs Team. Nominated by Shivika Singh.
"The things you do for your teams does not go unnoticed. You have done well teaching yourself to work with new technology and applications. I appreciate your dedication and service and I know others do too."
Dudley Tate - Charge Nurse Manager, Te Aka Unit, Mason Clinic. Nominated by Shivika Singh.
"Your professionalism, leadership qualities, and passion for the job are what make you an incredible person to work with. Thank you."
Simon Portelli - Charge Nurse Manager, Rimu Unit, Mason Clinic. Nominated by Shivika Singh.
"Thank you for being a workplace advocate. As part of the management team, you made important decisions that were in your team's best interest."
Kevin Seaton - Charge Nurse Manager, Court Liaison Team, Mason Clinic. Nominated by Shivika Singh.
"You are a wealth of knowledge when it comes to the area of your work. You advocate for your staff and ensure they are getting the best teaching and working experiences. Thank you."
Dave Fuimaona - Mental Health Psychiatric Assistant, Kauri Unit, Mason Clinic. Nominated by Azizun Nisha.
"Dave continues to work in partnership with the patients. He would make himself available to sit in reviews by the MDT and advocates on the patient's behalf, and he works closely with the patients to support them in their recovery journey. Dave is a very hard working staff member on Kauri Unit."
The following people have been nominated by Azizun Nisha.
Christine Hakaraia - Registered Nurse, Kauri Unit, Mason Clinic.
Eugene William - Mental Health Psychiatric Assistant, Kauri Unit, Mason Clinic.
"Both Christine and Eugene would complete any tasks assigned to them even if it's prior to start of their shift. Eugene ensures that all BEIMS reports are followed-up and Christine maintains Kauri Units Quality and Health and Safety board in the staffroom. Their contribution towards the team and ward is extremely valued."
Dr Kristy Usher - Registrar, Assessment Treatment and Rehab. Nominated by Martin Connolly.
"Kristy has been working hard and long hours without a house officer for the past two weeks. She is amazingly hard-working, conscientious, and has a wonderful manner with patients and their families."
Ewan Morris - Physiologist, Respiratory Service. Nominated by Kelly Webster and Claudia Thomson.
"Ewan has been extremely supportive while we have been training and studying towards becoming registered and competent respiratory physiologists. We are privileged to have his depth of knowledge, time and guidance since starting our journey at the WDHB. He is a pleasure to work with and helps us achieve 'better, best, brilliant'. Thank you!"
Haidee Renata - Registered Nurse, Community Mental Health North. Nominated by Michael Storey.
"Haidee has not long returned to work from maternity leave, to the pleasure of our team welcoming back her expertise, professionalism and forever positive outlook and attitude. Haidee certainly warrants CEO recognition for the value she brings to Waitematā DHB."
Shari Johnston - Administrator, Forensics Management. Nominated by the Forensics Admin Team.
"Shari goes above and beyond to promote the Waitematā DHB values. She is happy to step in and help out in other departments when in need, and she is a valuable member of our team. Keep up the good work!"

Ashlee Kolodzinski - Security Administrator, Security Services. Nominated by Karen Fraser.
"I would like to nominate Ashlee for her amazing attitude and ability to calmly help many of us navigate getting new security and parking cards recently. She has an amazing sense of humour, is welcoming and efficient, and goes out of her way to make the process simple and quick. Ashlee is a great example of being 'better, best, brilliant'!"
Nicola Marchant - Enrolled Nurse, Home Health Support West. Nominated by Jacquie Cook.
"I would like to express my appreciation for Nicola working with the Waitakere District Nurses on a very stressful day. She demonstrated initiative, stepped up beyond her scope of practice, and assisted her Registered Nurse colleagues with patient care and needs. Thank you Nicky - you're a star!"
Hulita Mafile'o - Registered Nurse, Ward 14, North Shore Hospital. Nominated by Kirsten Ter Braak and Patient Feedback.
"Hulita role models the WDHB core values of 'with compassion' following patient feedback received recently who described Hulita as 'professional, thorough and genuinely considerate'. Hulita always wants to make a positive difference for her patients and is supportive and positive of her colleagues. We all really value Hulita within our nursing team."
Tony Bedford - Recreation Officer, Kauri Unit, Mason Clinic. Nominated by Chipo Gunda.
"Tony works alongside service users in supporting their recovery by providing vocational opportunities. With his skills, he supports them to make furniture for their rooms especially in rehabilitation units, and also helps facilitate family relationships by allowing service users to make items for their loved ones. Thank you Tony, for your hard work, and welcoming demeanour and patience."
Julie Gregory - Registered Nurse, Prison Liaison. Nominated by Sharon Price.
"Julie has been a long standing team member and her wealth of experience will be greatly missed, not only within the FPT but the wider Waitematā DHB."
Sarah Neall - Registered Nurse, Anawhata Ward, Waitakere Hospital. Nominated by Gaylene Kolodzinski.
"For the empathetic and compassionate care she gave to one of her patients. Sarah showed skill and understanding in her approach to a young woman facing a life threatening condition, focusing on her needs."
Anishma Ram - Dental Therapist, Dental South 3. Nominated by Linda Graham.
"Anishma is a 'jewel in the crown'. She is extremely professional in her approach to 'everyone matters'. She treats everyone as if they are the most important people in her world at that particular moment. She is caring, helpful, and generous of her time. Thank you Anishma for all that you do for the dental world."
Katrina Paterson - Dental Therapy Assistant, Dental South 3. Nominated by Linda Graham.
"Katrina is well suited to her position. She displays compassion towards the patients and parents and also to her fellow work colleagues. 'Everyone matters' to Katrina and everyone deserves the best possible treatment they can receive. She is happy to assist anyone where she can and tries hard to make sure everyone is 'connected' to what is happening."
Rafa Garalde - Dental Therapy Assistant, Dental South 1. Nominated by Linda Graham.
"Rafa has been amazing to work with. She has been very supportive whilst we are delivering our service to the our community. She has made sure our clinic is running smoothly as we address the arrears in our area. Rafa makes sure everyone is welcome, has a wonderful caring nature with the children and is supportive to me so that I can complete my work. Thank you Rafa for all that you do to help make our day run smoothly."
Leuila Matagi Stevenson - Dental Therapist, Dental South 3. Nominated by Linda Graham.
"Leuila is an excellent role model for his culture, and he is able to relate well to the clientele, and the patients of the area he is working in. I have observed elder members of the community visibly relax when they have seen Leuila is going to treat their child and they are able to converse in their native tongue as well. He displays compassion towards his patients and the staff. His clientele are made to

feel as though their opinion is important and that the treatment is a shared decision. Well done, Leuila."

The following staff have been nominated by Lisa Simonsen.

Steven Perryman - Painter, Maintenance and Utilities, Facilities and Development.

Wade Wilson - Fitter, Maintenance and Utilities, Facilities and Development.

"One afternoon recently I was stuck with a flat tyre in the car park after my shift when Wade and Steven came to my rescue. They took the time to make sure I could travel home safely, going above and beyond to help a damsel in distress. They are both a credit to the maintenance team."

Marivic Sy - ACC Revenue Specialist, Accident Compensation Unit. Nominated by Leanne Browne.

"Marivic has consistently gone over and above her role to support Allied Health teams across the DHB. Through her tireless efforts and committed approach these teams have been able to successfully access ACC revenue. We are grateful to have Marivic's breadth of experience and knowledge and value her dedication to these essential service improvements."

Gaye Nankervis - Registered Nurse, Kahikatea Unit, Forensics Service. Nominated by Chris McCloughen.

"For Gaye's continued valuable work in quality control/auditing; and in particular, Metabolic Screening. Gaye puts a lot of effort into this and takes time to talk to our Tangata Whaiora about the importance of regular exercise, good diet, and not smoking; explaining how they can reduce long term risk for cardiac and cerebral vascular incidents."

Rebecca Sinclair - Registered Nurse, Child & Family North. Nominated by Natasha Myers.

"Rebecca is a compassionate and dedicated public health nurse who shows a continual commitment to improving health outcomes for our community. She has recently celebrated a 10-year nursing anniversary and has recently published an article for the College of Nurses, Aotearoa NZ. Rebecca is also an inclusive, supportive and an inspirational colleague."

Maurice Wogan - Registered Nurse, Forensic Prison Team. Nominated by Sharon Price.

"This is for his outstanding dedication in his relatively new role within the Forensic Prison Team. He worked long hours into the night after the end of his working day following the release of a vulnerable prisoner to ensure the best outcomes for the client and safety for all."

Julie Morrow - Maternity Administration Clerk, Waitakere KYM. Nominated by Kirsty Pascoe.

"During the staff influenza campaign, Julie eagerly encouraged and supported her colleagues to get vaccinated and lead the way by being one of the first. I have always been impressed by Julie's manner with patients at reception and those attending clinics. Her positive and friendly manner often puts anxious and stressed patients at ease."

Dr Himadri Seth - SMO, Kauri Unit, Forensics Service. Nominated by Devika Judd.

"Dr Seth is a strong advocate for the community ID clients. He ensures (goes above and beyond) that continuity of care is maintained when clients are being transitioned between services by liaising consistently with the external providers."

Michael Nares - Registered Nurse, Intellect Disability Liaison (IDOLS). Nominated by Devika Judd

"This is for facilitating numerous staff education sessions to the ID NGO providers on medication and metabolic screening. Educating NGO services help maintain wellness for our ID client population by up-skilling and increasing knowledge base for the staff members supporting ID community forensic clients."

Susan Brook - Outpatient Clinic Coordinator, New Initiatives. Nominated by Rebecca Eade.

"Susan is committed to improving our outpatient service. She is friendly and patient in sharing her knowledge with all colleagues."

Setaita Tu'ungafasi – Cleaner, Clinical Support Services. Nominated by Waiatarua Nursing Team.

"Setaita is extremely hard working and always has a smile on her face. While she was away there was a noticeable difference in the standard of cleaning done. She is always on her feet, trying to find work to do. Setaita definitely deserves to be recognised for her hard work."

Leanne Parish - Specialty Nurse, General Surgery & ICU. Nominated by Julie Bale.

"Leanne is always approachable to all of the booking clerks, and often goes above and beyond. She also has a lovely phone manner whilst dealing with patients who are about to embark on surgery."
Prescilla Menezes - Registered Nurse, Kahikatea Unit, Mason Clinic. Nominated by Gaye Nankervis.
"Prescilla has worked tirelessly since coming to our unit and singlehandedly has reorganised our clinic structure into a more efficient and streamlined system that has made all our lives simpler."
Bev Hopper - Clinical Nurse Specialist, Ward 8. Nominated by Emilie Corgnet.
"Bev always goes above and beyond the call of duty and is incredibly compassionate with our patients and their whanau. She always listens and advocates for her patients actively."
Sarah Lee - Occupational Therapist, Inpatient North Therapies. Nominated by Gina Cavendish.
"This is for her professional and persuasive advocacy, swimming against the tide to get the best outcome for one of our patients on Ward 15."
Pippa Eldridge - Physiotherapist, Inpatient North Therapies. Nominated by Taryn Kearney.
"Pippa has been amazing to work with. She consistently demonstrates the DHB values and is a well-respected member of the team. Pippa is always willing to share her clinical knowledge and experiences, providing valuable learning for staff and students, while managing her own demanding caseload. Pippa is a huge asset to WDHB and the physio profession."
Priscilla Pearson - Volunteer, Ward 14. Nominated by Kirsten Ter Braak.
"Priscilla is one of the hardest working volunteers I have seen. Even on her own she tries to get around to all patients, as well as topping up stores in the kitchen, helping and interacting with our patients. She has a lovely positive personality and I appreciate all her amazing work."
Lizzy Hurrell - Occupational Therapist, Inpatient North Therapies. Nominated by Amy Mathews and Taryn Kearney.
"Lizzy has demonstrated exceptional skills as a new graduate and adapted well to fast-paced orthopaedic ward without prior hospital experience. She is a great team player and is always willing to cross-cover to support others when needed."
Fabian Hemopo - Mental Health Psychiatric Assistant, Inpatient Waiatarau. Nominated by Shance Lencse.
"Fabian is an exceptionally skilled and competent mental health clinician who's experience and expertise is invaluable in the inpatient setting. He consistently contributes to both the provision and delivery of service lead care and intervention, and frequently takes the lead in difficult and challenging situations with acutely unwell individuals."
Nick Maddern and Adele Downes - Registered Nurses, Ward 2. Nominated by Megan White.
"Nick and Adele always take a patient-centred approach, making extra time to ensure patients are comfortable and their voices are heard. They both work collaboratively with allied health and take an active part in their rehabilitation goals and journey. It is lovely working with you!"
Sally Furzer - Social Worker, Inpatient North Therapies. Nominated by Gina Cavendish.
"For her sense of humour and her persistent advocacy for a patient on ward 11. Sally truly represents 'best care for everyone'."
Mustafa Shaabany - Project Manager, i3. Nominated by Sue Brown.
"Mustafa has recently assisted me with producing a short instructional video for a project launch. He has been endlessly and unfailing helpful during the process. Mustafa has organised others to help make the process go more smoothly and he has produced a high quality product, over delivering on his brief with a day to spare on his deadline. He has been the embodiment of great customer service."
Olivia Hay - Orderly, Clinical Support Services. Nominated by Katrina Matich.
"Olivia recently showed great initiative on a particular job and was able to take direction with ease. Her fantastic attitude and common sense dramatically reduced the time to complete the job."
Alga Konkoth - Cleaner, Clinical Support Services. Nominated by Katrina Matich.
"Alga upholds and demonstrates the DHB values brilliantly. She is an outstanding team player always thinking of others and the job at hand."
Danielle Medek - Registrar, General Medical. Nominated by Dr Cheryl Johnson.

"For her extremely hard work in organising the teaching sessions for all 23 candidates we had preparing for the RACP Clinical Exam. Danielle worked tirelessly on scheduling cases with consultants and keeping a running tally of patients. Without her help our trainees would not have been so successful in passing the exam."

Elaine Docherty - Clinical Nurse Specialist, Health for Older Adults. Nominated by Dr Cheryl Johnson.
"This is for her continued work on the 'Get Up, Get Dressed, Get Moving' campaign. Elaine has championed the work of this campaign (formerly known as #EndPJParalysis) in the DHB for the last few years. She has led an educational campaign to benefit the patients of our DHB along with work to identify our frail older population and provide best care for these patients."

Lara Halligan - Facilities Administrator, Facilities and Development. Nominated by Carol Pack.
"Lara provides support to our staff with quiet, professional and consistent efficiency. She always has a smile and is willing to give a helping hand to everyone. She is the 'go to' person for where to find things and getting information in a hurry. We are extremely lucky to have someone that consistently provides superb assistance, support and information but is rarely recognised as the gem she is."

4.2 Health and Safety Performance Report

Recommendation:

That the Board receives the report.

Prepared by: Michael Field (Group Manager, Occupational Health and Safety Service)
Endorsed by: Fiona McCarthy (Director, Human Resources)

1. Purpose of report

The purpose of the Health and Safety Performance Report is to provide quarterly reporting of health, safety and wellbeing performance including compliance, indicators, issues and risks to the Waitematā DHB.

2. Strategic Alignment

Community, whanau and patient centred model of care	This report comments on issues and risks that impact on staff health and safety and therefore patient care and organisational culture.
Emphasis and investment on both treatment and keeping people healthy	This report comments on organisational health and safety information via incident reports, health monitoring and identified hazards.
Intelligence and insight	This report provides information and insight into staff workplace incidents and what Waitematā DHB is doing to respond to these and other workplace risks.
Evidence informed decision making and practice	The leading and lagging indicator dashboard is based on current best practice indicators and targets. Risk controls are regularly audited to align to an evidence base.
Outward focus and flexible, service orientation	Health, safety and wellbeing risks and programmes are focused on staff, visitors, students and contractors. All strategic and operational work programmes and policy decisions are discussed with relevant Services, such as site visits and approaches to reduce risks.
Operational and financial sustainability	As appropriate, programmes of work will outline how Services will ensure operational sustainability, how measures of success are set and value and return on investment is monitored.

3. Executive Summary

For the June reporting period, Waitematā DHB has met the majority of leading and lagging indicators.

A particular highlight is our influenza vaccination rate which is 66% against a target of 60%.

Our target for pre-employment health screening prior to commencement was 53% against a target of 70%. Managers have been contacted to follow up staff that have not been screened and to clarify the expectation that all staff complete their pre-employment health screening prior to commencement. As previously advised, we are employing extra nursing resource for six months, to help screen and follow up staff to ensure pre-employment screening has occurred before commencement.

The Lost Time Injury Frequency Rate (LTIFR) remains challenging, with a higher number of incidents requiring lost time per million hours worked than our target (18 against a target of 10). Programmes to address incident rates are ongoing, with regular communications and advice being provided to staff, both electronically, through posters and during face-to-face Divisional meetings. Although the LTIFR remains challenging, the Lost Time Incidents (LTIs) requiring less than seven days off work remains strong at 58%, compared with a target of 65%. This shows that many of the actions we have undertaken to reduce the consequence of incidents are delivering positive results.

Overall, reported incidents have reduced with a downwards trend since June 2018. In relation to top accident types:

1. Slips, trips and falls increased by two this month to a total of 12:

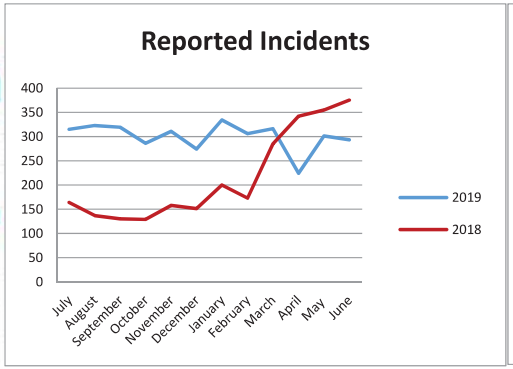
    - Three tripped over equipment or objects
    - Three tripped due to uneven pavement
    - Three fell while exiting vehicles
    - One tripped up stairs
    - One fell off chair
    - One tripped over own feet

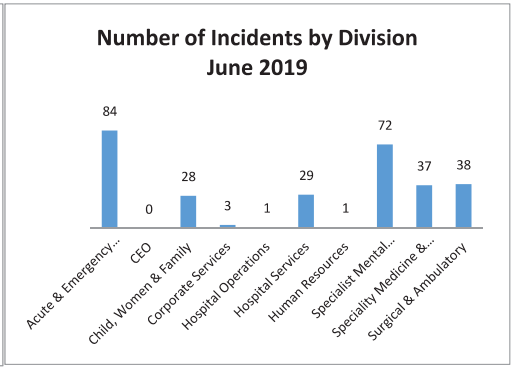
2. Moving and Handling of patient incidents increased this month, from 15 in May to 18 in June, with the Moving and Handling team reviewing and following up on all incidents, including auditing moving and handling equipment in the areas injuries were sustained.

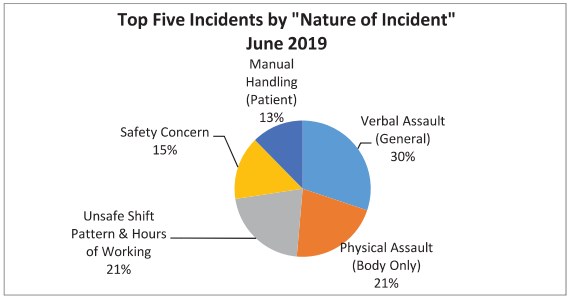
3. Aggression incidents overall, have decreased over the past few months. The number of physical incidents has steadily decreased from 89 in March to 65 in April to 61 in May to 43 in June. As previously reported, a number of actions are in place to manage the likelihood of incidents occurring and/or to reduce the severity of consequence when incidents occur.

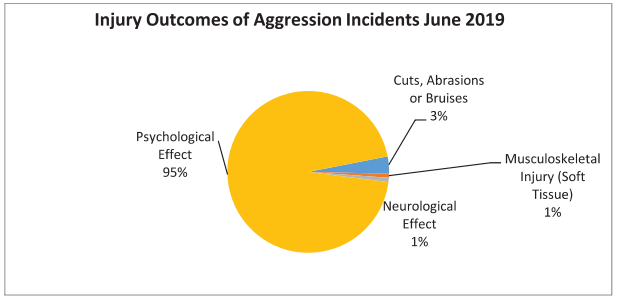
4. In June, all incidents were caused by people who had no intent to cause harm (100%) and 100% of incidents were instigated from patients.

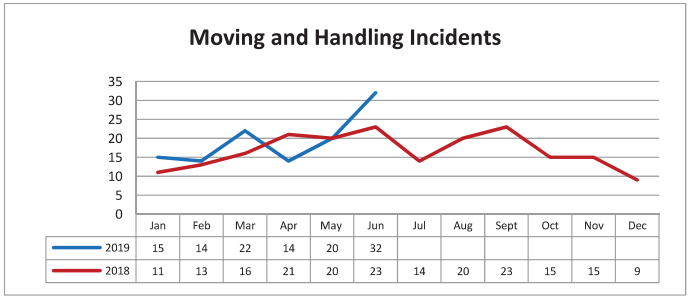
4. Performance Dashboard

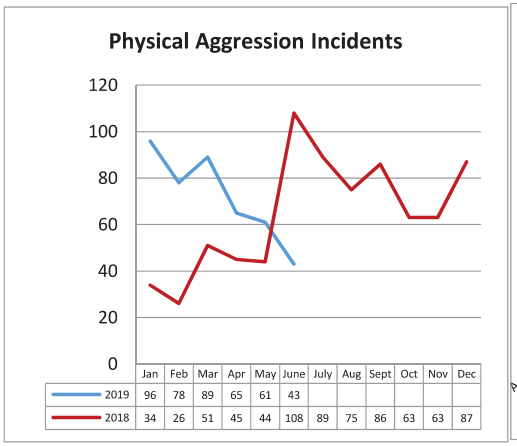


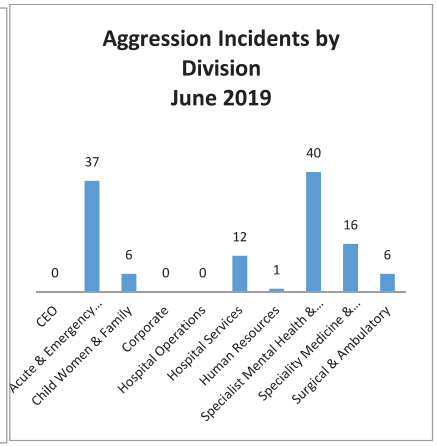


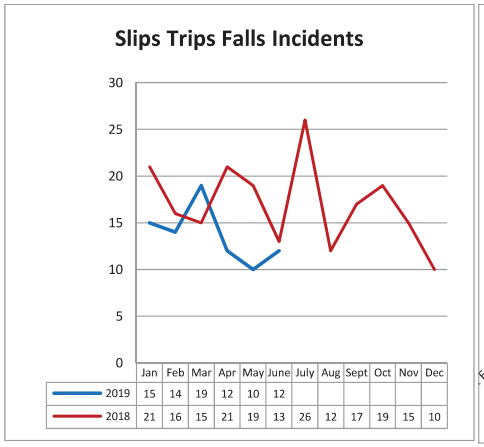


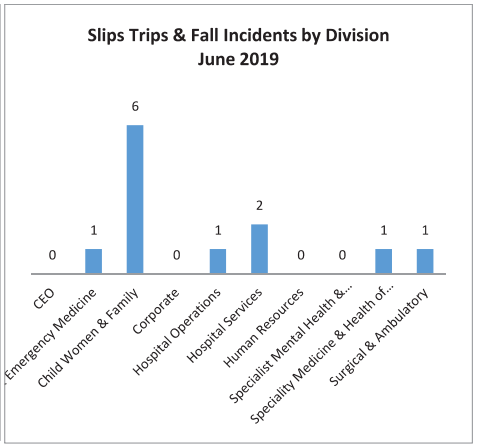












5. Work related injury Claim Data for June 2019

Outlined below is our injury claims data for June. Work injury claims data is for all work injuries currently managed by the DHB, including injuries that occurred in previous years, up to and including injuries for June 2019.

INJURY CLAIM DATA

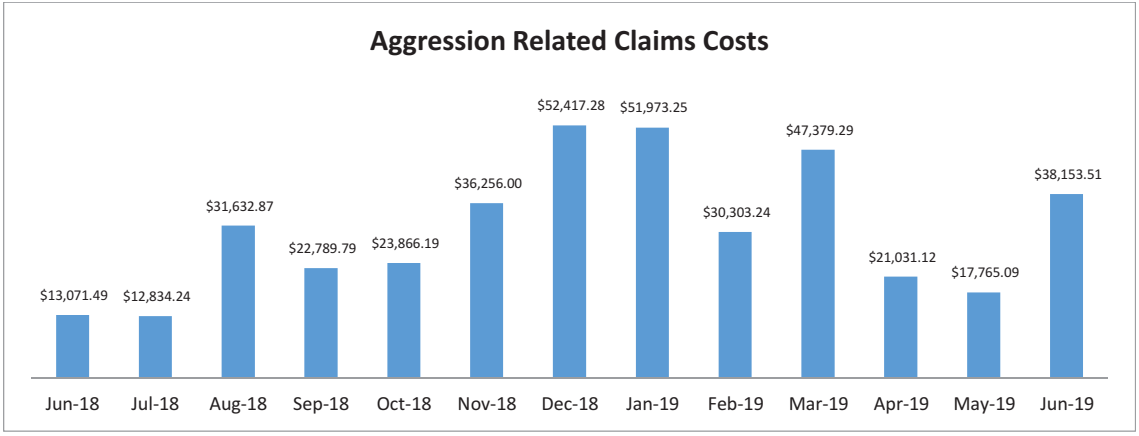
Total: Injury Claim Report for June 2019				
Lost days	**Treatment cost**	**Weekly compensation costs (80% of salary)**	**Staff cover cost**	**Total**
Number of lost days for month	Total $ for month	Total $ for month	Total $ cover cost for month	Total $ cost for month
221	$34,007.53	$48,114.23	$60,142.79	$142,264.55

High accident events account for approximately 60% of the claims, as below:

High Accident Injury type	Lost days this month	% of cost this month	Cost this month	Year to date trend for injury claims
Moving and Handling	39	18%	$27,934.37	↓
Slips Trips Falls	49	22%	$33,123.71	↓
Aggression	45	20%	$38,153.51	↑* pls see note below

*Actions taken to mitigate high accident types are noted in the Executive Summary.

The following table has been included to provide information on the total cost of aggression related injury claims only (13 month rolling table).



Although there are the expected peaks and troughs, the overall trend is unfavourable due to higher costs in prior months. Please note, these costs are those expensed by Waitematā DHB during the reported periods, and do not reflect incidents that occurred within that same reported period. This is because there is a lag between an incident occurring and costs being expensed and that injuries

can span multiple report periods, sometimes over multiple years, depending on the severity and time required to return to work (RTW).

6. Stakeholder feedback

6.1 Facilities and Development – Health and Safety Management Systems (HSMS)

Key Highlights

- All nine health and safety management system (HSMS) training modules have now been delivered across Facilities and Development. The recent completion of the Tanekaha Early Works project at Mason Clinic has demonstrated the successful end to end processes established within the Facilities HSMS.
- A review of the Facilities and Development Risk Register regarding Contractor Management has been completed. The findings demonstrate Facilities have developed and established appropriate controls embedded into the Facilities Contractor Management.
- Facilities Maintenance and Facilities Projects have succeeded in meeting the June KPI's regards safety inspections and Health and Safety meetings.

Risk and Issues

A 'Gap Analysis Review' has been completed addressing a recent incident where air handling ducting, containing Asbestos Containing Material (ACM), was removed without the appropriate sign-off. The report identified key findings and gaps that resulted in the miscommunication around the timeliness of approvals. Background air monitoring and a review of the completed works confirmed that no ACM's had been disturbed during the work, posing no health risk to the workers or those interacting within and around the area.

Recommendations from the report will be tracked to completion to ensure all practicable steps are taken to prevent any future occurrence of this nature.

The table below provides an oversight of the department's adherence to work monitoring, contractor management and health and safety performance.

Health and Safety Statistics - June 2019			
	Facilities Development	**Facilities Management**	**Total**
Incidents and accidents			
Lost Time Injuries	0	0	0
Serious Harm Accidents	0	0	0
Accidents Requiring Medical Attention	0	0	0
Accidents Requiring First Aid	0	0	0
Near Miss Incidents			
This Month	0	0	0
Monthly Average			0
Year to Date			28
Safety Inspections completed this Month			
Projects	100%		
Facilities Operations		100%	
H&S / Toolbox Meetings this Month			
Projects	100%		
Facilities Operations		100%	
Contractor Site Inductions			
This Month			6
Year to Date			457

Injuries and Accidents	Incidents and accidents are monitored across all DHB sites and include data for staff and contractors.
Near Miss / Incidents	Near Miss and Incidents are monitored across all DHB sites and include data for staff and contractors
Safety inspections	Safety Inspections are expected to be completed weekly during the construction period for all projects.
Health and Safety Toolbox meetings	• All contractors and staff are expected to attend one health and safety / toolbox meeting per construction week for projects. • Facilities Management staffs are expected to attend fortnightly health and safety / toolbox meetings.
Contractor site inductions	This is an indication of the number of new contractor staff on site and will vary significantly with construction project work load.

7. Health and Safety Risks

As discussed during the Board Health and Safety Workshop, we have introduced new reporting of our key hazard areas and the resulting actions. The table below outlines our key health and safety risk categories, commentary on the current projects related to that risk and whether those projects impact the likelihood or consequence/outcomes of that risk. Traffic lights indicate progress of each project.

Key	
Progress Indicator	
Red	Major delays
Amber	Minor delays
Green	On track
Risk Measure Addressed	
L	Likelihood
C	Consequence

Risk	Update	Start Date	Est. Date to Complete	Progress Indicator	Risk Measure Addressed
Biological Risks	**Blood and Body Fluid Exposures (BBFE)**				
Needle stick injuries	Needleless Systems: Both North Shore and Waitakere Hospital audits have been completed and recommendations either closed or being followed up. Audits Complete: 100% Audit findings and recommendations to be discussed at the next Executive Health, Safety and Wellbeing meeting. A 'sharps safety week' has been scheduled for December 2019, in-line with the international sharps awareness month. Complete: 0%	Sept 2018 Dec 2018	Aug 2019 Dec 2019	 	L L
Splashes	Incorporated within all BBFE related projects, including Personal Protective Equipment (PPE).	Ongoing	Ongoing		L/C
Substances hazardous to health					
Asbestos Register	Work has commenced with uploading information from Management, Refurbishment and Demolition surveys. 100% of existing surveys have been uploaded. Complete: 100% Refurbishment surveys are carried out prior to invasive works. Current projects underway are: Taharoto building demolition Various other refurbishment surveys have also been completed for smaller projects managed by Facilities, in line with Safe	Oct 2017 Ongoing	July 2019 Ongoing	 	L

	Systems of Work (SSOW) process. No concerns to date.				
Mould	OH&SS continue to review all air testing reports relating to mould and provide advice to the relevant Service managers and Facilities. No concerns to date.	Ongoing	Ongoing		C
Chemicals	Hazardous Substances and New Organisms (HSNO) Audits: Review of new Act has been completed and audits of 33 high risk areas (67 physical locations) have recommenced. Audits completed: 58% Hazardous Goods Store for Waitakere Hospital: Case approved to install hazardous goods bunkers by mid-2020 Complete: 20%. Trial on transferring HSNO waste within the main hospitals: new trial set to commence Aug 2019 for a further 6 weeks. New Trial: Complete: 0%	Sept 2016 Dec 2016 Jun 2018	Dec 2020 April 2020 Sept 2019	 	L L L/C
Ergonomics					
Moving and Handling	On-going actions: Meetings with managers will continue to be held to discuss moving and handling requirements including training, to provide support to services. There are no concerns to date.	Ongoing	Ongoing		L/C
Posture	There is online self-assessment guidance available for all staff to access. Workstation assessments are ongoing, as staff requests them.	Ongoing	Ongoing		L
Physical					
Machinery	A schedule has been set up for Facilities Maintenance staff to check/review and service all machinery. There are no concerns to date.	Ongoing	Ongoing		L
Equipment	Clinical Engineering holds a master file of all clinical equipment across WDHB and this equipment is serviced on a recurring schedule. There are no concerns to date.	Ongoing	Ongoing		L
Electrical safety	A project to identify all electrical equipment has been completed, with all external contract maintenance providers having been contacted and the standards that equipment is serviced to have been reviewed for compliance. Clinical Engineering holds all records, including service maintenance schedules. Clinical Engineering following up with all non-compliant suppliers. Complete: 100%	Ongoing	Ongoing		L/C

Uneven surfaces	On-going actions: Communications continue to be developed and released regarding Slips, Trips and Falls hazards, focussed heavily on staff rushing to complete tasks. Each incident of this type is followed up by OH&SS, with any corrective actions tracked to completion. There are no concerns to date. BIEMS Upgrade: Delivery Complete: Stage 1 build: 100% and Stage 2 rollout: 70%	Ongoing Dec 2017	Ongoing Sept 2019	 	L/C L
Roading	Pedestrian Crossings: Stage 1 of the North Shore Hospital pedestrian crossings programme (repainting of existing crossings) has been completed. Stage 2 – Scoping for new pedestrian crossings completed. Costing and planning works underway. Helipad: The pedestrian crossing to service the helipad, including appropriate lighting, has been scheduled for completion in 2019. Construction is estimated to start end of August and will take a total of 16 days. Helicopters will need to be diverted during this time. Planning complete: 70% Physical works complete: 50%	Oct 2017 Oct 2017 Feb 2017	March 2019 April 2019 August 2019	 	L L L
Buildings	Loading Docks: CAPEX has been approved to finalise the concept design. A Business Case is due to the Executive Leadership Team once confirmation has been received from Fire Engineer regarding the proposed location for the waste/recycling bins. Estimate time for construction to be confirmed. Planning complete: 85%	Feb 2017	July 2019		L
Emergency Management					
Fire	Fire evacuation drills are conducted regularly by the Fire Safety Officer and fire safety equipment, such as sprinklers and smoke alarms, are regularly audited for compliance, overseen by Facilities. Responsibility for hospital-based emergency management sits with the Director Hospital Services and for Community Services sits with the Director of Nursing.	Ongoing	Ongoing		L/C

Civil emergency	WDHB conduct desk-top emergency drills on an ongoing basis. Emergency response team personnel have been identified and trained. This includes contact points with Civil Defence. An audit on emergency preparedness is planned for 2020.	Ongoing	Ongoing		C
Bomb threats	WDHB conduct desk-top emergency drills on an ongoing basis. Emergency response team personnel have been identified and trained. This includes evacuation and contact points with Emergency Services (Police and Fire). Drills are completed annually.	Ongoing	Ongoing		C
Firearms	WDHB conduct desk-top emergency drills on an ongoing basis. Emergency response team personnel have been identified and trained. This includes evacuation and contact points with the NZ Police. Drills are completed annually.	Ongoing	Ongoing		C
Psychological					
Aggression	The new Managing Aggression and Potential Aggression (MAPA) training is being implemented across Waitematā DHB. The following actions have been completed: • Four educators were accredited to deliver the MAPA Foundation programme • Three educators are attending the MAPA Advanced programme and will be accredited during August 2019 • Five MAPA Foundation (2-day) programmes were delivered to 60 ED, Security and Duty Manager staff during June 2019 • We are reviewing currently available education resource due and taking account of a busy winter period, we are scheduling MAPA delivery to the following month: ➢ 1 x MAPA Foundation (1-day) ➢ 1 x MAPA Foundation (2-day) ➢ 1 x MAPA Advanced (2-day) • First MAPA Advanced workshops scheduled for September and targeting Code Orange roles to attend first. E.g. Security staff, duty managers etc. Complete: 90% (due Dec 2019)	Feb 2018	Dec 2019		L/C
	Additional Security Door Access, North Shore Hospital: New access way and design approved by internal stakeholders (OH&SS, ED and Security). Design stage: 100% Installation complete: 0% (completion due Aug 2019)	Oct 2016	Install from Aug 2019		L/C

Bullying and harassment	Toolkit on Speaking up about bullying and harassment on Staffnet. Complete 100% Manager communication on the launch was completed on 23 July at the new monthly HR Learn sessions.	Ongoing	Ongoing		L/C
Lone workers	Following on from the previous work completed, a new project has commenced to review all organisational policies and procedures covering lone worker emergency response plans. This is to ensure that response plans are available within all areas with lone workers and that they are complete and communicated to staff. Complete: 5%	Jun 2018	Dec 2019		C
Stress/Distress/Fatigue	Wellbeing research pilot survey complete and data being analysed for staff feedback. Complete: 100% EAP services in place. No issues. Partnering with the Mental Health Foundation on: Development of wellbeing resources. Pilot – 5 ways of wellbeing and creating positive work environments. Pilot commencing in August. Complete: 100% Evaluation of Mental Health Wellbeing education. Session on Mental health wellbeing will commence in pilot in September in Mental Health awareness week. Complete: 100%	Aug 2018 Ongoing	Jan 2018 Ongoing Aug 2019 July 2019	 	L/C
Safe staffing	Centralisation of nursing rosters: Complete: 100% RMO rosters: House Officers rosters developed, consulted and implemented: 100% Registrar rosters: rosters developed, consulted and implemented: 25% Consultation complete but not yet implemented. Rosters will be implemented once recruitment for specific rosters is complete- this is occurring with all urgency. Complete: 75% Nursing Care Capacity Demand Management (CCDM) and NZNO MECA Accord recruitment: CCDM: Trend care team recruitment: Complete 100% CCDM: Services completing CCDM FTE reviews: 0%	Sept 2018 Dec 2018 Nov 2018 Feb 2019	Dec 2018 Jun 2019 Feb 2019 Jun 2021	 	L

	Accord recruitment: Complete: ICU 100%; ED 0%; Midwifery 100%; Critical Care Outreach 100%; RNs/Shift Co-ordinators 100% District Nurses 100%; Health Care Assistants 100%	Dec 2018	Jun 2019		

4.3 Communications Report

Recommendation:

That the report be received.

Prepared by: Matthew Rogers (Director, Communications)

Communications support

The communications team provided advice and support to the following projects/campaigns/issues/ events over the last six weeks:

- Preparations for start of works on new hospital building on North Shore campus
- Staff parking changes
- Telehealth clinics proactive communications
- 2019 Yearbook planning
- 'Hello, My Name Is…' campaign
- 'Where to go' video series advising public on the best place to seek treatment
- Appointment of new Chief Medical Officer
- Asian Health Collaboration online publishing
- Preparation for potential industrial action
- MMR vaccination social media campaign
- Mental health reviews
- Staff flu immunisation programme
- Health Excellence Awards promotion
- Site works staff communications
- Career profiles for Recruitment Team
- Compassion campaign
- Annual Plan content
- Ongoing implementation of Board decision re incorporation of macron
- Major facilities development communications
- Identification, scheduling and production of social media content and issues management
- Ongoing publication of messages via the Medinz primary care communications platform
- Health Heroes awards coordination
- Coordination of responses to 'Dear Dale' emails to the CEO from DHB staff
- Review of content for submission to health sector publications
- Ongoing weekly internal communication via StaffNet home page and Waitematā Weekly
- Ongoing management of Official Information Act responses
- Liaison with Well Foundation Marketing and Communications
- Ongoing liaison with Metro Auckland DHB communications leads
- Ongoing after-hours and weekend media line cover and senior management communications support
- Proof-read leaflets, booklets and brochures for various departments
- Ongoing compilation and distribution of proactive media material
- Event photography and video
- Drafting of correspondence from the corporate office
- CEO Board Report
- Review of copy for DHB website

- Management of organisation-wide screen saver content
- Approval of all-user staff emails
- Weekly Board briefing
- Fortnightly *A Note From the CEO* email to all staff
- Weekly National Health Targets and clinically-led metrics updated and communicated

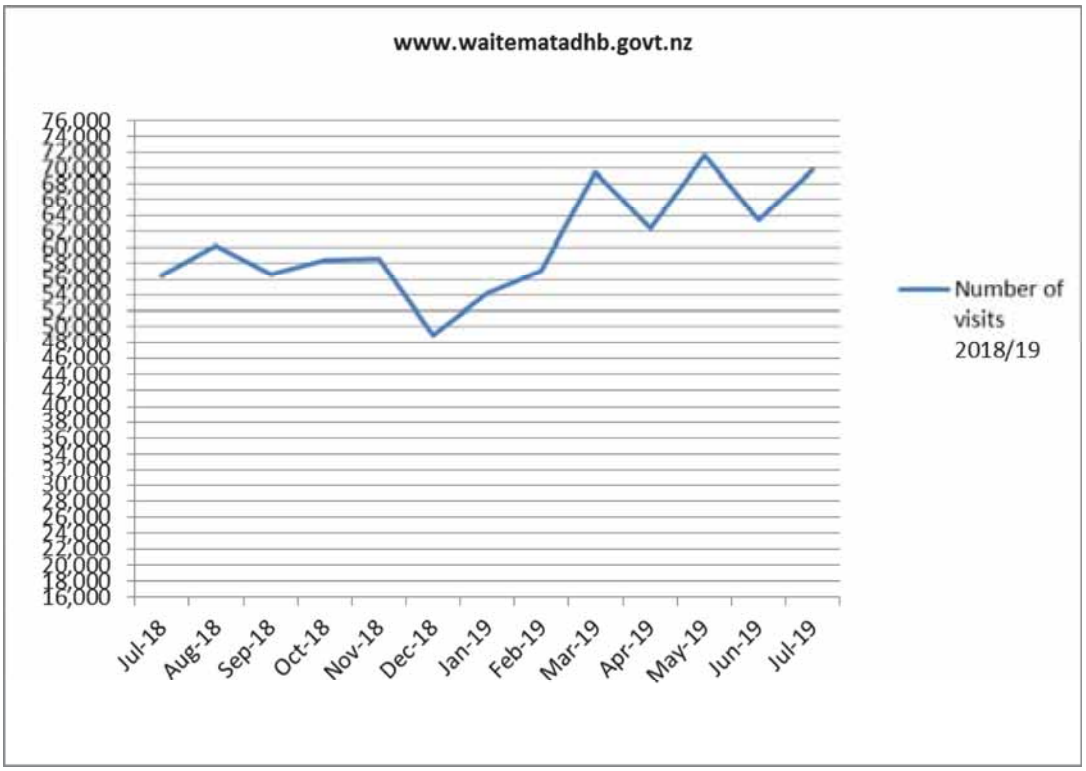
Waitematā DHB website – Google Analytics Statistics

Waitematā DHB website

Number of visits	**July 2018**	**July 2019**
Total visits to this site	56,521	69,680 (+23.20%)
New Zealand	26,387	31,861
Australia	812	1,021
USA	377	823
United Kingdom	288	307

Top areas	**July 2018**	**July 2019**
Waitemata DHB staff page	29,476	36,377
Home page	13,399	13,238
North Shore Hospital	6,044	4,245
Waitakere Hospital	3,159	3,135
Contact us	2,550	3,001

Traffic sources	**July 2018**	**July 2019**
Search traffic	75%	73%
Direct traffic	21%	23%
Referral traffic	4%	4%


www.waitematadhb.govt.nz
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Jul-19
Number of visits 2018/19

Social media

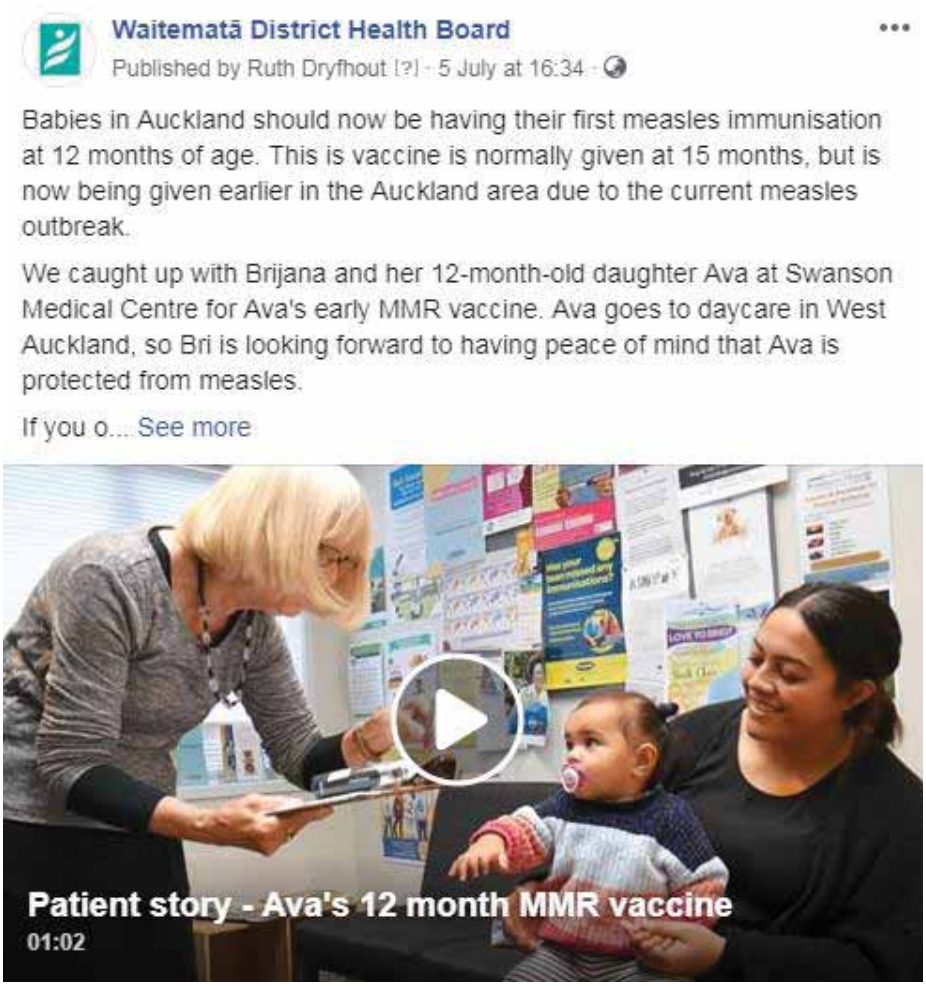
Facebook

Waitematā DHB Facebook page likes have increased by 89.9% since July 2018, with 7,651* current likes (4,030 likes - July 2018).

Total audience reach between 1 July 2019 and 31 July 2019 was 102,300 views.

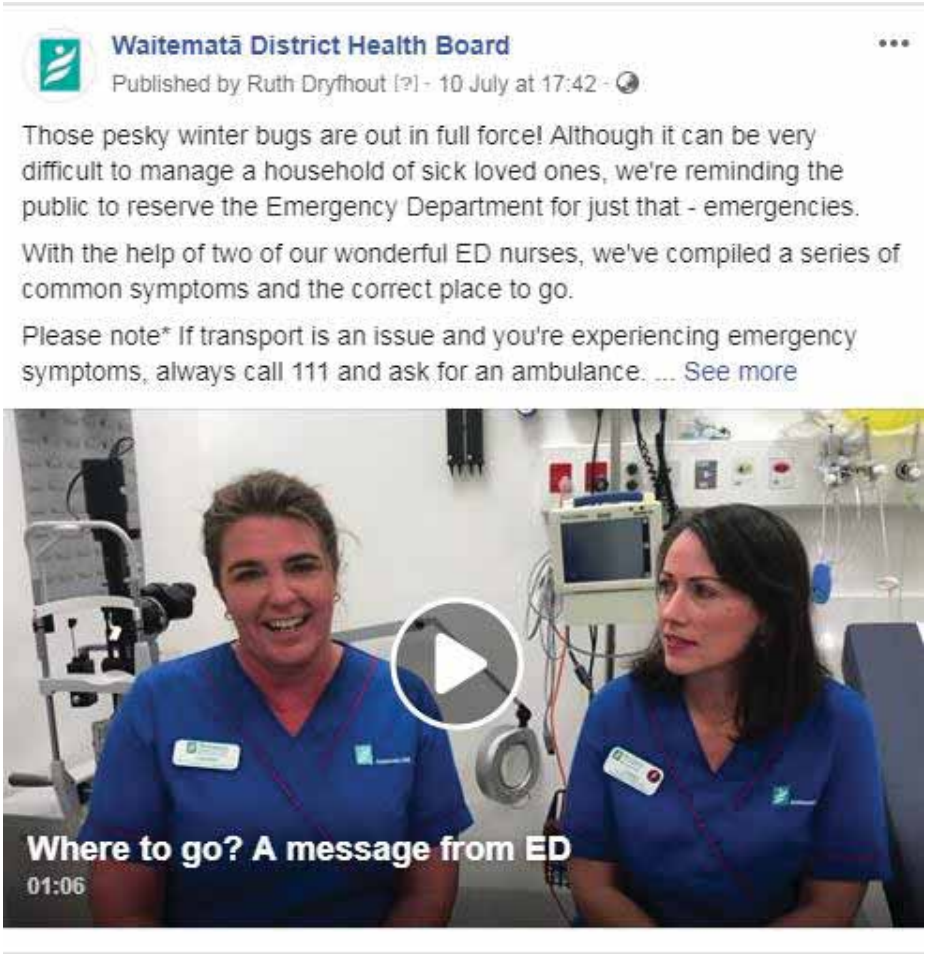
The top three posts between 1 July 2019 and 31 July 2019 are:

1. **Patient story - Ava's 12-month MMR vaccine (Audience reach: 34,155 including 1,656 engagements)**



*As at 5 August 2019

2. Where to go? A message from ED (Audience reach: 22,275 including 4,334 engagements)



3. **#WindbackWednesday (Audience reach: 17,165 including 1,274 engagements)**

Twitter
Waitematā DHB Twitter followers have grown by 10.1% since July 2018, with 2,499 current followers* (2,268 followers as at July 2018).

Total audience reach between 1 July 2019 and 31 July 2019 was 23,700.

Top tweets between 1 July 2019 and 31 July 2019:

End PJ Paralysis video (3,407 reach)

*As at 5 August 2019.

OIAs received

A total of 28 new Official Information Act requests were received between 26 June and 5 August 2019 as follows:

- B. Burke (RNZ) - Outpatient care for mental health patients including wait times for psychologists and psychologist numbers.
- Requester's name withheld to protect privacy - What input the Ministry of Health has had into the Terms of Reference and reports regarding He Puna Waiora review.
- T. Lorck (Taxpayers' Union) - Salary of CEO for 2017/18 financial year.
- K. Orr (Right to Life) - Total funding required for termination-of-pregnancy services.
- Mohammed A M (FYI website) - Total number of hired PGY1 house officers.
- O. Hamed (APEX) - Number of dental therapists employed by ARDS and number of vacancies.
- H. Martin (Stuff) - Number of staff who contracted measles between 1 March and 1 July 2019.
- M. Smith (National Party) - Clinical priority assessment criteria threshold levels for a range of elective procedures.
- R. Quinn (Radio NZ) - Transfers of mothers/newborn babies to DHBs outside Auckland.
- M. Morrah (Mediaworks) - Instances where police/security were called when patients/visitors were impaired by alcohol.
- S. Dick - Number of measles cases caused by vaccine strains of the virus over the last five years.
- 'Hannah' - Number of measles cases caused by vaccine strains of the virus over the last five years.
- L. Owen (RNZ) - Copy of report sent to the Coroner and any draft reports relating to a patient's death.
- S. Roughton - Stats on inspections carried out at establishments and homes under the Prostitution Reform Act.
- W. Roberts - Information regarding electronic health records and access to them by GPs and patients.
- L. Keene - Various KPI data including discharges, referrals and presentations from July 2016.
- L. Owen (Radio NZ) - Copies of all correspondence and patient notes relating to an individual.
- Requester's name withheld to protect privacy - Copy of HR organisational charts.
- H. Martin (Stuff) - The number and cost of bariatric surgeries from 2014 – 2019.
- H. Martin (Stuff) - Number of staff disciplined for social media use from 2014 – 2019.
- N.Blake-Persen (RNZ) - Number of babies born to drug-dependent mothers since 2014 and associated questions.
- M. Duff (Stuff) - Various questions regarding maternity staffing, vacancies and recruitment issues.
- J. Whyte (APEX) - Information regarding expenditure on outsourcing and budgets for MIT, MRA and MECA data.
- N. Jones (NZ Herald) - Copies of He Puna Waiora review documents.
- J. Hall (Park Legal) - Mason Clinic policies for visitation and communication between patients and family members.
- A. Hudson (HealthWEST) - Documentation and minutes relating to the establishment of the Child Health Information Platform (CHIL Hub).
- E. Gibson (Newsroom) - Vaccination and immunisation rates among health workers.
- L. Nichols (NZME) - Copy of terms of reference regarding He Puna Waiora review.

Media Clippings – 26 June – 5 August 2019

Positive	**+**
Neutral	**0**
Negative	**-**

Page no.	**Dominion Post**	
14	Tidal wave of hospital assaults	-
44	Smoke signals	0
80	Paralysed toddler to be discharged	0

Page no.	**Franklin County News**	
4	127 confirmed measles cases in Auckland	0
62	Nominations open for elections	0

Page no.	**Listener New Zealand**	
56	Robotic relief	0

Page no.	**Mahurangi Matters**	
58	Heart in right place: new group forms for cardiac support	0

Page no.	**Metro**	
87	Different gears	0

Page no.	**Nor West News**	
6	Horse rider's forest rescue	0
7	What's On: Waitakere Hospital craft market	0

Page no.	**North Harbour News**	
37	155 measles cases recorded in city	0

Page no.	**North Shore Times**	
12	Louie, 2, battles rare cancer	0
29	What's On: Waitakere Hospital craft market	0
66	Nominations open for elections	0
78	Five star feeling perfect for Mum	0

Page no.	**NZ Catholic**	
1	Multi-faith centre opened	+

Page no.	**NZ Doctor**	
31	Jumping to conclusions in leaps and bounds: DHB's IT programme a winner	+
33	Lester Levy pops up in Canterbury	0
34	The first time (for a while) attending Rotorua GP CME	0

36	Trivia is about the small things	0
59	New WDHB chief medical officer	+
83	The greening of health	+

Page no.	**NZ Herald / Weekend Herald**	
2	Car crash seriously injures child	0
3	1st XV player knocked out for 40 minutes	0
39	Delays hit birthing unit	-
41	Hundreds more babies get measles jab	+
53	I was really happy before I went to New Zealand	0
60	Family wait eight hours for doctor - twice	0
72	Visit to ailing man didn't happen	0
73	Racism blamed for poor health	0
90	Measles outbreak widens in city	0

Page no.	**Otago Daily Times**	
81	Poor information and obfuscation need to be addressed	0

Page no.	**Rodney Times**	
68	Sick boy 'dodged a bullet'	0
70	'Step up, help lead region forward'	0

Page no.	**The Press, Christchurch**	
19	Tidal wave of hospital assaults	-
47	Smoke signals	0

Page no.	**Waikato Times**	
10	Dentists – a costly pain	0
24	Tidal wave of hospital assaults	-
38	Arrest after bomb scare	0
50	Smoke signals	0

Page no.	**Western Leader**	
42	No police search for days	0
64	Nominations open for elections	0
88	'We shouldn't have to choose'	-

5.1 Adoption of Waitematā DHB Governance Manual (including review of Code of Conduct and Standing Orders)

Recommendation:

That the Board:

a) **Approve the amended Code of Conduct as shown as Chapter 7 in the attached proposed Governance Manual. (Note: changes proposed are detailed in the agenda report.)**

b) **Approve the amended Standing Orders as shown as Appendix 2 to the attached proposed Governance Manual. (Note: changes proposed are detailed in the agenda report and, to be approved, require the support of three quarters of members present and voting.)**

c) **Approve the minor updates to the Waitematā DHB Member Remuneration, Fees and Expenses Policy (as summarised in the agenda report).**

d) **(Subject to any changes approved by the Board) Adopt the Waitematā DHB Governance Manual.**

e) **Note that the State Services Commission, in its review of Crown entity and state sector legislation, is preparing a Code of Professional Conduct for Crown Entity Board members. When approved this will be incorporated into the Waitematā DHB Governance Manual.**

Prepared by: Peta Molloy (Board Secretary) and Judy McGregor (Board Chair)

1. Summary

A Governance Manual has been developed aimed at helping members with their governance roles. It is hoped that it will be particularly useful for new Board members

The State Services Commission has recommended that District Health Boards produce a governance manual that reflects good practice standards and the range of legislation that applies to them. The guidelines the Commission provided have been a useful starting point for this.

Code of Conduct

Waitematā DHB had an existing resource for Board members – its Code of Conduct. This had been developed and a lot of thought had been put into it over the years, sometimes in relation to a particular issue that had arisen. It is more than just good practice standards, but a code of behaviour that all Board members have been expected to maintain.

In developing the Governance Manual, the authors considered it important to preserve the Code of Conduct as something that members would subscribe to. The Code of Conduct is therefore included as Chapter 7 of the Governance Manual with the expectation that it will continue to have that

special status. In the course of this exercise, the Code of Conduct has been reviewed and a few amendments are proposed, summarised below. At times in the Governance Manual, there will be some overlap between the contents of the Code of Conduct and the general good practice advice given elsewhere in the Governance Manual. Cross references have been used where it seemed appropriate.

Code of Professional Conduct for Crown Entity Board Members

The State Services Commission in its review of Crown entity and state sector legislation is preparing a Code of Professional Conduct for Crown Entity Board members. When approved this Code will be incorporated into the Waitematā DHB Governance Manual.

Standing Orders

In developing the Governance Manual, it was relevant to also review the Board's Standing Orders (guidance on procedures and processes associated with meetings).

The Board's general approach to Standing Orders, over many years, is given both in Standing Orders and the Code of Conduct, namely:

"The Board's Standing Orders provide a formal (and highly regulated) framework for meeting conduct and debate. The Standings Orders include a provision whereby:

> *The Chairperson of the Board or a Committee may, subject to agreement of all members present but without a formal resolution, conduct the meeting of the Board or committee in a less formal manner than is strictly required by Standing Orders provided:*
> *(a) The procedures followed are not inconsistent with the NZPH&D Act; and*
> *(b) The procedures followed do not inhibit any member from contributing to the discussion or voting on any item; and*
> *(c) All decisions are fully minuted.*

As a general practice members have agreed that meetings of the Board and committees should be conducted in as informal manner as possible, consistent with the above provision. In order to achieve this, to work as an effective team, and to make meetings as productive and efficient as possible, members undertake to observe the protocols set out below. It is expected that these behaviours will apply to and in respect of all participants at meetings including managers and other staff. .."

Nevertheless, it important that Standing Orders are up to date in terms of legislation, as there are matters which are not discretionary in terms of procedure, but stipulated by legislation. Also, if any procedural issues are raised, it is important that they are resolved in terms of the adopted Standing Orders.

Standing Orders have been checked and a few amendments are proposed and summarised below. Any changes to Standing Orders require the approval of three quarters of the members present and voting.

Waitematā DHB Member Remuneration, Fees and Expenses Policy

The proposed amended policy to the Governance Manual, shown in Appendix 5, is not a substantial review, but updates a few details in line with current practice. The changes are also listed below.

2. Strategic Alignment

The Governance Manual should assist the Board with the following Strategic Themes

	Intelligence and insight	Strengthening understanding of legislative frameworks and good practice standards.
	Evidence informed decision making and practice	Strengthening understanding of legislative frameworks and good practice standards.

3. Proposed Changes to the Code of Conduct (incorporated in Chapter 7 of the Governance Manual)

- f) Public Statements – a section has been added on social media

- l) Conflict of Interest Protocol – this is the revised policy approved by the Board at its meeting in March 2019.

  One minor addition is suggested – the following note (shown on page 22):

  "Note: depending on circumstances, where an interest is declared but the member states that there is no conflict, it may be appropriate to ask a further question about whether that could change in the short to medium term future – for example the member declares that a business he/she has an interest in does not provide the service under discussion – is it the case that there is no intention of providing that service in the short to medium – term future?"

- Presentations/Proposals to the Board – an out of date clause on this subject is recommended for deletion. It included reference to matters current when it was written in 2002 such as considering private venture partnerships.

4. Proposed Changes to Standing Orders (incorporated in Appendix 2 of the Governance Manual)

- In Clause 1.6 'First Meeting of Board following the election', there was a clause which stipulated that the first meeting would be a special meeting and listed the business to be considered. There is no statutory requirement for this and it appears to have been taken from the local government requirements. In fact, the DHB's first meeting of an incoming Board has normally been an ordinary meeting. It is proposed to delete that particular clause.

- With Clause 2.5 'Dealing with Extraordinary or Urgent Business at Meetings', it is proposed to insert the full legal requirements (previously the clause just included a reference to the legislation). It is considered important that members are aware of the requirements.

- It is proposed to delete an existing clause 2.7 'Time limit at meetings'. This reads:

  "Unless pursuant to a resolution of the Board to other effect, no meeting shall sit for more than six hours nor beyond 10.30p.m. Any business on the order paper not dealt with shall be listed for attention at the next ordinary or special meeting."

  There is another clause (2.14.1(a)) that allows members to move that meetings be adjourned and Clause 2.7 seems unnecessary. There is no statutory requirement for it.

- In clause 2.8 'Quorum at Meetings', it is suggested that the same quorum requirements apply for non-statutory committees as for statutory committees. In practice, this means that any Committee meeting would require a quorum of half the members (including vacancies) if the number of members is even and a majority if the number is odd. This seems like normal sound practice.

- In clause 2.9 'Failure of a Quorum', it is suggested that the meeting lapse if no quorum is present within 30 minutes (currently it is ten minutes).

5. Proposed Changes to Waitematā DHB Member Remuneration, Fees and Expenses Policy (incorporated in Appendix 5 of the Governance Manual)

These are very minor. References to the Cabinet Fees Framework have been updated to the latest Fees Framework. A few other details have been updated in line with revised organisational policy (such as air travel not accruing air points; non-reimbursement of airline lounge subscriptions).

Following the new Cabinet Fees Framework (July 2019), it is understood that the Minister will review fees as part of the incoming Board appointments around the 2019 Board elections.

6. Adoption of the Governance Manual

Following consideration of the above recommended policy changes, and subject to any other changes the Board requests, it is recommended that the Governance Manual be adopted. It will need to be updated on an ongoing basis.

DRAFT

Waitematā DHB Governance Manual

(including review of Code of Conduct and Standing Orders)

August 2019

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Tihe mauri ora!
E ngā mana, e ngā reo, e ngā hau e wha
Tēnā koutou, tēnā koutou,
Tēnā koutou katoa

Behold the breath of life!
To all the authorities, all the voices,
To the four winds gathered here
Greetings, greeting, greetings to everyone.

Foreword from the Board Chair

Welcome to the Waitematā District Health Board's Governance Manual aimed at helping members with their governance role.

Good governance requires practice and is an evolving activity. International research suggests that "governance of the health system is the least well-understood aspect of health systems" and that "the road to good governance is long and uneven"[1]. We can always do better and the Waitematā District Health Board (WDHB) strives for self-improvement.

Waitematā is the largest District Health Board in New Zealand. It is a values-based organisation and the Board is guided by the promise to provide the best care for everyone.

The Board has developed a collegial, constructive style of consensus-decision making. This doesn't mean that Board members always agree but they strive to be guided by evidence-based discussion and a commitment to the organisation's values. Members ask questions and make inquiries of the chief executive and the senior executive team, as well as clinical and administrative managers, in the best spirit of critical enquiry and improvement.

Members base their involvement on close reading of Board and committee papers, on feedback from communities and patients, and from their own expertise and backgrounds. The Board is a mixture of elected and appointed members, some experienced and some new. As Chair I believe everyone's perspective and contribution is equally valued.

The Board has specific governance functions: financial efficiency; legal and ethical obligations; ministerial expectations; Ministry of Health directions; and risk management. It must help provide a more equitable health system, and enhance authentic relationships with Maori partners in the spirit of the Treaty of Waitangi. Ultimately the Board will be judged on whether it acts to promote wellness, relieve suffering and reduce ill health with care and compassion.

Judy McGregor, Chair.

[1] Siddiqi,S., Masud,T.I., Nishtar,S., Peters,D.H., Sabri,B., Bile, K.H. and Jama,M.A. (2009) Framework for assessing governance of the health system in developing countries: Gateway to good governance. *Health Policy* Vol.90,Issue 1, pp13-25

Introduction

District Health Boards are expected to have a governance manual that reflects good practice standards and the range of legislation that applies to them.

This Manual is intended to provide Waitematā District Health Board members with the guidance and information they may require to assist them meet their governance responsibilities. It may also provide useful reference information for staff members on matters relating to the Board.

The Manual is based on the State Services Commission guidelines (prepared in conjunction with the Ministry of Health), *Resource for Preparation of District Health Board Governance Manuals* (August 2010, updated September 2011 and September 2014).

While this document contains links to relevant websites and other documents, Waitematā District Health Board 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.

Waitematā DHB Promise, Purpose, Priorities and Values

The Board and individual Board members have an important role in communicating the organisation's promise and upholding its values. These values provide the foundation for the way the organisation functions and behaves, both in its internal workings and in the way it treats and deals with others.

Our Promise

Best care for everyone

This is our promise to the Waitematā community and the standard for how we work together.

- Regardless of whether we work directly with patients/clients or support the work of the organisation in other ways, each of us makes an essential contribution to ensuring Waitematā DHB delivers the best care for every single patient/client using our services

Our Purpose

- Relieve suffering
- Promote wellness
- Prevent, cure and ameliorate ill health

Our Priorities

- Patient experience
- Better outcomes

Our Values

Everyone matters

- Every single person matters, whether a patient / client, family member or a staff member

With compassion

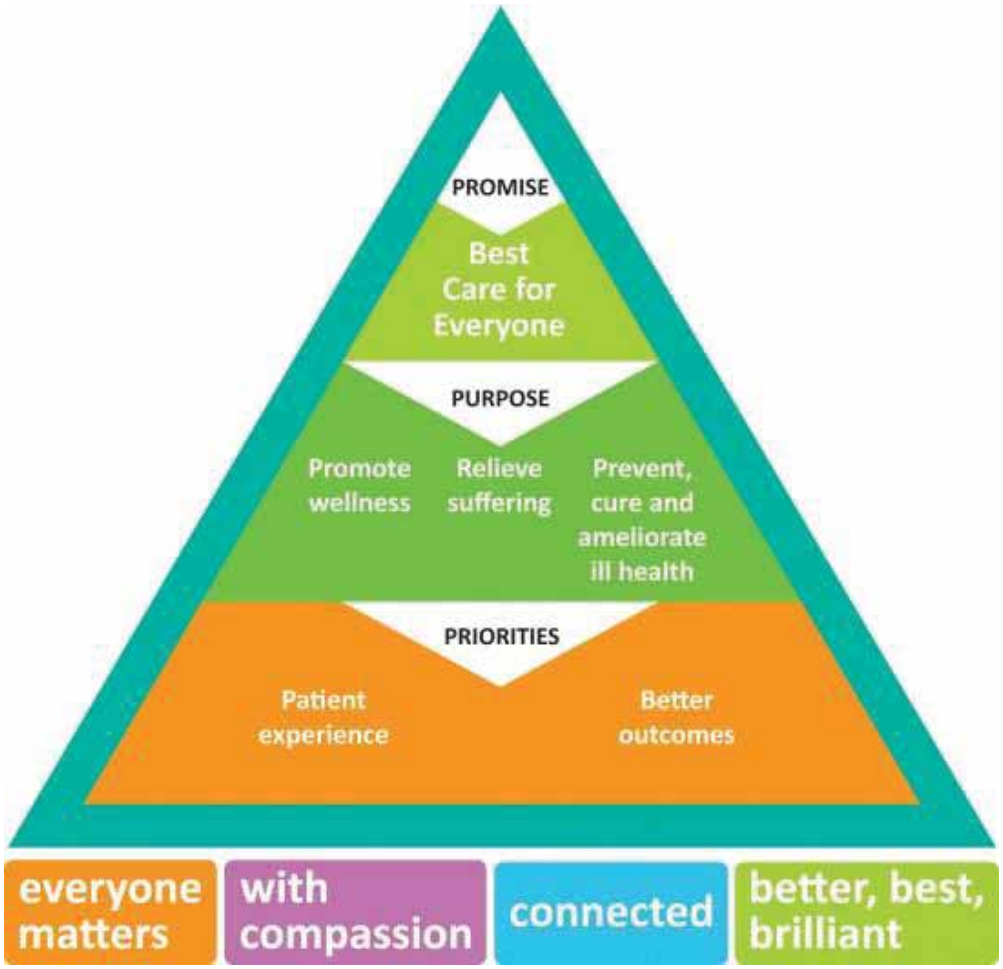
- We see our work in health as a vocation and more than a job
- We are aware of the suffering of these entrusted to our care
- We are driven by a desire to relieve that suffering
- This philosophy drives our caring approach and means we will strive to do everything we can to relieve suffering and promote wellness

Connected

- We are connected with our community
- We need to be connected within our organisation – across disciplines and teams
- This is to ensure care is seamless and integrated to achieve the best possible health outcomes for our patients/clients and their families

Better, best, brilliant

- We seek continuous improvement in everything we do
- We will become the national leader in health care delivery


PROMISE
Best Care for Everyone
PURPOSE
Promote wellness
Relieve suffering
Prevent, cure and ameliorate ill health
PRIORITIES
Patient experience
Better outcomes
everyone matters
with compassion
connected
better, best, brilliant

District Health Board Environment (Chapters1-5)
Chapter 1: Relevant Legislation and Regulations

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 key legislation that applies to DHBs includes:

- State Sector Act 1988
- Public Finance Act 1989
- Commerce Act 1986
- Various pieces of employment legislation, e.g. Employment Relations Act 2000, Health and Safety at Work Act 2015
- Official Information Act 1982
- Privacy Act 1993
- Protected Disclosures Act 2000
- Public Records Act 2005
- Human Rights Act 1993
- Oranga Tamariki Act 1988

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.

In summary, the NZPHD Act sets out the duties and roles of DHBs and other key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations.

The NZPHD Act 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 Māori participation in the health and disability support sector with a view to improving Māori health outcomes.

The NZPHD Act was amended in October 2010 to support reforms in the health sector. The objective was to streamline the public health system, to improve co-ordination of local, regional and national planning, enhance the quality of health care and reduce the duplication of corporate and administrative work.

Details of the key provisions of the NZPHD Act are given in the relevant Chapters of this Governance Manual.

Crown Entities Act 2004

The CE Act provides a consistent framework for the establishment, governance and operation of Crown entities, as described in the various chapters of this Governance Manual. 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, strategy and performance – related planning and reporting requirements. The CE Act needs to be read in conjunction with the provisions of the NZPHD Act.

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.

Key parts of the CE Act as it applies to DHBs

Government policy directions	DHBs *must give effect to* government policy when directed by the responsible Minister (i.e. 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. 107,110)
Planning and reporting	DHBs must prepare a Statement of Intent once every three years (to include statements of strategic intentions) and an annual Statement of Performance Expectations. A DHB's Annual Report must report progress in relation to its strategic intentions, and a full report in relation to its performance expectations (s.139 to 153)
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 Cabinet Fees Framework (s. 47) – Cabinet Circular CO(19/1)

A number of sections of the CE Act do not apply to DHBs, or to their boards, board members, committee members or employees. Those sections are listed in s.21 of the NZPHD Act.

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 promote leadership capability and strategies for workforce capacity and capability
- to review governance and structures across all areas of government in order to advise on:
  - the allocation and transfer of functions and powers, and
  - the cohesive delivery of services
  - the establishment, amalgamation and disestablishment of agencies;
- to promote and reinforce standards of integrity and conduct in the State Services; and to promote transparent accountability. 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*).

Note: the Government has announced its intention to make significant changes to the State Sector Act. Its intention is to introduce a Bill at the end of August 2019, with legislation enacted by mid-2020. For information on what is proposed refer to https://www.ssc.govt.nz/changes-state-sector-act-1988.

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:

- s.19, s. 26Z and s.29A provide for the Secretary to the Treasury to request information necessary to prepare government financial statements;
- 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 shall 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.

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 s. 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 s. 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 significant legislation/regulations 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 the legislative requirements, the chief executive invariably acts under delegation from the board. The **Health and Safety at Work Act 2015** is New Zealand's workplace health and safety law. It has introduced new responsibilities for managing the work – related risks that could cause serious injury, illness or even death. It sets out the responsibilities of all involved including personal liabilities for Board members if their obligations under the legislation are not met.

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.

For further guidance, see: www.ombudsmen.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/how-to-comply-with-the-privacy-act/

Of particular relevance to DHBs is the **Health Information Privacy Code**, which is a code of practice established under the Privacy Act 1993 and relates specifically to the collection, use and disclosure of health information. For further guidance, see: http://privacy.org.nz/the-privacy-act-and-codes/codes of practice/health-information-privacy-code/

The **Protected Disclosures Act 2000** 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 in relation to record keeping.

The **Code of Rights** is a regulation under the Health and Disability Commissioner Act. It grants a number of rights to all consumers of health and disability services in New Zealand, and places corresponding obligations on providers of those services. The Code extends to any person or organisation providing, or holding themselves out as providing, a health service to the public or a section of the public – whether that service is paid for or not.

For further guidance, see: Code of Health and Disability Services Consumers' Rights – Health and Disability Commissioner

The intention of the **Human Rights Act 1993** is to help ensure that all people in New Zealand are treated fairly and equally. The Act also sets out the role of the Human Rights Commission.

Under the Act, the Commission has the power to resolve disputes relating to unlawful discrimination. If people believe that they have been discriminated against they can ask the Commission for help.

The Human Rights Act protects people in New Zealand from discrimination. Discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances.

The Human Rights Act lists the areas and grounds where discrimination is unlawful and also some exemptions or exclusions.

Protection includes protection against discrimination on the grounds of disability, and the Commission's work in that area focuses on both individual and systemic discrimination, including addressing such issues as better design, political participation and the right to sign language.

The **Oranga Tamariki Act 1988** concerns protection of the welfare and safety of children. Reporting of concerns (for which DHB staff have instructions and processes) falls under the scope of this Act.

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 s. 25 of the Crown Entities Act (CE Act) and s. 26 of New Zealand Public Health and Disability Act 2000 (NZPHD Act).

S. 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

S. 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;

ba) Seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs;

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 s. 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.

S. 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;

ba) To collaborate with relevant organisations to plan and co-ordinate at local, regional and national levels for the most effective and efficient delivery of health services;

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:

S. 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

As noted at the start of the chapter, an entity's powers are exercised by, or under the authority 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 or issue a licence.
- Natural powers: s. 17 provides that 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. S.103 is subject to s. 113 of the CE Act, under which the independence of Crown entities is safeguarded.

Under ss. 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, the DHB's annual plan and any other plan the DHB is a party to. The Minister must also consult the DHB before issuing a direction notice.

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 s. 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 (ss. 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)).

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 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.

Structure

The structure of the DHB, including the board and committees, needs to support the implementation of the functions and powers of the board and is reviewed from time to time.

The Board is required by the legislation to have the following Committees: a Hospital Advisory Committee; a Community and Public Health Advisory Committee; and a Disability Support Advisory Committee. The Board has also established an Audit and Finance Committee and Mānawa Ora (the Māori Health Gain Advisory Committee).

As at August 2019 the Community and Public Health Advisory Committee has combined meeting arrangements with Auckland DHB, reflecting the integrated planning and funding arrangements between the two DHBs. The Disability Support Advisory Committee operates on a metro-wide basis (for Auckland, Waitematā and Counties-Manukau DHBs). The Māori Health Gain Advisory Committee has operated as an Auckland /Waitematā DHB Committee but is expected to be superseded in the second half of 2019 by a Northern Iwi-DHB Partnership Board (refer Chapter 4 of this Governance Manual).

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) 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 functions and powers with regard to all DHBs on the appointment and removal of members, matters of strategic direction and targets, operations and 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. S. 133, 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.

The Minister of Health is responsible to the House of Representatives for overseeing and managing the Crown's interests in, and relationships with, the DHBs, and is politically answerable on a day-to-day basis in connection with them. This can include answering to the public for problems or controversies relating to DHBs. The Minister also tables in the House each DHB's statement of intent, statement of performance expectations, 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 17 Planning and reporting*).

Letter of Expectations: This is a mechanism used by the Minister (normally on an annual basis) to inform the DHBs of his/her expectations for the period ahead including financial expectations, priority performance areas etc. Careful attention needs to be paid to the expectations set out.

"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/expectations-letter-crown-entities-jul12), 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 (this may involve proactively managing media interest in a DHB-related matter and letting both the Minister and the Minister's Office know of the media inquiry and the DHB response as soon as possible); and
- inform the Minister in advance of any major strategic initiative.

Relationship with the Ministry of Health (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 supported in this engagement with Crown entities by departmental officials who in this role are known as the 'monitoring department'. 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. This role is provided for in section 27A of the CE Act.

Guidance for departments on how to monitor an entity is available at:www.ssc.govt.nz/guidance-depts-crown-entities

The Ministry reports on quarterly progress towards achieving annual health targets by each District Health Board.

It is important for DHB managers to have a good working relationship with relevant Ministry officials at all levels.

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 Health Select Committee will provide written questions for answer (a major exercise as the questions can be very detailed and run into the hundreds), 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 avoid springing 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/officials-and-select-committees-2007. Within that guidance, the term 'official' includes board members and employees of DHBs.

Relationship with Consumers/the Community

Waitematā DHB's Promise, Purpose, Priorities and Values (refer Introduction section of this document) are focused on the promise of best care for everyone.

Waitematā DHB values community involvement in its day to day activities, future planning and the improvement of services. Ways people can get involved include:

1. Providing their personal feedback on their experience of coming into the hospital or using one of the outpatient and/or community based services.
2. Taking part in public consultation processes.
3. Joining the online community panel - Reo Ora Health Voice - to receive surveys by email as well as invitations to attend focus groups or other opportunities.
4. Contacting Waitakere Health Link who work closely with health providers to connect health services with health consumers (patients) and distribute health information to the community and collect feedback to inform service planning.
5. Becoming a Health Consumer Representative on the Consumer Council.
6. Becoming a volunteer to help within the hospitals through a range of roles.

<u>The Consumer Council</u>
Waitematā DHB has established a Consumer Council, which held its first meeting on 3 July 2019. The aim is to encourage feedback from patients and families on patient experience and to provide input towards the design, planning and delivery of accessible, safe and high quality healthcare services. The Council is authorised to give advice and make recommendations to the Chief Executive as well as any DHB services or divisions that seek its input. Membership has been recruited from a broad cross-section of candidates to represent a diverse community. The Council includes people with strong connections to local Māori, Pacific, Asian, disability and

youth communities. All members have experienced Waitematā DHB within the last two to three years – either as patients or family and whānau.

Relationship with Patients/Whānau/Families

Waitematā DHB's Promise, Purpose, Priorities and Values are focused on the promise of best care for everyone.

At the governance level the Board has a duty to ensure that it has oversight of a range of family consent and family inclusion policies and to ensure that Waitematā DHB responds appropriately to complaints from patients and their families. Detailed reporting on complaints occurs at Hospital Advisory Committee meetings.

The organisation has been in the forefront of initiatives such as Kōrero mai – a co-design project with the Health and Quality Commission aimed at making patients, families and whānau feel comfortable in escalating care for deteriorating patients, and that they have a way to do this that suits their needs.

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 (s. 26(3), NZPHD Act). The board and the chief executive must be clear about the boundaries between governance and management and what duties have been delegated to the chief executive. Guidance on this is provided in the Board's Code of Conduct (Chapter 7 of this Governance Manual). Issues concerning relationships and communications between board members and staff are also addressed there.

Co-operative agreements with persons in the health and disability sector

For a DHB to fulfil its obligations, it must "actively investigate, facilitate, sponsor and develop" co-operative 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).

Iwi Partnership

This is a major focus of the DHB. Please refer to the following Chapter 4.

Other Co-operative Agreements or Arrangements

The Board is a participant in numerous other local, regional and national co-operative arrangements,

The Board has collaborative arrangements with Auckland DHB, Counties Manukau DHB and Northland DHB, including a range of shared services.

The **Northern Region Long Term Health Plan** is intended to improve health outcomes and reduce inequalities for the 1.87 million people living in the Northern Region. It places emphasis upon selected actions that will be progressed in a joined up manner across the four District Health Boards (DHBs) in our Region. These are actions that it makes sense to progress once, in a collaborative and consistent manner, rather than independently by each DHB. This plan outlines a series of initiatives. This plan is founded upon working together as a region to provide health care that makes best use of available resources, is sustainable, and improves access.

At the governance level there is the Northern Regional Health Plan **Regional Governance Group** (RGG) - Membership comprises the four Northern Region Chairs, with Chief Executive Officers and Chief Medical Officers attending in an ex officio capacity and others by invitation. The Regional Governance Group's role is to:

- Provide a collective regional forum to address, monitor and influence current and long term planning of regional health services and capital planning
- Shape thinking on the regional direction, particularly in relation to long-term planning of regional health services
- Identify any issues impacting on the ability of the Region to efficiently deliver health services to the Northern Region population
- Agree annual and three year strategic priorities and the Northern Regional Long Term Health Plan

In addition there is a **Regional Executives Forum** whose role is to provide active leadership and operational oversight to all regional activities.

The Northern Regional Alliance (NRA) works in conjunction with the four Northern DHBs in areas where there is benefit from working regionally. Broadly its scope of services includes corporate and business support; workforce development, training and Resident Medical Officer (RMO) operations and regional health service planning, coordination and delivery. Its roles do not include information systems support or other matters in the scope of healthAlliance.

healthAlliance NZ provides non-clinical shared services and an ICT platform to the four Northern Region DHBs. Waitematā DHB is represented on the governing Board.
The Chief Executive of healthAlliance regularly attends the DHB's Audit and Finance Committee meetings to brief the Committee and respond to questions.

healthAlliance FPSC provides finance, procurement and supply chain shared services to the four Northern Region DHBs. Waitematā DHB is represented on the governing Board.

All New Zealand DHBs currently have shareholdings in **New Zealand Health Partnerships Ltd** which focuses on national shared service initiatives for DHBs particularly in banking and insurance.

Chapter 4: The Relationship with Māori and the Responsibility to Address Health Inequalities

As noted in Chapter 2, the objectives of a DHB under section 22 of the NZPHD Act include:

" 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"

The functions of a DHB under section 23 of the NZPHD Act include:

" 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; "

Also as noted in Chapter 2, 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 (ss. 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)).

The Board's responsibilities to address both the health disparities affecting Māori and the special responsibilities to recognise and respect the principles of the Treaty of Waitangi are reflected in:

- The pending establishment of the **Northern Iwi-DHB Partnership Board**:
  Following consultation with Northern Iwi and the Auckland and Northland DHBs, the Board has endorsed (at its meeting on 29 May 2019) seeking the Minister of Health's approval for establishment of the Northern Iwi – DHB Partnership Board.

  The proposed delegated functions specified in the Terms of Reference of the Northern Iwi-DHB Partnership Board are to:

a. Determine Māori health outcomes and Māori health equity priority areas for the three northern DHBs
b. Provide Māori health leadership, advice and guidance across all DHB funded and provided services, activities and workforce to meet their Treaty of Waitangi and statutory obligations to Māori
c. Oversee resource allocation and investments made by the three DHBs for the purpose of achieving Māori health outcomes and advancing Māori wellbeing
d. Engage experts and advisors to carry out work and complete specific tasks on behalf of the Northern Iwi-DHB Partnership Board

The intention is that the Partnership Board would oversee the expenditure of up to $2M Māori Health Equity Budget set aside to invest in Māori equity initiatives by Waitematā DHB in 2019/20.

- The MOUs with Te Runanga o Ngati Whatua Trust (May 2001) and Te Whanau o Waipareira Trust (April 2003). These are attached as **Appendix 1**.
- A Māori Health team (combined service with Auckland DHB) focussed on addressing Māori Health outcomes disparities. Practical support is also offered to inpatients and their families including:
    - cultural and clinical assessment, designed to help Māori patients and their whanau during their stay in hospital
    - case management, social work support and advocacy
    - tikanga and bereavement support for families of inpatients
    - help and support for people whose language is Māori
    - organising overnight accommodation for whanau using North Shore Hospital services.
- Manawa Ora (the Māori Health Gain Advisory Committee). This has held combined meetings and had common membership with Auckland DHB's Manawa Ora and had extensive Māori representation. It is focused on addressing Māori health outcomes disparities and meeting the Board's responsibilities under the Treaty of Waitangi. Manawa Ora will be superseded by establishment of the Northern Iwi-DHB Partnership Board.
- The Waitematā DHB Māori Health Plan.
- Extensive reporting on Māori health inequalities and the measures being taken to address them, not just to Manawa Ora, but also in Board and committee agendas.

<u>Health Outcomes Disparities experienced by other population groups</u>

The Board also has a responsibility to reduce health outcomes disparities for other population groups. In the Waitematā DHB area these include Pacific and Asian ethnicities. This is also a significant focus of attention for the DHB and the subject of ongoing reporting and initiatives in areas of particular concern.

A Pacific Health Team (combined service with Auckland DHB) provides a range of Mental Health and Addiction Services and general support services including:

- Communication (language) support to Waitematā DHB staff and Pacific patients/clients and their families using Waitematā DHB services
- Cultural, emotional and communication support to Pacific patients/clients
- Working to improve access to health services and health information
- Working to provide cultural training and resources to Waitematā DHB staff to enhance cultural competence

Waitematā DHB Asian Health Support Services provides support services including:

- Communication (language) support to Waitematā DHB staff and Asian patients/clients and their families using Waitematā DHB services
- Cultural, emotional and communication support to Asian patients/clients
- Working to provide cultural training and resources to Waitematā DHB staff to enhance cultural competence
- Providing Health information for the Asian population.

Chapter 5: 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.

S. 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.

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 current statement of performance expectations (s. 49, CE Act);
- Perform their functions efficiently and effectively, and consistently with the spirit of service to the public, and in collaboration with other public entities where practicable (s. 50, CE Act);
- Operate in a financially responsible manner (s. 51, CE Act); and
- Ensure that the DHB complies with ss96 to 101 of the CE Act.

The board of a DHB must also ensure that the DHB acts in a manner consistent with its annual plan and any national and regional plans (to which it is a party), and with any directions the Minister of Health may have issued requiring the DHB to provide or arrange for the provision of any services (ss. 27(1) and 33 of the NZPHD Act). The board of a DHB must also act in a manner consistent with s. 103 or s. 107 of the CE Act.

In recent years there has been an increasing focus on the importance of identifying and mitigating risk, whether this relates to delivery of key business/strategic objectives, to business cases, to clinical risk (as may be identified through Coroner's reports, Health and Disability Commissioners' reports

etc.) or to Health and Safety risks for workers and others. Extensive work is carried out to continually update the DHB's Risk Register and this is regularly brought to the Board's Audit and Finance Committee for consideration.

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).

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:

- 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.

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

Chapter 19 Board Appointments and Reappointments describes 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 6: 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)(also see *Chapter 1 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 17 Planning and reporting*);
    - signing-off formal governance documents (Statement of Intent, Statement of Performance Expectations, 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 3 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
- 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 19 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 board members (see *Chapter 18 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 19 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.
- Overseeing the employment of the chief executive, including succession planning and organising induction for a new chief executive.
- Organising annual formal assessments of the chief executive's performance and remuneration review, and representing the Board 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 15 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.

Board Conduct (Chapters 7-11)

Chapter 7: Code of Conduct

The Board has adopted the following **Code of Conduct**:

This Code of Conduct has been agreed to by all Board members of the Waitematā DHB Board. The Code sets out key principles that govern the conduct of Board members, both individually and collectively.

In developing the Code, Board members recognise the unique nature of the District Health Board, which embraces the disciplines and accountabilities expected of a corporate "board of directors", and the wider mandate of publicly elected board members. The principles in the Code endeavour to address potential differences in attitudes and behaviours of Board members. The Board is ultimately accountable for the successful performance of the DHB, and the actions of members, both public and private, should support the decisions and activities of the organisation.

a) Fiduciary Responsibility

Each Board member has the duty to ensure that the District Health Board is properly governed. To meet this obligation, members are expected to:

- Comply with the NZ Public Health and Disability Act 2000 and the Crown Entities Act 2004;
- Act with honesty and integrity;
- Act in good faith and lay aside all private and personal interests in their collective decision-making;
- Exercise reasonable care, diligence and skill at all times in carrying out their duties.

(Refer Crown Entities Act 2004, s53-56.)

b) Accountability

Members are accountable to the Minister of Health (through the Board Chair) for the performance of the DHB. The Minister, in turn, holds DHB Boards to account for all decisions made by the DHB.

c) Commitment

In accepting their positions, Board members have made a commitment to undertake the work of the Board, and to commit the time required to acquit these responsibilities. Members are expected to make every effort to attend scheduled meetings, but it is recognised that there will be occasional conflicts which require the courtesy of notice.

Members undertake to be diligent in preparing for and attending Board meetings. They will endeavour to be as informed and as knowledgeable as possible about the responsibilities of the District Health Board and the issues they are confronted with in order to arrive at the best decisions possible.

d) Training

Members are required to be familiar 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 Waitematā district. The Board is required to fund training for members not familiar with any of these areas and members are expected to avail themselves of opportunities for

training in these areas.

Members have an obligation to assist the Board secretariat to maintain an up-to-date record of their training (Note: The NZPH&D Act requires DHBs to maintain a training register for all members [Schedule 3, Section 5 (2)])

(e) Collective Responsibility

The collective duties of the Board are set out in sections 49-51 and 58 of the Crown Entities Act 2004 and sections 26 and 27 of the NZ Public Health and Disability Act 2000. Members recognise that there may at times be tension between the concepts of collective accountability of a Board of directors and the expectations the public may have of individual members, especially when they are elected. Members agree to support and abide by the following principles:

- Members may clearly express their individual views at Board meetings, and endeavour to achieve a particular decision and course of action. However, 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 member to undermine a decision of the Board once made, or to engage in any action or public debate which might frustrate its implementation.
- Individual members will not attempt to re-litigate previous decisions at subsequent meetings of the Board, unless the majority of members agree to re-open the debate.
- Member's personal actions should not bring the Board into disrepute or cause a loss of confidence in the activities and decisions of the Board.

f) Public Statements

All statements on behalf of the Board and/or relating to Board or Government policy are to be made by the Chair. Either the Board Chair or the Chief Executive (or other senior staff under his delegation) speak on operational matters. On occasions members may be asked their opinions and when talking to the media members should:

a. Make clear the capacity in which they are speaking.
b. Make it clear that they are expressing their own personal views and not speaking for the Board.
c. Remember Government and Ministerial expectations of all Board members.
d. Not make any promises in relation to funding or service provision.
e. Be aware of the governance role, and that management is responsible for policy implementation and operational issues.
f. Inform the Board Chair if they are contacted by or intend to speak to the media.

<u>Note: Social Media</u>
Members may choose to operate social media accounts via platforms such as Facebook, Twitter and Instagram as a means of staying connected with the Waitematā community. If doing so, members should:

a. Adhere to the above principles when publishing posts and responding to feedback on social media channels.
b. Refer any operational queries or concerns from constituents received via social media to the office of the Chief Executive.
c. Avoid featuring Waitematā DHB staff in social media feeds unless prior approval has been granted from the Chief Executive's office and the staff concerned have given their explicit consent.

d. Seek approval from the Chief Executive's office before entering DHB premises for the purposes of taking photographs or video footage
e. At all times, respect the right to privacy of patients in our care and that of their families and whānau.

g) Clarity about Roles

Under section 26(3) of the NZPH&D Act, the Board must delegate to the Chief Executive the power to make decisions on management matters relating to the DHB on whatever terms and conditions it sees fit. The Chief Executive is expected to provide the Board with relevant and appropriate information and with free and frank advice to assist it in reaching high quality decisions on strategy, policy and other governance matters.

Members recognise that, for the purposes of accountability, clarity between the roles of governance and management is essential. Members must take care to avoid becoming involved in management's activities and are prohibited from interference in matters involving individual staff members other than the Chief Executive (refer clause 44 of Schedule 3 to the NZPH&D Act).

Members will not make commitments for work or expenditure by the DHB that have not been previously approved by the DHB, nor create any obligation or liability for the DHB.

h) Employment Relationship

The Board employs the Chief Executive who is responsible for the employment and management of all other staff in the organisation. Board members will:

- Be supportive of employees of the District Health Board, and will not criticise employees or the service provided by the District Health Board in public. Any concerns relating to staff will be raised with the Board Chair 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 unduly influence any employee of the District Health Board to present material in a particular way that might affect the outcome of a decision to be made by the Board.
- Exercise care in communicating privately with employees of the District Health Board, and refer any staff with complaints or concerns back to the Chief Executive.

i) Contact with Individual Staff Members

In some circumstances it will be quite appropriate for members to communicate directly with individual staff to further their knowledge/ understanding of organisational issues relevant to their governance role. Such communication needs to be carried out in an open and considerate manner. As a general rule, requests to individual staff should be governed by the following protocols:

- In the first instance, such approaches should be made "through the management line", either via or with the knowledge of the Chief Executive (and Chair) and subsequently through the appropriate management levels (i.e. top down).
- E-mails (or other written requests) and subsequent communication should be copied to the Chief Executive and Chair.

- Consideration should be given to staff pressures and workloads and requests should not impose unreasonable burdens on staff.

Any concerns about responsiveness to Board member requests should be taken up directly with the Chair/Chief Executive.

j) Complaints Procedures and Representations

Board members have an important role in providing a community voice to the activities of the DHB. However, members recognise that the organisation, through the mandate of the Board, has processes in place to seek public consultation, prioritise resources, establish waiting lists and times, and respond to consumer complaints etc.

- Members will advise residents / health consumers who desire personal matters to be brought to the attention of the DHB to follow the proper procedures for raising issues and registering complaints.
- Members will not advocate on behalf of an individual beyond advising them of the complaints procedures and checking that the matter has been addressed satisfactorily by the organisation (Note: 'satisfactorily' refers to the procedures followed by the organisation in addressing the matter, not necessarily whether the outcome is as the individual would wish).
- Note: the foregoing provisions do not preclude members pursuing in a general way issues relating to policy or systemic failure that may have been indicated by or arise from an individual case/complaint.

k) Confidentiality – duty not to disclose information

Members receive information that is both public and private and must recognise that the release of information, and access to and handling of personal information about any individual, is governed by the Official Information Act 1982 and the Privacy Act 1993. In order to protect the organisation from inappropriate use of information:

- Members are expected to be familiar with this legislation, and refer any requests for 'Official Information' to the Chief Executive.
- Members will 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.

Members accept that they may acquire information of a confidential nature (for example about health and disability providers and/or other local and national organisations) and agree not to use any such information for personal advantage, nor to disclose it to any other person unless first authorised by the Board (refer section 57, Crown Entities Act 2004).

l) Conflict of Interest Protocol (adopted by the Board on 6 March 2019)

Executive Summary

The Waitematā District Health Board is committed to the highest standards of honesty, openness, transparency and integrity in its governance role. Conflicts of interest are natural and unavoidable given New Zealand's size and the wide scope of Board members' other legitimate commercial, professional and community interests.

The Board has reviewed and amended its Conflict of Interest protocol for inclusion in the Guidelines and Protocols for Board and Committee Members.

It has done so at a governance level in the expectation of an organisational commitment to honesty, integrity and to foster a spirit of full and open disclosure of conflicts of interest, and to the effective management and reporting of potential conflicts.

The protocol outlines:

- Legal and regulatory obligations
- The procedure for Board and Committee members to review and disclose conflicts of interest in a Register of Interest.
- The process for active management of and recording conflicts of interest disclosed during Board or Committee meetings.
- The availability of Board and Committee Chairs to discuss conflicts of interests with members including the provisions of access to professional advice if required
- The handling of complaints or breaches of the conflict of interest protocol.

The development of the protocol has been informed by legal obligations, relevant case law, and guidance from government departments such as the State Services Commission and the Ministry of Health. Relevant materials will be on Diligent Boardbooks.

Legal and regulatory obligations

The New Zealand Public Health and Disability Act 2000 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 of the Board relating to the transaction unless the majority of the members present permit the member to do so.
3. The Board member must not take part in any decision of the Board relating to the transaction or be included in the quorum for any such decision.
4. The disclosure must be recorded in the minutes and entered in a separate interests register.

Definitions (NZPH&D Act Section 6)

*A **"transaction"** in relation to DHB, means:*

(a) the exercise or performance of a function, duty or power of the DHB; or

(b) an arrangement, agreement, or contract to which the DHB is a party; or

(c) a proposal that the DHB enter into an arrangement, agreement, or contract.

***"Interest in a transaction"** is defined in section 6(2) as arising:*

"if the board member:

(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 ...; 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."

Unless "*his or her interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence him or her in carrying out his or her responsibilities"*

However, the Ministry in its guidance to DHBs notes that a 'good practice' approach to Conflicts of Interest extends beyond strict legal compliance.

The Waitematā DHB has traditionally:

- Recognised that at times there may be a 'perception of interest' which is a wider interpretation than that defined in the legislation. A "perception of interest" arises where any member is "perceived to have an interest greater than the general public" but would normally preclude community involvement and activities. Commonly, when a conflict of interest has become an issue, the person concerned has neither taken advantage of the situation for personal benefit nor been influenced by improper personal motives. However, failure to appropriately disclose and manage conflicts can cause a real or perceived unfairness.

- Noted that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action. Matters of interest may include:[2]

  - Family Members – Any family connection could give rise to an interest where there is a reasonable apprehension of bias, e.g. a member could have a close relative who is personally interested either by way of a financial interest or in some other way such as when a family member is a patient of Waitematā DHB, as an example.

  - Friendship – Members may have an interest in matters affecting the interests of close friends. Close and reasonably long-standing relationships with demonstrable intimacy are likely to create strong perceptions of interest.

  - Acquaintances – General acquaintances are not likely to give rise to an interest. Involvement in professional or sporting associations with people interested in a party dealing with the entity would rarely create an interest. Overlapping directorships or similar interests could, however, mean a member is interested, especially where relationships are long-term or close collegiality has developed. Where a member has acted as an advocate, adviser or material witness in a matter, or a member's business partner has done so, and the matter is being considered by the entity or relates to a matter it is considering, the member is likely to be seen as having an interest.

[2] Board Appointment and Induction Guidelines, State Services Commission, November 2009

- Prior and current Business Relationships – Where someone had a close association with a business for a significant period before becoming a board member, there may well be a strong perception of an interest for at least six months after ending all associations. There is no set time period which establishes remoteness, but ending a long business relationship is unlikely to immediately make that interest so remote as to be irrelevant. Current business relationships involve a higher risk of conflict of interest and need special attention by the Board.

- Pre-judgement – Pre-judgement of issues would exclude a member from participation in a matter before the entity. Having a definite point of view about a question of law or legislative interpretation of a policy is not sufficient to give rise to an interest, nor is prior knowledge of circumstances which are in issue. However, a publicly-stated opinion on those facts could raise issues of apparent pre-judgement.

- Noted that members should:

  - Recognise that where a conflict of interest is declared (or where it is considered that there is a clear "perception of interest") the normal practice is for the member concerned to leave the room. A majority of the other members of the Board may, however, resolve to allow the member to remain and take part in its deliberations, but not the decision, as long as the resolution and anything said by the member concerned are minuted. (NZPH&D Act Schedule 3 clause 36(4) and (5).

  - Avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducements and which could compromise the Board's integrity.

  - Note that under the 'no-surprises' principle, the Board Chair may keep the Minister informed if public comment on a member's situation is likely.

  - Exercise care and judgement in accepting any gifts, and advise the Chair and/or Board of any offer received. Any gift over $50 has to be declared to the Board Secretary.

Board members and staff should note that under section 135 of the Crown Entities Act they are "officials" for the purposes of sections 105 and 105A of the Crimes Act 1961 which relate to bribery and corruption:

Diligent Boardbooks contains Acting in the Spirit of Service, Conflicts of Interest, published by the State Services Commission and Conflicts of Interests Guidelines for District Health Boards, published by the Ministry of Health. There is also a comprehensive staff policy on Conflict of Interest and Gifts and Benefits which provides further guidance and examples of possible conflict situations. Another good reference is: Controller and Auditor General (2007), Managing conflicts of interest: Guidance for public entities: Good Practice Guidelines.

Procedure relating to the Register of Interest.
In the case of an interest, the details of the interest should be disclosed and recorded in a manner which makes clear 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, the nature of the conflict, and how it could benefit the member (or other parties as per s6(2)(d) of NZPH&D Act) or disadvantage the DHB and impact on the member's role on the board should be disclosed and recorded.

Board and committee members should identify and disclose all interests in writing to the Board Secretary at the start of their appointment. A Register of Interests will be published as part of the agenda for each Board/committee and is maintained by the Board Secretary. Members themselves bear the responsibility for updating their interests register and can do this either at a Board or Committee meeting or in writing to the Board Secretary.

At each Board/committee meeting each board member is explicitly asked to disclose any previously undisclosed interests and to identify any potential conflicts of interest. Two questions relating to disclosure of interests are printed in Board papers. They are:

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

Note: depending on circumstances, where an interest is declared but the member states that there is no conflict, it may be appropriate to ask a further question about whether that could change in the short to medium term future – for example the member declares that a business he/she has an interest in does not provide the service under discussion – is it the case that there is no intention of providing that service in the short to medium – term future?

The Disclosure of Interest protocol acknowledges that proper disclosure of interest errs on the side of more disclosure, rather than less, and that interests and conflicts often change. Board/ committee members must list all of their interests that might possibly give rise to a conflict of interest situation during the course of the members' duties.

In the case of an interest, the details of the interest should be disclosed and recorded in a manner which makes it clear what the member's interest is, and why and how it might impact on their role on the board/committee.

Process for managing conflicts of interest

A Board member's interests, if not disclosed, registered and managed properly, have the potential to lead to conflicts that will undermine decisions taken by a board and the confidence of stakeholders in the actions of the DHB.

A board member who makes a disclosure 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 required for any such deliberation or decision; or sign any document relating to the entry into a transaction or the initiation of the

transaction**.** (Clause 36, Schedule 3, NZPH&D Act)

However, a board member may take part in deliberations (but not any decision) of the board relating to a transaction in which s/he has an interest if a majority of the other members of the board permits the member to do so. In this case, the board must record in the minutes of the meeting:

(i) the permission and the majority's reasons for giving it; and
(ii) what the member says in any deliberation of the board relating to the transaction concerned.

This exemption should be used only when absolutely necessary, and not as a common practice. Exercise of any such exemption must be recorded in the DHB's annual report (s42(4), NZPH&D Act).

In making the decision, the Board will take into account all relevant factors including:

- the type and the extent of the member'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 interest could affect, or be affected by, the DHB's decision or activity
- the nature of 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

Where a conflict of interest may be significant, the member should not participate in conflicted activities unless/until the conflict is resolved to the satisfaction of the Board Chair.

Several potential conflicts of interest situations require specific attention. These include:

Members undertaking consultancy work for the DHB

Clause 7 of Schedule 2 to the NZPH&D Act explicitly provides that employees of the DHB may also be elected as board members. Employment relationships must be declared as a conflict of interest (see section 6 NZPH&D Act).

For consultancy work, paragraph 58 of the Fees Framework [CO(12)6 at 113] applies:

"The practice of members or other appointees receiving payments as consultants from bodies to which they are appointed should not take place. If, however, the responsible Minister agrees that there are overriding reasons for members and other appointees to carry out consulting assignments, any proposal to do so should be submitted to Cabinet Appointments and Honours Committee (APH) Cabinet for consideration. Where the arrangement results in the risk of a conflict of interest, the Minister should identify the conflict in the submission to APH, and propose a suitable regime for managing the conflict. (See the SSC Board Appointment and Induction Guidelines, sections 31 and 62 of the Crown Entities Act 2004, and the appointments section of the CabGuide for further guidance on conflicts of interest)."

In the event of any such approval, the Minister will specify any conditions or expectations

that will apply to the consultancy relationship.

Contracts between DHB and members

Members are prohibited from signing documents relating to the entry into a transaction or initiation of a transaction in which they have an interest with the DHB under clause 36(2), Third Schedule of the NZPH&D unless the Minister of Health grants a waiver.

Examples of the kinds of interests/transactions which might be covered by clause 36(2) include but are not limited to:[3]

- a contract between the DHB and a company owned by a member or family members to purchase a product
- a contract between the DHB and a member to provide a service (other than consultancy services)
- a contract between the DHB and an NGO which employs a member.

If a member is contemplating initiating a transaction in which she/he has an interest with the DHB, she/he must advise the Chair immediately. The Chair will decide whether it is appropriate for the DHB to enter into the contract. If the Chair decides it is appropriate, the Chair will seek a waiver from the Minister of Health. Work on the transaction must not begin until the Minister grants the waiver.

Board and Committee Chair advice.

If a member identifies any potential conflict of interest in papers, proceedings or Board activities and operations, they should in the first instance discuss these with the Board and/or Committee Chair and ask for advice. The matter may be referred to legal counsel. This could apply to their own position or that of another member.

Handling of complaints or breaches of the conflict of interest protocol.

In the event that there is a complaint about a potential conflict of interest that was not disclosed or which was disclosed but not appropriately handled, or about other breaches of the conflict of interest protocol, then the Board Chair will convene a sub committee comprising the Chair or Deputy Chair and the Chair of Audit and Finance, assisted by general legal counsel. The matter may also be referred to Internal Audit. Advice will be sought from the State Services Commission if required.

m) Consultation and Participation

The Board has legislative obligations to consult with the public in developing its District Strategic Plan (note, 'consultation' is a term with specific meaning that has been derived from case law - DHBs are required to consult to the standard defined in the Local Government Act 2002). Further, the Board is required/committed to engage with the community to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services. It has a special responsibility to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement.

The Board and individual members:

- Must keep an open mind during formal consultation with the public and be

[3] Conflict of interest includes the employment or engagement of the person, or of the person's spouse or partner, as an employee or contractor of the DHB (s6(1)(c), NZPH&D Act).

prepared to listen, to develop their individual and collective understanding, and if appropriate to change their views.
- Will ensure that the consultation process provides the public with an effective opportunity to give their views.
- Will be respectful and attentive to members of the public.
- Note the Court of Appeal's view of consultation as outlined in its decision in Wellington International Airport v Air New Zealand Limited.

n) Requests for items to be placed on Board or Committee agendas

Requests by members for items to be placed on agendas should be made to the Board Chair or the Chair of the appropriate Committee. The Board Chair or Committee Chair will make a decision following discussion with the Chief Executive or other relevant senior manager, and will arrange for an accompanying paper providing management comments and recommendations as appropriate. As a matter of general practice, the decision would normally be confirmed by e-mail to all Board members – with reasons if declined and/or suggesting a different way of handling/progressing.

o) Board and Committee Meetings

The Board's standing orders provide a formal (and highly regulated) framework for meeting conduct and debate. The Standings Orders include a provision whereby:

The Chairperson of the Board or a Committee may, subject to agreement of all members present but without a formal resolution, conduct the meeting of the Board or committee in a less formal manner than is strictly required by Standing Orders provided:
(a) The procedures followed are not inconsistent with the NZPH&D Act; and
(b) The procedures followed do not inhibit any member from contributing to the discussion or voting on any item; and
(c) All decisions are fully minuted.

As a general practice members have agreed that meetings of the Board and committees should be conducted in as informal manner as possible, consistent with the above provision. In order to achieve this, to work as an effective Team, and to make meetings as productive and efficient as possible, members undertake to observe the protocols set out below. It is expected that these behaviours will apply to and in respect of all participants at meetings including managers and other staff.

- Members will behave in a polite and respectful manner with colleagues and the executive – showing compassion and concern for others.
- Issues will be raised in an objective manner – no personal reference or innuendo will be made to any persons associated with the matter being raised. Members will not undermine each other to other members of the team. Members should not stereotype other members.
- Members should respect the views and acknowledge the contributions and achievements of others.
- Members will not interrupt each other or talk while another member is speaking – no side discussions.
- Members will only make a point if it has not already been raised and is relevant to the topic.
- Members will endeavour to achieve closure on one point before another point is raised.
- Members, the Chair and the Chief Executive will endeavour to clarify questions,

issues, requests, before taking actions or responding.

- When there are concerns about matters that may be based on rumour or that are controversial, sensitive or political in nature, members should check with the Board Chair or Chief Executive for understanding and clarification.
- Members will be prepared to listen to other view points and work through difficult sensitive issues.
- Members will acknowledge mistakes and misunderstandings – and show generosity in accepting these.
- Discussions will be terminated by the Chair if information is not available to pursue the discussion.
- Members will act consistently with what is agreed demonstrating collective responsibility.
- No cell-phones will be on during Board meetings.
- Members and management participating in meetings should signal their intention to leave the meeting and such departures should only be made with good reason.
- All members will assist the Chair to uphold the behaviour protocols agreed to by the Board and to challenge departures from agreed values and standards.

Use of Email

- E-mail is a written means of communication and its use should be governed by common courtesy. Indeed, special care needs to be taken as e-mails are susceptible to misunderstanding and misinterpretation.
- Messages should not be sent "in the heat of the moment". Members should not send e-mails to vent anger or frustration. If in doubt, sleep on it.
- E-mails should only be copied on a "needs to know" basis. In acknowledging the commitment to openness and respecting confidentiality and privacy, e-mails should not be blind copied. If the message is relevant to other parties they should be openly displayed as acc.
- E-mails should not be used to criticise or comment adversely on the actions of other members or staff (if issues arise between members they should be dealt with face to face or by telephone). Members should avoid using e-mails to conduct arguments or "score points" with a cc'd audience.
- E-mails to individual staff (other than the Board Secretary and Executive Assistant - Board Chair and Governance) should generally be copied to the Chief Executive and Chair. This applies especially in the case of requests for information/support (Refer also Section (i) Contact with Individual Staff Members).
- E-mail questions/requests should be acknowledged and/or responded to as promptly as possible.

Note: The Senior Management Team has committed to a similar set of norms for team behaviours as part of their Terms of Reference.

Chapter 8: Members' interests and conflicts: identification, disclosure and management

Note: this detailed Guidance on the identification, disclosure and management of interests is also set out in the Board's adopted Code of Conduct, section (l) (Chapter 7 of this Governance Manual).

Conflict of Interest Protocol (adopted by the Board on 6 March 2019)

Executive Summary

The Waitematā District Health Board is committed to the highest standards of honesty, openness, transparency and integrity in its governance role. Conflicts of interest are natural and unavoidable given New Zealand's size and the wide scope of Board members' other legitimate commercial, professional and community interests.

The Board has reviewed and amended its Conflict of Interest protocol for inclusion in the Guidelines and Protocols for Board and Committee Members.

It has done so at a governance level in the expectation of an organisational commitment to honesty, integrity and to foster a spirit of full and open disclosure of conflicts of interest, and to the effective management and reporting of potential conflicts.

The protocol outlines:

- Legal and regulatory obligations
- The procedure for Board and Committee members to review and disclose conflicts of interest in a Register of Interest.
- The process for active management of and recording conflicts of interest disclosed during Board or Committee meetings.
- The availability of Board and Committee Chairs to discuss conflicts of interests with members including the provisions of access to professional advice if required
- The handling of complaints or breaches of the conflict of interest protocol.

The development of the protocol has been informed by legal obligations, relevant case law, and guidance from government departments such as the State Services Commission and the Ministry of Health. Relevant materials will be on Diligent Boardbooks.

Legal and regulatory obligations

The New Zealand Public Health and Disability Act 2000 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 of the Board relating to the transaction unless the majority of the members present permit the member to do so.
3. The Board member must not take part in any decision of the Board relating to the transaction or be included in the quorum for any such decision.
4. The disclosure must be recorded in the minutes and entered in a separate interests register.

Definitions (NZPH&D Act Section 6)

*A **"transaction"** in relation to DHB, means:*

(a) the exercise or performance of a function, duty or power of the DHB; or

(b) an arrangement, agreement, or contract to which the DHB is a party; or

(c) a proposal that the DHB enter into an arrangement, agreement, or contract.

***"Interest in a transaction"** is defined in section 6(2) as arising:*

"if the board member:

(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 ...; 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."

Unless "*his or her interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence him or her in carrying out his or her responsibilities"*

However, the Ministry in its guidance to DHBs notes that a 'good practice' approach to Conflicts of Interest extends beyond strict legal compliance.

The Waitematā DHB has traditionally:

- Recognised that at times there may be a 'perception of interest' which is a wider interpretation than that defined in the legislation. A "perception of interest" arises where any member is "perceived to have an interest greater than the general public" but would normally preclude community involvement and activities. Commonly, when a conflict of interest has become an issue, the person concerned has neither taken advantage of the situation for personal benefit nor been influenced by improper personal motives. However, failure to appropriately disclose and manage conflicts can cause a real or perceived unfairness.

- Noted that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action. Matters of interest may include:[4]

    - Family Members – Any family connection could give rise to an interest where there is a reasonable apprehension of bias, e.g. a member could have a close relative who is personally interested either by way of a financial interest or in some other way such as when a family member is a patient of Waitematā DHB, as an example.

[4] Board Appointment and Induction Guidelines, State Services Commission, November 2009

- Friendship – Members may have an interest in matters affecting the interests of close friends. Close and reasonably long-standing relationships with demonstrable intimacy are likely to create strong perceptions of interest.

- Acquaintances – General acquaintances are not likely to give rise to an interest. Involvement in professional or sporting associations with people interested in a party dealing with the entity would rarely create an interest. Overlapping directorships or similar interests could, however, mean a member is interested, especially where relationships are long-term or close collegiality has developed. Where a member has acted as an advocate, adviser or material witness in a matter, or a member's business partner has done so, and the matter is being considered by the entity or relates to a matter it is considering, the member is likely to be seen as having an interest.

- Prior and current Business Relationships – Where someone had a close association with a business for a significant period before becoming a board member, there may well be a strong perception of an interest for at least six months after ending all associations. There is no set time period which establishes remoteness, but ending a long business relationship is unlikely to immediately make that interest so remote as to be irrelevant. Current business relationships involve a higher risk of conflict of interest and need special attention by the Board.

- Pre-judgement – Pre-judgement of issues would exclude a member from participation in a matter before the entity. Having a definite point of view about a question of law or legislative interpretation of a policy is not sufficient to give rise to an interest, nor is prior knowledge of circumstances which are in issue. However, a publicly-stated opinion on those facts could raise issues of apparent pre-judgement.

- Noted that members should:

  - Recognise that where a conflict of interest is declared (or where it is considered that there is a clear "perception of interest") the normal practice is for the member concerned to leave the room. A majority of the other members of the Board may, however, resolve to allow the member to remain and take part in its deliberations, but not the decision, as long as the resolution and anything said by the member concerned are minuted. (NZPH&D Act Schedule 3 clause 36(4) and (5).

  - Avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducements and which could compromise the Board's integrity.

  - Note that under the 'no-surprises' principle, the Board Chair may keep the Minister informed if public comment on a member's situation is likely.

  - Exercise care and judgement in accepting any gifts, and advise the Chair and/or Board of any offer received. Any gift over $50 has to be declared to the Board Secretary.

Board members and staff should note that under section 135 of the Crown Entities Act they are "officials" for the purposes of sections 105 and 105A of the Crimes Act 1961 which relate to bribery and corruption:

Diligent Boardbooks contains Acting in the Spirit of Service, Conflicts of Interest, published by the State Services Commission and Conflicts of Interests Guidelines for District Health Boards, published by the Ministry of Health. There is also a comprehensive staff policy on Conflict of Interest and Gifts and Benefits which provides further guidance and examples of possible conflict situations. Another good reference is: Controller and Auditor General (2007), Managing conflicts of interest: Guidance for public entities: Good Practice Guidelines.

Procedure relating to the Register of Interest.

In the case of an interest, the details of the interest should be disclosed and recorded in a manner which makes clear 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, the nature of the conflict, and how it could benefit the member (or other parties as per s6(2)(d) of NZPH&D Act) or disadvantage the DHB and impact on the member's role on the board should be disclosed and recorded.

Board and committee members should identify and disclose all interests in writing to the Board Secretary at the start of their appointment. A Register of Interests will be published as part of the agenda for each Board/committee and is maintained by the Board Secretary. Members themselves bear the responsibility for updating their interests register and can do this either at a Board or Committee meeting or in writing to the Board Secretary.

At each Board/committee meeting each board member is explicitly asked to disclose any previously undisclosed interests and to identify any potential conflicts of interest. Two questions relating to disclosure of interests are printed in Board papers. They are:

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

Note: depending on circumstances, where an interest is declared but the member states that there is no conflict, it may be appropriate to ask a further question about whether that could change in the short to medium term future – for example the member declares that a business he/she has an interest in does not provide the service under discussion – is it the case that there is no intention of providing that service in the short to medium – term future?

The Disclosure of Interest protocol acknowledges that proper disclosure of interest errs on the side of more disclosure, rather than less, and that interests and conflicts often change. Board/ committee members must list all of their interests that might possibly give rise to a conflict of interest situation during the course of the members' duties.

In the case of an interest, the details of the interest should be disclosed and recorded in a manner which makes it clear what the member's interest is, and why and how it might impact on their role on the board/committee.

Process for managing conflicts of interest

A Board member's interests, if not disclosed, registered and managed properly, have the potential to lead to conflicts that will undermine decisions taken by a board and the confidence of stakeholders in the actions of the DHB.

A board member who makes a disclosure 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 required for any such deliberation or decision; or

  sign any document relating to the entry into a transaction or the initiation of the transaction**.** (Clause 36, Schedule 3, NZPH&D Act)

However, a board member may take part in deliberations (but not any decision) of the board relating to a transaction in which s/he has an interest if a majority of the other members of the board permits the member to do so. In this case, the board must record in the minutes of the meeting:

(i) the permission and the majority's reasons for giving it; and
(ii) what the member says in any deliberation of the board relating to the transaction concerned.

This exemption should be used only when absolutely necessary, and not as a common practice. Exercise of any such exemption must be recorded in the DHB's annual report (s42(4), NZPH&D Act).

In making the decision, the Board will take into account all relevant factors including:

- the type and the extent of the member'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 interest could affect, or be affected by, the DHB's decision or activity
- the nature of 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

Where a conflict of interest may be significant, the member should not participate in conflicted activities unless/until the conflict is resolved to the satisfaction of the Board Chair.

Several potential conflicts of interest situations require specific attention. These include:

Members undertaking consultancy work for the DHB

Clause 7 of Schedule 2 to the NZPH&D Act explicitly provides that employees of the DHB may also be elected as board members. Employment relationships must be declared as a conflict of interest (see section 6 NZPH&D Act).

For consultancy work, paragraph 58 of the Fees Framework [CO(12)6 at 113] applies:

"The practice of members or other appointees receiving payments as consultants from bodies to which they are appointed should not take place. If, however, the responsible Minister agrees that there are overriding reasons for members and other appointees to carry out consulting assignments, any proposal to do so should be submitted to Cabinet Appointments and Honours Committee (APH) Cabinet for consideration. Where the arrangement results in the risk of a conflict of interest, the Minister should identify the conflict in the submission to APH, and propose a suitable regime for managing the conflict. (See the SSC Board Appointment and Induction Guidelines, sections 31 and 62 of the Crown Entities Act 2004, and the appointments section of the CabGuide for further guidance on conflicts of interest)."

In the event of any such approval, the Minister will specify any conditions or expectations that will apply to the consultancy relationship.

Contracts between DHB and members

Members are prohibited from signing documents relating to the entry into a transaction or initiation of a transaction in which they have an interest with the DHB under clause 36(2), Third Schedule of the NZPH&D unless the Minister of Health grants a waiver.

Examples of the kinds of interests/transactions which might be covered by clause 36(2) include but are not limited to:[5]

- a contract between the DHB and a company owned by a member or family members to purchase a product
- a contract between the DHB and a member to provide a service (other than consultancy services)
- a contract between the DHB and an NGO which employs a member.

If a member is contemplating initiating a transaction in which she/he has an interest with the DHB, she/he must advise the Chair immediately. The Chair will decide whether it is appropriate for the DHB to enter into the contract. If the Chair decides it is appropriate, the Chair will seek a waiver from the Minister of Health. Work on the transaction must not begin until the Minister grants the waiver.

Board and Committee Chair advice.

If a member identifies any potential conflict of interest in papers, proceedings or Board activities and operations, they should in the first instance discuss these with the Board and/or Committee Chair and ask for advice. The matter may be referred to legal counsel. This could apply to their own position or that of another member.

Handling of complaints or breaches of the conflict of interest protocol.

In the event that there is a complaint about a potential conflict of interest that was not disclosed or which was disclosed but not appropriately handled, or about other breaches of the conflict of interest protocol, then the Board Chair will convene a sub committee comprising the Chair or Deputy Chair and the Chair of Audit and Finance, assisted by general legal counsel. The matter may also be referred to Internal Audit. Advice will be sought from the State Services Commission if required.

[5] Conflict of interest includes the employment or engagement of the person, or of the person's spouse or partner, as an employee or contractor of the DHB (s6(1)(c), NZPH&D Act).

Chapter 9: 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.

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.

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.

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/health-information-privacy-code/.)

Guidance on confidentiality is also set out in the Board's adopted Code of Conduct, section (k) (refer Chapter 7 of this Governance Manual).

Chapter 10: Communications/Media

In addition to the requirements relating to disclosure of information (Chapter 9), before considering commenting on a subject to the media, members need to consider the agreed principles of section (f) of the Code of Conduct, namely:

"All statements on behalf of the Board and/or relating to Board or Government policy are to be made by the Chair. Either the Board Chair or the Chief Executive (or other senior staff under his delegation) speak on operational matters. On occasions members may be asked their opinions and when talking to the media members should:

a. Make clear the capacity in which they are speaking.
b. Make it clear that they are expressing their own personal views and not speaking for the Board.
c. Remember Government and Ministerial expectations of all Board members.
d. Not make any promises in relation to funding or service provision.
e. Be aware of the governance role, and that management is responsible for policy implementation and operational issues.
f. Inform the Board Chair if they are contacted by or intend to speak to the media.

<u>Note: Social Media</u>
Members may choose to operate social media accounts via platforms such as Facebook, Twitter and Instagram as a means of staying connected with the Waitematā community. If doing so, members should:

a. Adhere to the above principles when publishing posts and responding to feedback on social media channels.
b. Refer any operational queries or concerns from constituents received via social media to the office of the Chief Executive.
c. Avoid featuring Waitematā DHB staff in social media feeds unless prior approval has been granted from the Chief Executive's office and the staff concerned have given their explicit consent.
d. Seek approval from the Chief Executive's office before entering DHB premises for the purposes of taking photographs or video footage
e. At all times, respect the right to privacy of patients in our care and that of their families and whānau."

Chapter 11: 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, every board should have a set of principles to 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.

The Waitematā DHB's policy on Board Member Remuneration, Fees and Expenses (shown in Appendix 5 of the Governance Manual) includes a section on the approach to be taken to gifts, koha and donations. This states:

"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 Audit and Finance Committee) who will determine how to respond.

Gifts or donations to the WDHB Board, accepted on the Board's behalf by individual Board members, are the property of the Waitematā DHB Board. The only exceptions are small gifts (e.g. a bottle of wine; a diary) worth less than $50.

Board members are governed by the WDHB Corporate policy on Koha. (Note: there are relevant sections on koha in corporate policies: Travel Policy and Engagement and Consultation Financial Recognition Policy.)

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 purposes of sections 105 and 105A of the Crimes Act 1961 relating to bribery and corruption. "

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/2007/sensitiveexpenditure/part8.htm) 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.

The Board in Action (Chapters12-17)

Chapter 12: 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
- 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 and Protocols for Meetings

As required by legislation, the Waitematā DHB has adopted "Standing Orders" to provide more detailed guidance on procedures and processes associated with meetings. These are shown at **Appendix 2**.

However, as noted in clause (o) of the Board's **Code of Conduct**:

"The Board's Standing Orders provide a formal (and highly regulated) framework for meeting conduct and debate. The Standings Orders include a provision whereby:
The Chairperson of the Board or a Committee may, subject to agreement of all members present but without a formal resolution, conduct the meeting of the Board or committee in a less formal manner than is strictly required by Standing Orders provided:
(a) The procedures followed are not inconsistent with the NZPH&D Act; and
(b) The procedures followed do not inhibit any member from contributing to the discussion or voting on any item; and
(c) All decisions are fully minuted.

As a general practice members have agreed that meetings of the Board and committees should be conducted in as informal manner as possible, consistent with the above provision. In order to achieve this, to work as an effective team, and to make meetings as productive and efficient as possible, members undertake to observe the protocols set out below. It is expected that these behaviours will apply to and in respect of all participants at meetings including managers and other staff.

- Members will behave in a polite and respectful manner with colleagues and the executive – showing compassion and concern for others.
- Issues will be raised in an objective manner – no personal reference or innuendo will be made to any persons associated with the matter being raised. Members will not

undermine each other to other members of the team. Members should not stereotype other members.

- Members should respect the views and acknowledge the contributions and achievements of others.
- Members will not interrupt each other or talk while another member is speaking – no side discussions.
- Members will only make a point if it has not already been raised and is relevant to the topic.
- Members will endeavour to achieve closure on one point before another point is raised.
- Members, the Chair and the Chief Executive will endeavour to clarify questions, issues, requests, before taking actions or responding.
- When there are concerns about matters that may be based on rumour or that are controversial, sensitive or political in nature, members should check with the Board Chair or Chief Executive for understanding and clarification.
- Members will be prepared to listen to other view points and work through difficult sensitive issues.
- Members will acknowledge mistakes and misunderstandings – and show generosity in accepting these.
- Discussions will be terminated by the Chair if information is not available to pursue the discussion.
- Members will act consistently with what is agreed demonstrating collective responsibility.
- No cell-phones will be on during Board meetings.
- Members and management participating in meetings should signal their intention to leave the meeting and such departures should only be made with good reason.
- All members will assist the Chair to uphold the behaviour protocols agreed to by the Board and to challenge departures from agreed values and standards."

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.

Chapter 13: 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 the Community and Public Health, Disability Support and Hospital Advisory Committees. 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 Māori 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. The NZPHD Act 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

The DHB's board remains accountable for decisions that are made by its committees. 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 and should include members with financial expertise, and a committee chair who is not the board chair.

Waitematā DHB Committees

The Waitematā DHB currently (as at August 2019) has five Board Committees. The Community and Public Health Advisory Committee and Manawa Ora (the Māori Health Gain Advisory Committee) share joint meeting arrangements and membership with the equivalent Auckland DHB Committee, as part of the strengthening collaboration between the two district health boards. The Disability

Support Advisory Committee shares joint meeting arrangements and membership with the equivalent Auckland and Counties Manukau DHB Committees. The five Committees are:

- The Hospital Advisory Committee
- The Audit and Finance Committee
- The Community and Public Health Advisory Committee (collaboratively with Auckland DHB)
- The Disability Support Advisory Committee (collaboratively with Auckland and Counties-Manukau DHBs)
- Manawa Ora (the Māori Health Gain Advisory Committee) (collaboratively with Auckland DHB). This Committee is expected to be superseded when the Northern Iwi-DHB Partnership Board is established.

Terms of reference for each Committee will be attached as Appendix 3 once the incoming Board has confirmed its Committee structure and delegations following the 2019 DHB elections.

In addition to the above, the Board normally appoints each year an Executive Committee to deal with any urgent decisions required in the break between Board meetings in December and February.

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:
www.health.govt.nz/publication/audit-risk-and-finance-committee-handbook-district-health-boards.

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/2008/audit-committees/.

Chapter 14: 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 policy document should only contain reference to classes of persons to whom delegations are made on particular matters. Particular people should not be referred to as this would result in the Minister needing to approve the policy document each time there is a change in personnel.

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.

To whom can the board delegate?

DHB Boards may (by written notice) delegate any of the functions, duties or powers of the board or of the DHB to:

- Any committee of the board;
- Any member of the board or employee of the DHB (either to a named person or to any member of a specified class of persons); or
- Any person or class of persons approved by the Minister for the purpose (either a named person or any member of a specified class of persons). This applies where a power is delegated to a person outside the DHB (i.e. that are not members of the board or employees).

If a delegate is to be able to further delegate a function, duty or power it should be expressly stated in the delegation authority.

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. Ss. 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.

Chief Executive and other staff

Boards may give their chief executive broad delegations, which reinforces accountability and control of the DHB. Boards also have the flexibility to delegate directly to specialist staff without first delegating to the chief executive. When this approach is taken, the accountability relationship between the staff member, the chief executive and board needs to be made clear.

Under s. 26 of the NZPHD Act, the board of a DHB must delegate to the chief executive of the DHB 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.

Making delegations

Boards should take professional advice when developing their delegations policy and in making delegations.

Boards should also note the effect of delegations in clause 40 of Schedule 3, the requirements relating to delegates with conflicts in clause 39(8) of Schedule 3, and the requirement under s.26(3) for the Board to delegate to its chief executive the power to make decisions on management matters relating to a DHB.

Waitematā DHB Delegation Policy
The current Waitematā DHB Delegated Authority Policy is available on the Waitematā DHB intranet under "Controlled Documents-Management".

Chapter 15: the District Health Board as employer

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 (contact: 04 495-6600).

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 is recommended by the Commission, 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 and are available at www.ssc.govt.nz/modelagreements.

Chief Executive performance management

Good practice in relation to chief executive performance management includes:

- 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 Human Rights Commission when assessing Crown entities as good employers looks at seven key elements. They are:

- Leadership, accountability and culture
- Recruitment, selection and induction
- Employee development, promotion and exit
- Flexibility and work design
- Remuneration, recognition and conditions
- Harassment and bullying prevention
- Safe and Healthy Environment

The Waitematā DHB has an extensive range of programmes to fulfil its good employer commitment and demonstrate its strength as an equal opportunity employer. These programmes have significant staff input on steering and working groups and are discussed at Board and Committee meetings, union/staff forums, workforce meetings and the staff health, safety and wellbeing committee.

The Board has taken a keen interest in many of these issues, including holding workshops on such issues as health and safety; bullying and harassment policy; and whistle blowing.

Performance as a good employer is reported on as a separate section in the Board's Annual Reports.

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, together with additional guidance on its interpretation and application.

Government Expectations on Employment Relations in the State Sector

The Government Expectations (the Expectations) on Employment Relations in the State Sector were reintroduced on 30 April 2018.

The Expectations set out the priorities and approach the Government will be taking for employment relations in the state sector. The Expectations cover general work place relations, negotiation of employment agreements and policies on pay and conditions.

Waitematā DHB is well placed to respond to the expectations, already having many of the core principles in place as a result of national, regional and local negotiations and combined activities; and from significant focus on wellbeing over recent years.

One of the expectations is "closing the gap' between lower and high paid workers. DHBs have been interpreting the expectation thorough employment negotiations as follows:

1. Removing low paid steps and introducing new steps to salary scales

2. Aligning low paid steps close to or above the Living Wage
3. Where possible, although not in all cases, when new steps are being contemplated some steps are: focused at mid-level pay scales rather than higher paying scales; some higher steps are accessed via a merit process or other criteria; or higher steps have a time period delay before staff can access the higher rates

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 16: Subsidiaries and Trusts

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.

Waitematā DHB is one of the parents in the following multi-parent subsidiaries: healthAlliance NZ; healthAlliance FPSC and the Northern Regional Alliance (NRA).

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;
- Relevant chapters of this Governance Manual.

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 *Chapter 20 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.

TRUSTS:

The Board has responsibilities relating to two trusts: the Three Harbours Health Foundation and the Wilson Home Trust.

The Three Harbours Health Foundation

The Foundation is a registered charitable trust established on 24 April 1995 under the Charitable Trusts Act 1957. The settlor at the time was Waitematā Health Limited. Under the NZ Public Health and Disability Act 2000 the role of settlor passed to Waitematā DHB.

In 2001 the Foundation's deed of trust was varied to establish, under the Foundation's umbrella, two new trusts: one to facilitate fundraising to assist North Shore Hospital and health services in North Shore City and Rodney District, the other to assist fundraising for Waitakere Hospital and health services in Waitakere City and Rodney District.

The Foundation funds comforts and amenities for patients and clients, education and training for staff, and approved health research. The Foundation solicits, receives and invests donations from

various sources and disburses these funds to meet the purposes of the Foundation as set out in its Deed of Charitable Trust.

The Foundation is an independent charitable trust but minutes of its meetings are provided to the DHB Board. The Foundation's accounts are audited by the DHB's external auditors.

The Trust Deed specifies not less than four and not more than eight trustees. One trustee must be a **salaried employee of the DHB** who is able to provide expert advice on the health needs or health service requirements in the DHB's area and at least one further trustee must be **a Board member**.

The Wilson Home Trust

In 1937 The Wilson Home property at Takapuna was left to the Auckland Hospital Board of the day to hold in trust and use as a facility for the accommodation and care of physically disabled children.

Trusteeship subsequently passed by law to the Auckland Area Health Board, then to Waitematā Health and, under the NZ Public Health and Disability Act 2000, to Waitematā DHB. The Trust Deed was updated in 1999 in accordance with the Charitable Trusts Act 1957.

The Trust's land and buildings at Takapuna are used for the accommodation, diagnosis and treatment of physically disabled children and respite care for children and their carers. In practice, the trust leases premises to service providers (principally Waitematā DHB) who provide the health services; the trust's role is largely a landlord role but the trust can, and does, provide comforts and amenities for clients of Wilson Home. Part of the site is leased to the Ministry of Education which operates a school for physically disabled children on the site.

Waitematā District Health Board is trustee and, in accordance with the trust deed, appoints a Wilson Home Trust Committee of Management which it holds accountable for ensuring that the terms of the trust deed are met. The Committee is responsible for day to day running of the Trust subject to the control of Waitematā DHB. The Committee of Management comprises three Waitematā DHB appointees and two New Zealand Crippled Children's Society (Auckland) appointees.

Both the Trust (consisting of Waitematā DHB Board members) and the Committee of Management have meetings on a regular basis.

Chapter 17
Planning and Reporting

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

The Crown Entities Act 2004 (CE Act) sets out planning and reporting obligations of Crown entities, including the requirements for key accountability documents - the Statement of Intent, Statement of Performance Expectations and Annual Report. The expectation that boards are fully engaged in these areas is reflected by the requirement that these accountability documents are signed by members of the board.

Each DHB has a statutory responsibility to prepare:

- an Annual Plan for approval by the Minister of Health (Section 38 of the New Zealand Public Health and Disability Act 2000) – providing accountability to the Minister of Health
- a Statement of Performance Expectations (SPE) (Section 149C of the Crown Entities [CE]Act 2004 as amended by the Crown Entities Amendment Act 2013) – providing financial accountability to Parliament and the public annually
- a Statement of Intent (SOI) (Section 139 of the CE Act) – providing accountability to Parliament and the public at least triennially.

Following a decision by Cabinet in 2010 [SOCMin (10)15/2], DHBs may now produce a single planning document that integrates the content required of the Statement of Intent (SOI) with that required of the annual plan.

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.nsfl.health.govt.nz/.

Annual and Strategic Planning

The Minister of Health (the Minister) and each DHB must agree on an annual plan for the DHB. The Minister may also direct any DHB to prepare or contribute to one or more additional plans, e.g. a regional service plan (s. 38, NZPHD Act).

All such plans must address local, regional and national needs for health services; how health services can be properly co-ordinated to meet those needs; and the optimum arrangement for the most effective and efficient delivery of health services. They must also demonstrate how a DHB that is a party to the plan is to operate in a financially responsible manner and give effect to the purposes of the NZPHD Act; and must reflect the overall direction of, and be consistent with, the New Zealand Health Strategy and the New Zealand Disability Strategy (s. 38, NZPHD Act).

The Minister's consent must be obtained for all such plans, or amendments to them. Where there is a dispute over the contents of any plan between one or more DHBs, the Minister may issue a directive and a DHB that is a party to the dispute must give effect to the Minister's decision (s. 39 of the NZPHD Act).

Northern Region Long Term Health Plan (Regional Services Plan)

Regional Services Plans (RSPs) are the medium term (3-5 years) accountability documents for DHBs. The **Northern Region Long Term Health Plan (NRLTIP)** is prepared by the four northern region DHBs

and sets out the strategic context and plans for an integrated and collaborative approach to sustainable health and disability services – reflecting regional health directions for primary and community services as well as population health services.

Annual Plan

The **Annual Plan (AP)** aligns the DHB's direction to national (Minister's Letter of Expectations, national policy), regional and local priorities. It provides clear actions on how the DHB intends to deliver on its objectives and how it will measure its success.

Statements of Intent (SOIs)

Within the AP is the Statement of Intent (SOI). The purpose of the 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 strategic medium-term intentions and medium-term 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.

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 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.

The 2013 amendments to the CE Act provide a stronger focus on strategic planning. The changes are:

- The SOI is solely about the strategic intentions of the entity.
- The content of an SOI must cover a minimum of four financial years.
- An SOI can last up to 3 years, but should be regularly reviewed and updated where circumstances require. (The 3-year period is measured from the date that the SOI was provided to the responsible Minister.)
- The responsible Minister can ask for a new SOI at any time.
- The Crown entity can provide a new SOI to the responsible Minister instead of providing an amendment to the final SOI.
- In certain circumstances, the responsible Minister can give a Crown entity an extension of time for, or waive the requirement to provide an SOI.
- The Crown entity must publish the SOI (or any amendments) on its website once it is provided to the responsible Minister, unless the Minister has delayed publication during the pre-Budget period.
- There are a various options for when and how an SOI is presented to the House (after publishing) eg, a Crown entity's SOI can be presented with the annual report from the previous year (giving Parliament both a backward and forward looking performance story) or with other agencies' documents.

Section 141 of the CE Act specifies what a SOI must contain. An SOI must set out the strategic objectives that the Crown entity intends to achieve or contribute to (strategic intentions) and explain how the entity proposes to assess its performance.

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

Advice on preparing a meaningful SOI can be found at:

- Performance Expectations – "What's Intended to Be Achieved": http://www.treasury.govt.nz/publications/guidance/planning/performanceexpectations-achieved
- Performance Expectations – "How Performance Will Be Assessed": http://www.treasury.govt.nz/publications/guidance/planning/performanceexpectations-assessed

Statement of Performance Expectations (SPE)

The 2013 amendments to the CE provide for a Crown entity's statement of intent (SOI) to last up to 3 years. To give effect to this change, the information a Crown entity needs to provide to Parliament on an annual basis was removed from the SOI. This annual information is now in a document called a "statement of performance expectations" or an SPE. The information is:

- the statement of performance expectations (previously known as the statement of forecast service performance), and
- the annual forecast financial statements.

The purpose of an SPE is to (s. 149B, CE Act):

- enable the responsible Minister to participate in the process of setting annual performance expectations;
- enable the House of Representatives to be informed of those expectations; and
- provide a base against which actual performance can be assessed.

Section 149E of the CE Act specifies the contents of an SPE. An SPE must include a concise explanation of what the each reportable class of outputs is intended to achieve and explain how the performance of each reportable class of outputs will be assessed.

The Minister may participate in determining the content of the SPE, by agreeing with the DHB on any additional information to be incorporated; specifying the form in which any information must be presented; commenting on a draft SPE; and directing amendment in relation to some of its content (s. 149H, CE Act).

- SPEs are required to be published annually, and set out financial and non-financial performance measures against which the DHB's performance can be assessed.

Crown Funding 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 (s 10, NZPHD Act). The CFA may be agreed annually between the DHB and the Minister.

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

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 and the SPE. 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 following information must also be included in the annual report:

- the annual financial statements for the DHB;
- a statement of service performance;
- any direction given to the DHB by a Minister in writing;
- the total value of the remuneration paid to each board member during the financial year;
- 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 DHB's 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 performance expectations, 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, or by the Commissioner. 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/annual-report-guidance-crown-entities. The Minister presents the annual report to Parliament according to the timetable set out in this guidance.

The Waitematā DHB's latest Annual Report can be found on the Waitematā DHB website.

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/expectations-letter-crown-entities-july12. 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, increased transparency, and delivery of Better Public Services. An enduring letter remains 'in force' until it is replaced.

Annual Ministerial letter of expectations

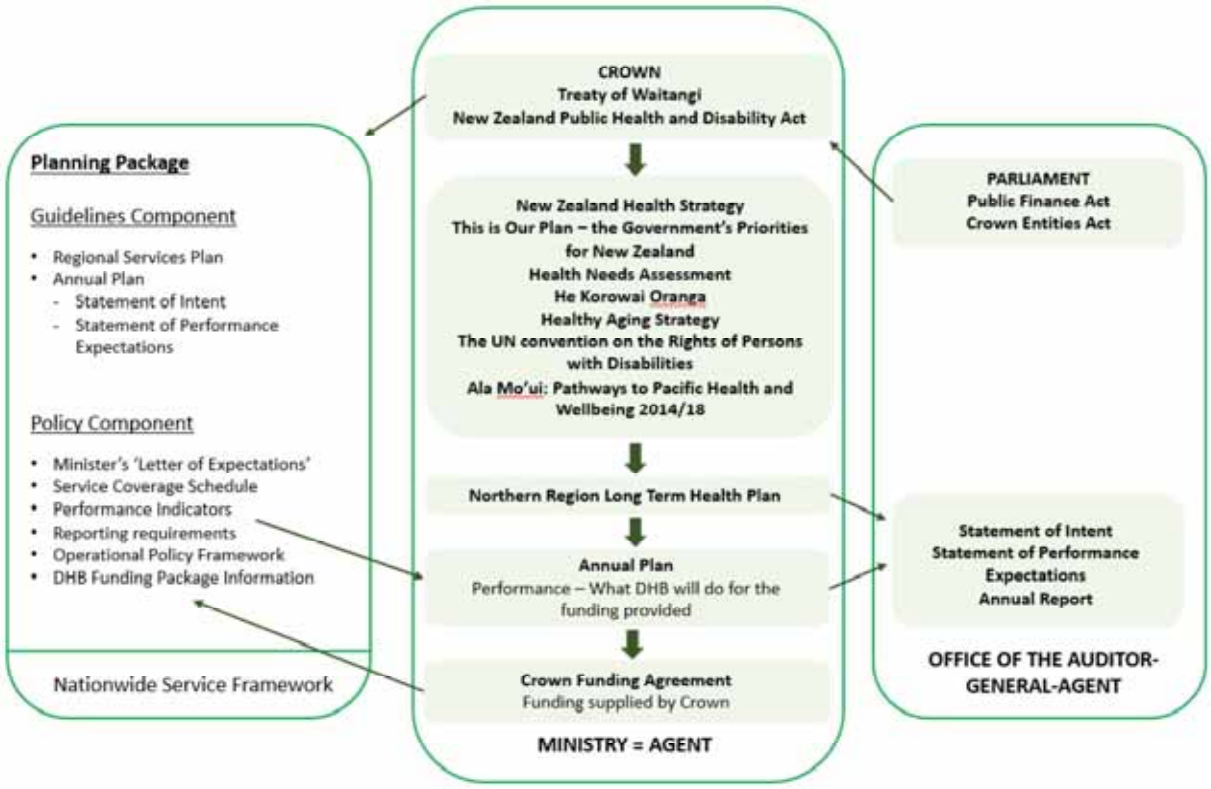
Ministers "participate in the process of setting the entity's strategic direction and performance expectations and monitoring the entity's performance targets" (s. 27(1)(f), CE Act). Ministerial expectations for DHBs' strategic direction and their specific priorities for the planning period may be provided through meetings with the Chair or Board and/or reflected in an annual letter of expectation from the Minister to the DHB. The letter will usually be sent to the Chair before the Board starts its strategic review and planning in October.

Directions to support a whole of government approach

Under section 107 of the Crown Entities Act, the Minister of State Services and the Minister of Finance may jointly direct Crown entities to support a whole of government approach by complying with specified requirements.

DHB accountability framework

Collectively all the above planning and reporting documents and process make up a 'health sector framework'. The following is a diagrammatic view of the DHB accountability framework.



Chapter 18: Board and 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.

Evaluating performance should be undertaken each financial year. Having an agreed process and method will assist with the evaluation.

The process for undertaking evaluations is determined by each board: for example evaluations may be managed internally or the board may be assisted by an external facilitator.

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.nsfl.health.govt.nz.

Chapter 19: Board Appointments and 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 chair, 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 (e.g. 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 ss. 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 Chapters 7 and 8 of this Governance Manual 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 member of the board of any other DHB, but under the New Zealand Public Health and Disability Amendment Act 2010 may be appointed by the Minister of Health as a member of another 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 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.

The board secretary maintains a register of such induction and training activities. 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 (i.e. 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.

Chapter 20: 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), i.e. 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. The current version is located at: www.dpmc.govt.nz/cabinet/circulars and is Circular CO (19)1 (17 June 2019)

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 if they are a member of a board's committee. However, the Fees Framework does provide additional payments for DHB board members who sit on the DHB's Community and Public Health Advisory Committee, Disability Support Advisory Committee, or Hospital Advisory Committee ($250 per meeting to a maximum of $2,500 pa for a committee member, $325 per meeting to a maximum of $3250 pa for a committee chair). Additionally, each DHB has a dispensation to provide additional payments to members of an Audit, Risk and Finance committee, at the same rate as the statutory advisory committees; 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. For example, this may be based on a percentage of the fee paid to a board member.

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.

Waitematā DHB fees

The fees set by the Minister of Health for Waitematā DHB are set out in **Appendix 4**. Advice has been received that the Minister will be reviewing fees as part of the incoming Board appointments around the 2019 DHB elections.

Waitematā Board Member Remuneration, Fees and Expenses Policy (including administrative matters)

Please refer to **Appendix 5**.

Other general Information

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).

Chapter 21: 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 board'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.

Appendix 1: MOUs with Te Runanga o Ngati Whatua Trust and Te Whanau o Waipareira Trust

PROFILE

- **Waitemata District Health Board**

Waitemata DHB is a District Health Board providing hospital, community and home-based services principally to the people of North Shore City, Waitakere City, Rodney and South Kaipara Districts. In addition, Waitemata DHB has a funder role of health services for the district.

Extensive medical, surgical, maternity, mental health and community health services are provided through North Shore Hospital and Waitakere Hospital and a number of sites in the community. These include alcohol and drug services and the school dental services to the Auckland region and forensic psychiatry services at the Mason Clinic and child disability services at the Wilson Home to the Auckland and Northland regions.

Waitemata DHB serves a rapidly increasing population of around 442,000 people and employs approximately 4,000 staff, including full time, part time and casual staff.

- **Te Runanga o Ngati Whatua Trust Profile**

Te Runanga o Ngati Whatua Trust was established on 18 January, 1989 as a Trust Board under the Maori Trust Boards Act 1955. The Runanga is the authorised voice for the Iwi in respect to all issues affecting the whole of the Ngati Whatua rohe.

The Runanga is lead by an 11 member Board of Directors made up of representatives from the 32 marae within the Ngati Whatua rohe. The responsibilities of the Runanga are grouped into five broad functional areas or Responsibility Centres:

- Rangatiratanga
- People Development
- People Caring
- Economic Development
- Support Services

Within the five Responsibility Centres, there are ten portfolios which comprise a range of activities closely associated with core responsibility for the Runanga:

RANGATIRATANGA	Rangatiratanga portfolio; Fisheries portfolio
PEOPLE DEVELOPMENT	Education, Employment, Training & Youth portfolio; Cultural & Marae Development portfolio
PEOPLE CARING	Health & Lifestyle portfolio; Environment, Land & Customary Fisheries portfolio
ECONOMIC DEVELOPMENT	Business portfolio; Tourism portfolio
SUPPORT SERVICES	Administration & Finance portfolio

Through the work of its strategic health purchasing and service provision arms, and in accordance with its manaaki tangata obligations the Runanga seeks to achieve demonstrable health gains for all of the 72,255 Maori living within the Ngati Whatua rohe. Te Runanga o Ngati Whatua Trust currently employs approximately 80 staff across its business units.

MEMORANDUM OF UNDERSTANDING dated the 9th day of May 2001

BETWEEN

TE RUNANGA O NGATI WHATUA TRUST a statutory trust board in terms of the Maori Trust Boards Act 1955 (the "Runanga").

AND

WAITEMATA DISTRICT HEALTH BOARD being an organisation established under section 19 of the New Zealand Public Health and Disability Act, 2000("WDHB").

1. PREAMBLE

[THE PARTIES] The Runanga and WDHB wish to enter into a partnership for the delivery of health and disability services (health services) in the Rohe o Ngati Whatua.

This memorandum of understanding sets out the basis of the partnership under the headings:

Background
Interpretation of Partnership
Awareness of Relationships and Issues
Meetings and Procedures
Information Sharing
Relationships with Third Parties

2. BACKGROUND

Te Tiriti o Waitangi, (the Treaty of Waitangi) as New Zealand's founding document, establishes the nature of the relationships between Te Tino Rangatiratanga and Kawanatanga. In recognition of s4 New Zealand Public Health and Disability Act 2000 and with a view to achieving the objectives and discharging functions outlined in ss22 & 23 of the legislation the parties now seek to define the nature of those relationships based upon the provisions of the Treaty and the terms of this memorandum. These principles include partnership, manaakitanga, awhinatia, authoritative agency, acknowledgement of obligations, co-operation, goodwill, mutual respect for cultural diversity and equity.

Therefore the Runanga accepts and acknowledges the capacity of WDHB to exercise Article One rights based on Crown agency. In turn, WDHB accepts and acknowledges the capacity of the Runanga to exercise Article Two on behalf of the iwi of Ngati Whatua. Both parties acknowledge that the obligations of the iwi of Ngati Whatua to manaaki all Maori residing within the rohe is implicit in the exercise of te tino rangatiratanga based on the manawhenua status of Ngati Whatua..

Both parties also acknowledge that the principle of partnership implicit in Articles One and Two and as such underpinning the relationship between WDHB and Ngati Whatua is in no way inconsistent with all Maori enjoying the same level of health as non-Maori under Article 3.

Waitemata District Health Board, by statutory and Treaty obligation, intention and explicit expression, is committed to achieving improvements in the general Maori health status within

its defined DHB area.[1] Therefore, the parties now agree to establish relationships, aimed at enabling the achievement of mutually agreed Maori health objectives.

Additionally, the parties further agree, pursuant to the provisions and principles of the Treaty and the principles and terms of this memorandum, to diligently pursue, by all measures that are lawful and in the common good, the ways and means of establishing relationships leading to contracts for health service provision. The provision of these health services shall protect and enhance the particular and general good health status of all iwi Maori, resident within te rohe o Ngati Whatua.

3. INTERPRETATION OF PARTNERSHIP

PARTNERSHIP, within the meaning of this memorandum shall include the acknowledgement and acceptance by both parties;

a) That each is a bona fide member of a "health partnership", based upon the Treaty. Through this partnership both parties are committed to reducing health disparities and achieving demonstrable health gains through the provision, of effective health services for all Maori resident in te rohe o Ngati Whatua. That both parties acknowledge these to be the partnership's primary purpose.

b) That the nature of human relationships, essential to the conduct of business between the parties, shall be characterised by equality of status and respect.

c) That the Runanga shall be consulted early and entitled, under Article Two of the Treaty, to be involved as a Co-Purchaser in all WDHB's planning, purchasing and monitoring decisions impacting upon Maori health, within te rohe o Ngati Whatua.

d) The WDHB as an agent of the Crown, shall ensure that the working relationships between the parties, encourages equitable opportunities and outcomes.

e) That contractual relationships between the parties are devised, determined and performed, according to the criterion of "utmost good faith".

f) That the parties are entitled to practise their respective individual duties, according to the cultural norms of each and that this right shall be subsequently referred to as Nga Kaupapa Tikanga e Rua (two independent cultural forms of conduct).

g) That the parties, either by explicit agreement or accepted general behaviour, may conduct their dealings with each other in a bi-cultural manner.

h) That although the parties will always seek to reach mutual agreement this does not in any way imply an obligation on either party to reach such agreement.

[1] see Schedule 1 New Zealand Public Health and Disability Act, 2000.

PROTOCOL 1 **AWARENESS OF RELATIONSHIPS AND ISSUES**

THE PARTIES

a) Shall be represented by personnel who are closely aware -

(i) of the need to adopt a more inclusive approach to ensuring appropriate engagement of manawhenua and mataawaka at all levels within the sector.

(ii) of the provisions implicit in Te Tiriti o Waitangi, and in particular the range and nature of relationships between Crown and Maori that arise from the various provisions.

(iii) of the principles of Te Tiriti o Waitangi and how partnership, participation and protection can be operationalised in the funding environment.

(iv) of the provisions and principles of this Memorandum of Understanding and its Protocols.

b) Shall undertake to respectively increase their awareness of the political, social, economic, religious and historical factors impacting upon the relationships between Maori and the Crown and its agencies.

c) Shall assist each other to gain greater appreciation of each other's professional and corporate cultural environments, in order to progress the relationship.

d) Shall provide personnel to attend any jointly organised hui, seminars or mutually beneficial functions, aimed at increasing and improving professional, cultural and social awareness.

e) Shall give early notice of any anticipated impediments to progress and shall find solutions based upon reasonable compromise.

f) Shall co-operate in negotiations, whilst keeping as a primary objective and essentiality of Maori involvement in health service provision.

g) Shall acknowledge and accept, as a "first step" in awareness, that the Maori health status requires urgent and co-operative attention.

h) Shall acknowledge and accept that the personnel of each party possess particular skills, talents and abilities of mutual benefit to the development of increased and improved awareness between them. Therefore, the parties shall make a commitment to the utilisation of such personnel, in the advancement of their common goals.

PROTOCOL 2 **MEETINGS AND PROCEDURES**

THE PARTIES

a) Shall meet whenever mutually agreed

b) All meetings shall be conducted according to the conventional protocols and procedures of the host party.

c) When or if required, the parties may nominate and engage independent meeting facilitators, selected by mutual agreement.

d) A written record of the resolutions of meetings shall be kept and when required, circulated as an 'action list' to each party's principal representative.

e) Subject to the provisions of the Official Information Act 1982, no record of any meeting shall be circulated beyond the representatives of the parties without the prior approval of the respective principal representatives.

f) The parties shall provide secretarial services for meetings from their own resources as required.

g) Each party shall be entitled to adjourn meetings by simple verbal notification, for the purposes of holding a "corporate caucus" meeting, but no such adjournment shall exceed one hour.

PROTOCOL 3 **INFORMATION SHARING**

THE PARTIES

a) Shall, in all dealings with each other, acknowledge and accept that all information received or supplied is to serve the "common good" of Maori health needs.

b) Shall give priority to sharing information that addresses the primary objective of the partnership.

c) Shall strenuously avoid unjustified notions of "commercial sensitivity" as a means of withholding information.

d) Shall agree to be bound in all dealings with each other by the various statutes, conventions and lawful practices, prescribing the obligations of secrecy, confidentiality and privacy.

e) Shall not intentionally withhold relevant information merely because it was unrequested. Proactive volunteering of information shall characterise the co-operative nature of the partnership.

PROTOCOL 4 RELATIONSHIPS WITH THIRD PARTIES

THE PARTIES

a) Shall, upon mutual agreement, be free to enter into discussions, negotiations and contracts with third parties where the core business of such third parties is essential or desirable to the objectives of the primary partnership between the Runanga and WDHB.

b) Shall encourage co-operative and professional relationships between themselves and third party health services providers, where such third party providers –

(i) enjoy good service reputations among Maori client groups, and

(ii) have been offered explicit human, financial or material resources to the benefit of the objectives of the primary partnership.

c) Shall retain the primary Te Tiriti o Waitangi relationship of partnership between themselves, when conducting discussions or negotiations with secondary third parties. For the avoidance of doubt, nothing in this clause prevents WDHB from entering into relationships with other Maori.[2]

d) Shall diligently pursue the extension of good working relationships with District Health Boards, local General Practitioners and other primary health service providers, operating within the te rohe o Ngati Whatua.

e) Shall, upon mutual agreement, amend and/or extend the substantive nature of their primary partnership and contractual relationships to include any third party hapu or Iwi or Maori Health organisation (located in and providing services to persons usually resident in the Rohe o Ngati Whatua) which by clear written intention, expresses the desire to join the, "Health Partnership".

[2] This aligns with Treaty partnership framework as outlined in the Waitemata District Health Board: Establishment Plan 13 October 2000.

The parties having agreed that these Protocols will in future govern their relationship with each, this Memorandum of Understanding is here of executed:

FOR THE RUNANGA	FOR WAITEMATA DHB
Russell Kemp – Chair	Alison Paterson – Chair
Allan Pivac - CEO	Dwayne Crombie - CEO

MEMORANDUM OF UNDERSTANDING

Between

WAITEMATA DISTRICT HEALTH BOARD

And

Te Whanau O Waipareira Trust

1.0 THE PARTIES

1.1 The Waitemata District Health Board is a statutory corporation established under the New Zealand Public Health and Disability Act 2000.

1.2 Te Whanau O Waipareira Trust is a Charitable Trust incorporated under the Incorporated Societies Act 1908.

2.0 DEFINITIONS

2.1 WDHB means the Waitemata District Health Board.

2.2 Waipareira Trust means Te Whanau O Waipareira Trust.

2.3 The Board means the Board of Directors of Waitemata District Health Board.

2.4 Waitemata Health means the provider arm of the Waitemata District Health Board.

2.5 Wai-Health Ltd means that health provider arm of Te Whanau O Waipareira Trust.

3.0 PARTNERSHIP INTENTION

3.1 The intention of this Memorandum of Understanding is to set out the terms of a relationship agreement between WDHB and Waipareira Trust.

3.2 The nature of WDHB's relationship with Waipareira Trust will have regard to the Treaty of Waitangi.

3.3 In particular, WDHB recognises Waipareira Trust's right and obligation to act on behalf of its community of interest. WDHB also notes that it has a Treaty partnership relationship with Ngati Whatua.

3.4 Both parties acknowledge that the basis of this Treaty relationship is the commitment to achieving improvements in Maori health status within the WDHB region and giving due priority to reducing any existing inequities.

4.0 THE ACT

4.1 The Act provides for mechanisms to enable Maori to contribute to decision-making on, and to participate in the delivery of, health and disability services[1].

4.2 These mechanisms include:

- a prescribed function of establishing and maintaining processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement[2].
- a prescribed function of fostering the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori[3]; and
- providing for Maori representation on the advisory committees required by the Act[4].

5.0 THE WDHB AGREES AS FOLLOWS:

5.1 To endeavour in good faith to meet its obligations with respect to Maori under the New Zealand Public Health and Disability Act 2000.

5.2 To maintain a relationship between the WDHB and Waipareira Trust that allows Waipareira Trust to appropriately discharge its responsibilities to its community.

5.3 To allow Waipareira Trust to maintain a strategic overview of the Board's activities. This will be facilitated by the respective Boards meeting at least annually to discuss each other's strategic priorities.

5.4 To ensure the development of links between Waipareira Trust's provider, Wai-Health Ltd, and WDHB's provider, Waitemata Health, on the one hand, and Waipareira Trust and the WDHB in the discharge of planning and funding responsibilities on the other.

5.5 To develop a Treaty relationship with Waipareira Trust within which cooperation between Waitemata Health and Wai-Health Ltd can occur.

5.6 To assist in building the capacity of Waipareira Trust and share information with them in accordance with its obligations under the Act.

5.7 To ensure that in the exercise of the Board's statutory power of appointment to advisory committees, that the Waipareira Trust has an opportunity to recommend nominations to each of the statutory committees of the Board at the appropriate times when this is being considered. Notwithstanding this, WDHB has the final responsibility for appointments to such advisory committees.

5.9 To consult with Waipareira Trust in the preparation of the Board's Strategic Plan and to allow Waipareira Trust to comment on and provide input into the Strategic Plan.

5.10 To consult with Waipareira Trust in the planning and funding responsibilities and activities that WDHB undertakes, and allow Waipareira Trust to comment on and provide input into these activities.

5.11 To acknowledge that consultation by the Board in respect to WDHB's catchment area should occur through Waipareira Trust but without restricting the Board's or Waipareira Trust's right to suggest more extensive consultation with third parties.

[1] Section 4
[2] Section 23
[3] Section 23
[4] Sections 34-36

6.0 WAIPAREIRA TRUST AGREES AS FOLLOWS:

6.1 To recognise the Board as the body appointed to ensure the provision of health and disability services under the Act.

6.2 To endeavour in good faith to discharge its obligations and responsibilities in relation to its community, especially pertaining to health matters.

6.3 To maintain a strategic overview of the Board's activities and advise where these are considered not to reflect the interests of Maori.

6.4 To respond to the Board, either directly or following the completion of consultation undertaken by Waipareira Trust itself, on all matters of which the Board seeks advice from Waipareira Trust.

6.5 To raise with the Board at its own initiative any matters relating to health issues within the Board's jurisdiction.

7.0 AMENDMENT OF AND WITHDRAWAL FROM MEMORANDUM

7.1 This Memorandum of Understanding shall be amenable to amendment by agreement of all parties to it at the time amendment is proposed.

7.2 The parties to this Memorandum of Understanding shall be free to withdraw from it upon giving three months notice to the other party.

The parties having agreed that this Memorandum of Understanding will in future govern their relationship with each other, here of execute this Memorandum of Understanding this fourteenth day of April, 2003.

For Te Whanau O Waipareira Trust:

Eynon Delamere – Chairperson

For Waitemata District Health Board

Kay McKelvie - Chairperson

APPENDIX 1

PROCESS FOR WAIPAREIRA TRUST RECOMMENDATIONS FOR APPOINTMENT TO STATUTORY COMMITTEES

1. For each of the statutory committees of the Board, Waipareira Trust shall recommend one person (who may or may not) be an employee of Waipareira Trust to be a member.

2. The persons recommended by Waipareira Trust to the membership of the statutory committees shall be chosen having regard to the skills and expertise required by the committees as advised to Waipareira Trust by the Board at any time that a vacancy arises.

3. In making recommendations for the appointment of persons to the statutory committees, Waipareira Trust shall recognise that the Board has authority, in law, to determine who shall be appointed and cannot abrogate its responsibility to do so in favour of another party.

4. Where a recommendation of Waipareira Trust is not appointed by the Board, Waipareira Trust shall have the opportunity to make a further recommendation.

5. The mandate of Waipareira Trust in respect of a person recommended for appointment to a statutory committee shall be deemed to continue for such period as the Board shall appoint such person[5].

[5] Appointments will ordinarily be made for a period expiring at the end of the calendar year in which the triennial elections are held.

Appendix 2: Waitematā DHB Standing Orders

WAITEMATĀ DISTRICT HEALTH BOARD

STANDING ORDERS

Adopted by the Board on 7 February 2001
Revised Version adopted by the Board on 21 August 2019

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1 GENERAL

1.1 Interpretation

In these standing orders, unless inconsistent with the context:

Act means the New Zealand Public Health and Disability Act 2000.

Board means the board members of the Waitematā District Health Board acting together as a board.

Chief Executive means the Chief Executive of the Waitematā District Health Board or the person to whom the Chief Executive has assigned responsibility for the function referred to in the standing order.

Chairperson means the Chairperson of the Board and where appropriate also includes any person acting as the Chairperson of any committee of the Board.

Committee includes:

(a) the three statutory committees established pursuant to Sections 34, 35 and 36 of the Act, namely the Community and Public Health Advisory Committee, the Disability Support Advisory Committee, and the Hospital Advisory Committee; and

(b) any committee appointed by the Board under Clause 38 of Schedule 3 of the Act; and

(c) any subcommittee of a committee described in paragraph (a) or paragraph (b) of this definition.

Deputation means a request from any interest group in the community to make a presentation to a meeting of the Board or a statutory committee.

Interest means knowledge of or involvement with a transaction of the Board that could give the member a pecuniary or other advantage that they would not otherwise have in common with the public.

Meeting means any first, ordinary, special or emergency meeting of the Board; and any meeting of a statutory committee; and any meeting of any other committee appointed by the Board at which resolutions or decisions are made under authority delegated by the Board.

Member means any person elected or appointed to the Board or appointed to any committee.

Minister means the 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 the Board in accordance with clause 16 of the Schedule 3 or clause 18 of Schedule 4 of the Act.

Authorised Officer means the authorised employee or agent of the Board as referred to in clause 19(2) of Schedules 3 and clause 21(2) of Schedule 4 of the Act, and includes for the purposes of these standing orders any other officer authorised by the Board.

Public excluded information includes:

(a) Information which:

(i) is currently before a public excluded session; or

(ii) is 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 Board as publicly available information); and

(b) Any minutes (or portions of minutes thereof) of public excluded sessions (other than those subsequently released by the Board as publicly available information); and

(c) Any other information which has not been released by the Board as publicly available information.

(See also clause 19 of Schedule 3 and clause 21 of Schedule 4 of the Act)

Public excluded session refers to those meetings or parts of meetings from which the public is excluded by the Board or a committee as provided for in Clause 32 of Schedule 3 and clause 34 of Schedule 4 of the Act.

Publicly notified means notified to members of the public by notice contained in one or more newspapers circulating in the Waitematā District Health Board district and may include notification via radio broadcasts or notices on the internet.

Statutory Committee means the Community and Public Health Advisory Committee, the Disability Support Advisory Committee and the Hospital Advisory Committee.

Working day means any day of the week other than –

(a) Saturday, Sunday, Good Friday, Easter Monday, Anzac Day, Labour Day, the Sovereign's Birthday, and Waitangi Day; and

(b) A day in the period commencing with the 25th day of December in any year and ending with the 15th day of January in 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 Board meetings and all statutory committee meetings 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 Chairperson's ruling final

1.3.1 The Chairperson 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 Chairperson's ruling shall be final and not open to debate.

1.3.3 If any member who is required, pursuant to a ruling under standing orders, to leave a meeting refuses or fails to leave the meeting; or having left the meeting, attempts to re-enter the meeting without the permission of the Chairperson, any officer or employee of the Board, may, at the request of the Chairperson, remove or, as the case may require, exclude that member from the meeting.

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, that it is proposed be suspended.

1.4.3 The Chairperson of the Board or committee may, subject to the agreement of all members present but without a formal resolution, conduct the meeting of the Board or committee in a less formal manner than is strictly required by Standing Orders provided:

(a) The procedures followed are not inconsistent with the Act; and

(b) The procedures followed do not inhibit any member from contributing to the discussion or voting on any item; and

(c) All decisions are fully minuted.

1.5 Alteration of standing orders

After the adoption of the first standing orders of the Board, the adoption or amendment of standing orders shall require, in every case, a vote of three-quarters of the members present.

1.6 First meeting of Board following election

1.6.1 The first meeting of the Board following elections held in conjunction with triennial general election shall be called by the Chief Executive as soon as practicable after members have taken office.

1.6.2 The Chief Executive shall give the persons elected or appointed to the Board not less than 10 working days notice of the meeting.

1.6.3 The meeting shall be chaired by the Chairperson appointed by the Minister under Clause 10 of Schedule 3 of the Act.

1.6.4 **Members to give notice of addresses**

Every member of the Board and its committees shall give to the Chief Executive a residential or business address (together with, if desired, facsimile, email, or other address) to which notices and material relating to meetings and Board business may be sent or delivered.

1.7 Appointment of Chairpersons and Deputy Chairpersons

1.7.1 The Chairperson and Deputy Chairperson of the Board are appointed by the Minister.

1.7.2 The Board must appoint a Chairperson of each committee and the Board may appoint a Deputy Chairperson of each committee

1.8 Appointment of committees *(see also clause 38 of Schedule 3 of the Act)*

1.8.1 The Board may establish one or more committees of the Board for a particular purpose or purposes and may appoint, as members of a committee of the Board, or as the Chairperson or Deputy Chairperson of any such committee either members of the Board, or other persons, or both.

1.8.2 A committee may appoint such subcommittees as it considers appropriate, unless prohibited from doing so by the Board.

1.8.3 Every committee shall be subject in all things to the control of the Board, and shall carry out all directions, general or special, of the Board given in relation to the committee or its affairs.

1.8.4 Every subcommittee shall be subject in all things to the control of the committee that appointed it, and shall carry out all directions, general or special, of the committee given in relation to the subcommittee or its affairs.

1.8.5 Subject to any provision to the contrary in the Act or any other Act, the Board, and a committee with respect to a subcommittee appointed by that committee, may at any time and from time to time discharge or reconstitute any committee or subcommittee.

1.8.6 The Chairperson of the Board shall be, at the Chairperson's option, an ex-officio member of any committee.

1.9 Powers of delegation

1.9.1 Except as otherwise provided in the Act or any other legislation, the Board may delegate by written notice to any committee any of its functions, duties, or powers. *(See also Clause 39(4) of Schedule 3 of the Act)*

1.9.2 Every committee to which any powers or duties are delegated may, without confirmation by the Board, exercise or perform the same in like manner and with the same effect as the Board could itself have exercised or performed the same.

1.9.3 Any committee may, with the consent of the Board, delegate any of the functions duties or powers of the committee to any subcommittee appointed by the committee.

1.10 Proceedings not invalidated by vacancies or irregularities

No act or proceedings of the Board or of any person acting as a member of the Board shall be invalidated in consequence of there being any vacancy in the membership of the Board or committee at the time of that act or proceeding, or of the subsequent discovery that there was some defect in the election or appointment of any person so acting.

1.11 General provisions as to meetings

1.11.1 The Board shall hold such meetings as are necessary for the carrying out of its functions and responsibilities under the Act.

1.11.2 Every member of the Board or of any 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 shall be called, publicly notified, and conducted in accordance with the Act, any other legislative provisions applying to the Board, and these Standing Orders.

1.12 Ordinary meetings

The Board shall hold ordinary meetings at such times and at such places as it from time to time appoints.

The Chief Executive shall give notice in writing to each of the members of the time and place of the meeting –

(a) Not less than 10 working days before the meeting; or

(b) Where the Board has adopted a schedule of ordinary meetings, not less than 10 working days before the first meeting on the schedule.

1.13 Special and emergency meetings

1.13.1 The Board may hold special meetings.

1.13.2 A 'special meeting' means a meeting called pursuant to –

(a) A resolution of the Board; or

(b) A requisition in writing delivered to the Chief Executive and signed by –

(i) The Chairperson; or

(ii) Not less than one-third 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.

1.13.3 Notice in writing of the time and place of the special meeting, and of the general nature of business, shall be given by the Chief Executive to every member of the Board –

(a) At least 3 working days before the day appointed for the meeting; or

(b) Where the meeting is called pursuant to a resolution of the Board, within such lesser period of notice, being not less than 24 hours, as is specified in the resolution.

1.13.4 The Board may hold emergency meetings.

1.13.5 An 'emergency meeting' means a meeting called by –

(a) The Chairperson; or

(b) If the Chairperson is unavailable, the Deputy Chairperson, –

to deal with matters specified by the Chairperson or Deputy Chairperson, being matters that require a meeting to be held at shorter notice than can be given under order 1.13.3.

1.13.6 Notice of the time and place of the emergency meeting and of the matters in respect of which the meeting is being called shall be given, by whatever means is reasonable in the circumstances, to every member of the Board and to the Chief Executive at least 24 hours before the time appointed for the meeting.

1.13.7 The person calling the emergency meeting shall give, or shall cause some other person to give, the notice required by order 1.13.6.

1.13.8 If a resolution is passed at an emergency meeting of the Board, the Board must publicly notify the resolution as soon as practicable, unless it was passed at a meeting or part of a meeting from which the public was excluded. *(See also clause 22 of Schedule 3 of the Act)*

1.14 Notices to members of meetings

1.14.1 The Chief Executive 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.

1.14.2 In the case of each meeting to which order 1.14.1 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 not less than two clear days before the day appointed for the meeting.

1.15 Meetings not invalid because notice not received

No ordinary meeting, special meeting, or emergency meeting of the Board shall be invalid because notice of that meeting was not received or was not received in due time by any member if the Chairperson or Chief Executive made all reasonable efforts to ensure each member was given notice. *(See also clause 18 of Schedule 3 of the Act)*

2 MEETINGS

2.1 Chairperson to preside at meetings

2.1.1 The Chairperson of the Board shall preside at every meeting of the Board at which he or she is present.

2.1.2 The Chairperson of any committee shall preside at every meeting of the committee at which he or she is present.

2.1.3 If at any meeting the Chairperson is absent, the Deputy Chairperson shall preside at the meeting. *(See also clause 27 of Schedule 3 and clause 29 of Schedule 4 of the Act)*

2.2 Order of business

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 Agenda

2.3.1 The Chief Executive shall prepare for each meeting an agenda setting forth the items of business to be brought before the meeting so far as is known. At the meeting the business shall be dealt with in the order in which it stands on the agenda unless the meeting determines otherwise. The Chief Executive shall place on a confidential agenda paper any matters that he/she reasonably expects the Board or committee to discuss with the public excluded.

2.3.2 The first three items on the agenda for an ordinary meeting of the Board shall be: Apologies for absence, Confirmation of minutes, and Actions arising out of the minutes.

2.4 Chairperson's report

The Chairperson shall, by report, have the right to direct the attention of the Board to any matter or subject within the role or function of the Board.

2.5 Dealing with Extraordinary or Urgent Business at meetings *(See clause 28 of Schedule 3 and clause 30 of Schedule 4 of the Act).*

2.5.1 If 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 Chair 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.

2.5.2 Despite 2.5.1, where an item is not on the agenda for a meeting:

The item may be discussed at that meeting if:

The item is minor matter relating to the general business of the Board and 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** 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)

2.5.3 Where matters are raised under general business:

i) the Board member is permitted to speak briefly to the matter; and

ii) the Board will then determine how the matter should be progressed.

No matter previously heard and determined should be raised again under general business.

2.6 Precedence of business

Notwithstanding anything to the contrary contained in these standing orders, and after the confirmation of the minutes of the previous meeting, the Chairperson as a matter of urgency, or the Board on a motion duly passed without debate, may accord precedence to any business set down on the agenda for consideration.

2.7 Quorum at meetings *(see also clauses 25 and 26 of Schedule 3 and clauses 27 and 28 of Schedule 4 of the Act)*

2.7.1 No authority, power, or discretion of the Board or a committee can be exercised, and no business shall be transacted, at any meeting unless at least a quorum of members is present during the whole of the time at which the business is transacted.

2.7.2 The quorum at any meeting of a Board or committee shall consist of half the members (including vacancies) if the number of members is even and a majority if the number is odd.

2.7.3 A Board member or committee member who has declared an interest in relation to a transaction must not, for the purposes of the transaction, be counted in the quorum for that Board or committee meeting.

2.8 Failure of a quorum

2.8.1 If a meeting is short of a quorum at its commencement, or falls short of a quorum, the business shall stand suspended and, if no quorum is present within thirty minutes, the Chairperson shall vacate the chair and the meeting shall lapse.

2.8.2 The business remaining to be disposed of following the lapsing of a meeting shall stand adjourned until the next ordinary meeting unless an earlier meeting is fixed by the Chairperson and notified by the Chief Executive.

2.8.3 If a meeting lapses by reason of failure of a quorum, the names of the members then in attendance, and the fact of the adjournment shall be recorded by the Chief Executive.

2.9 Leave of absence and apologies

2.9.1 The Board may grant leave of absence to a member from an ordinary meeting or other meetings of the Board or its committees upon application by the member.

2.9.2 If a member has not obtained leave of absence an apology may be tendered on behalf of the member and the apology may be accepted or declined by the Board. Acceptance of the apology shall be deemed to be a granting of leave of absence for that meeting.

2.9.3 The Chairperson of each meeting shall invite apologies at the beginning of each meeting, including apologies for lateness and early departure, and these and subsequent apologies during the meeting shall be recorded in the minutes, including whether they were accepted or declined.

2.10 Minutes of proceedings

2.10.1 The Chief Executive shall ensure minutes of meetings are kept. The minutes shall record the names of members and officers attending each meeting, the names of those voting in each division called, any declarations of interest, and every resolution, order, or other proceeding of the meeting. The names of any member absent and apologies received shall also be recorded together with the arrival and departure times of members not present for the entire meeting.

2.10.2 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 Chairperson of such succeeding meeting.

2.10.3 No discussion shall arise on the substance of the minutes at the succeeding meeting, except as to their correctness.

2.11 Minute books

2.11.1 The minute books of the Board, the statutory committees, and any other committees where meetings of the committee involve making decisions or resolutions on behalf of the

Board shall be kept by the Chief Executive and shall be open to public inspection. *(See also clause 21 Schedule 3 and clause 23 Schedule 4 of the Act)*

2.11.2 The Chairperson and the Chief Executive shall be responsible for confirming the correctness of the minutes of the last meeting of the Board prior to the next election of members.

2.12 Deputations

2.12.1 Deputations may be received by the Board or any of its statutory committees provided an application for admission setting forth the subject has been lodged with the Chief Executive at least ten clear working days before the relevant meeting and has been subsequently approved by the Chairperson of the Board or Chairperson of the relevant statutory committee. The Chairperson may refuse requests for deputations that are repetitious or offensive.

2.12.2 Notwithstanding order 2.13.1, where in the opinion of the Chairperson the matter that is subject of a deputation is one of urgency or major public interest, the Chairperson may determine that the deputation by received by the Board.

2.12.3 Except with the approval of the Board (or the relevant statutory committee) not more than two members of a deputation may address the meeting. After a deputation is received members may put to the deputation any question pertinent to the subject heard, but no member shall express an opinion upon, or discuss the subject, nor move a motion until the deputation has completed making its submissions and answering questions.

2.12.4 The Chairperson may terminate a deputation in progress which is disrespectful or offensive, or where the Chairperson has reason to believe that statements have been made with malice

2.12.5 Unless the meeting determines otherwise in any particular case, a limit of five minutes shall be placed on each of the two members of the deputation addressing the meeting.

2.13 Petitions

2.13.1 Every petition presented to the Board or to any statutory committee shall comprise less than 500 words and shall not be disrespectful, nor use offensive language nor include statements made with malice.

2.13.2 Any member of the Board who presents a petition on behalf of the petitioners shall confine themselves to the reading of the petition and the statement of the parties from which it comes, and the number of signatures attached to it.

2.13.3 Where a petition is presented by a petitioner, unless the Board determines otherwise, a limit of five minutes shall be placed on that person. If the Chairperson has reason to believe that the petitioner is disrespectful or offensive, or has made statements with malice, the Chairperson may terminate presentation of the petition.

2.14 Procedural motions to terminate or adjourn debate

2.14.1 Any member who has not spoken during debate on any matter may move any one of the following procedural motions to terminate or adjourn debate, but not so as to interrupt a member speaking:

(a) That the meeting be adjourned to the next ordinary meeting, unless an alternative time and place is stated; or

(b) That the item of business being discussed be adjourned to a time and place to be stated; or

(c) That the motion under debate be now put (a "closure motion"); or

(d) That the meeting move directly to the next business, superseding the item under discussion; or

(e) That the item of business being discussed does lie on the table, and not be further discussed at that meeting; or

(f) That the item of business being discussed be referred (or referred back) to the relevant committee of the Board.

2.14.2 Procedural motions to terminate or adjourn debate shall take precedence over other business (other than points of order), and shall, if seconded, be put to the vote immediately without discussion or debate.

2.14.3 All procedural motions to terminate or adjourn debate shall be determined by a majority of those members present and voting. If lost, a further procedural motion to terminate or adjourn debate may not be moved by any member within the next 15 minutes.

2.14.4 Adjourned items of business shall be taken first at the subsequent meeting in the class of business to which they belong.

2.14.5 The debate on adjourned items of business shall be resumed with the mover of such adjournment being entitled to speak first in the debate. Members who have already spoken in the debate may not speak again.

2.14.6 If a meeting is adjourned the items not dealt with shall be considered at the next meeting.

2.14.7 Notwithstanding order 2.15.3 a closure motion shall be put if there is no further speaker in the debate.

2.14.8 When an amendment to a motion is under debate, a closure motion relates to the amendment and not to the motion.

2.14.9 If a closure motion is carried, the mover of the motion then under debate is entitled to the right of reply, and the motion or amendment under debate shall then be put.

2.14.10 Business referred, or referred back, to a specified committee shall be considered at the next ordinary meeting of that committee.

2.15 Notices of motion

2.15.1 Notices of motion shall be in writing signed by the mover, stating the meeting at which it is proposed that the notice of motion be considered, and shall be delivered to the Chief Executive at least five clear days before such meeting.

2.15.2 The Chairperson may direct the Chief Executive to refuse to accept any notice of motion, which is:

(a) Disrespectful or which contains offensive language or statements made with malice; or

(b) Not within the scope of the role or functions of the Board; or

(c) Contains an ambiguity or a statement of fact or opinion which cannot properly form part of an effective resolution, and where the mover has declined to comply with such requirements as the Chief Executive may make.

2.15.3 No notice of motion shall proceed in the absence of the mover, unless moved by another member authorised in writing by the mover to do so.

2.15.4 A notice of motion may only be altered by the mover with the consent of the meeting.

2.15.5 Notices of motion not moved on being called for by the Chairperson shall lapse.

2.15.6 Any notice of motion referring to any matter ordinarily dealt with by a committee of the Board may be referred by the Chief Executive to that committee.

2.16 Repeat notices of motion

2.16.1 When a motion which is the subject of a notice of motion has been considered and rejected by the Board, no similar notice of motion which, in the opinion of the Chairperson, is substantially the same in purport and effect shall be accepted within the next six months unless signed by not less than one-third of the members of the Board (including vacancies).

2.16.2 Where a notice of motion has been considered and agreed by the Board, no notice of any other motion which is, in the opinion of the Chairperson, to the same effect shall be put again whilst such original motion stands.

2.17 Motions and amendments

2.17.1 All motions and amendments moved in debate (including notices of motion) must be seconded, following which the Chairperson shall state the matter raised and propose it for discussion.

2.17.2 Once motions or amendments have been seconded and put to the meeting by the Chairperson they cannot be withdrawn without the consent of a majority of the members present and voting. A motion to which an amendment has been moved and seconded cannot be withdrawn until the amendment is withdrawn or lost.

2.17.3 The meeting may allow a motion which is subject to an amendment to be withdrawn and replaced by the amendment as the substituted motion, provided a majority of the members present vote for the withdrawal of the original motion. In such case, members who have spoken to the original motion may speak again to the substituted motion.

2.17.4 The Chairperson may require the mover of any motion or amendment to submit it in writing signed by the mover.

2.17.5 The Chairperson or the meeting may require a complicated motion (whether an original motion, a substituted motion, or amendment) to be divided.

2.17.6 The Chairperson may, immediately prior to any division being taken, request the Chief Executive to restate the motion upon which the division is to be taken. Once the Chairperson has put the motion, no member may speak to that motion after it has been put and voted upon.

2.17.7 In speaking in any debate no member shall cast reflection on any resolution of the Board except by notice of motion to amend or revoke the same.

2.18 Amendments

2.18.1 When a motion has been seconded and proposed by the Chairperson for discussion, an amendment may be moved and seconded by any member who has not yet spoken to the motion (whether an original motion or substituted motion). The mover or seconder of a motion for the adoption of the report of a committee who desires to amend any item in the report may also propose or second an amendment.

2.18.2 Amendments, which are proposed but not seconded, are not in order and are not entered in the minutes.

2.18.3 Every proposed amendment must be relevant to the motion under discussion and not be in similar terms to an amendment which has been lost.

2.18.4 No amendment which amounts to a direct negative shall be allowed that, if carried, would have the same effect as negating the motion.

2.18.5 No further amendment shall be allowed until the first amendment is disposed of, although members may give notice to the Chairperson of their intention to move further amendments and the nature of their content.

2.18.6 Where an amendment is lost, another may be moved and seconded by any members who have not spoken to the motion (whether an original motion or substituted motion). Movers and seconders of previous amendments which were lost are regarded as having spoken to the motion only and shall be entitled to speak to the new amendment, but are not be entitled to move or second the new amendment.

2.18.7 Where an amendment is carried, the motion as amended becomes the substantive motion, and any member, other than previous movers or seconders in the debate, may then propose a further amendment.

2.19 Revocation or alteration of resolutions

2.19.1 All or part of a resolution agreed at a meeting of the Board may be revoked or altered as follows:

(a) Notice of motion for the revocation or alteration of all or part of a previous resolution shall be given to the Chief Executive by the member intending to move such a motion. Such notice shall set out:

(i) the resolution or part thereof which it is proposed to revoke;

(ii) the meeting date when it was passed;

(iii) the motion, if any, that it is intended to move in substitution therefore.

(b) Such notice shall be given to the Chief Executive at least five clear days before the meeting at which it is proposed to consider such motion and shall be signed by not less than one third of the members of the Board (including vacancies);

(c) At least two clear days' notice in writing shall then be given by the Chief Executive to the members of the intended motion and of the meeting at which it is proposed to move such motion (see (b) above and order 2.20.4).

2.19.2 Where a notice of motion has been given in terms of order 2.16.1 no action that is irreversible shall be taken under the resolution proposed to be revoked or altered until the proposed notice of motion has been dealt with by the Board. However, if in the opinion of the Chairperson, the practical effect of the delay so occasioned would be equivalent to a revocation of the resolution, or if, by reason of repetitive notices the effect of the notice is, in the opinion of the Chairperson, an attempt by a minority to frustrate the will of the Board then, in either case, action may be taken as though no such notice to the Chief Executive had been given or signed.

2.19.3 If, during the course of a meeting of the Board, fresh facts or information are received concerning a matter already resolved at the meeting, then such previous resolution may be revoked or altered by the consent of three-quarters of the members present and voting.

2.19.4 Any Board meeting may, on a recommendation contained in a report by the Chairperson or Chief Executive, or the report of any committee, revoke or alter all or part of any resolution previously passed by the Board or committee, provided that notification of such recommendation was given to the Chairperson and members at least two clear days before the meeting at which the recommendation is to be considered.

2.20 Rules of debate

2.20.1 The person in the chair shall be addressed in such terms as denotes the statutory office of that person with the choice of mode of address being as determined by that person.

2.20.2 A member may second a motion or amendment without speaking to it, reserving the right to speak later in the debate.

2.20.3 In speaking to any motion or amendment, members shall confine their remarks strictly to such motion or amendment, and shall not introduce irrelevant matter or indulge in tedious repetition. In this matter, the Chairperson's ruling is final and not open to challenge.

2.20.4 If three speakers have spoken consecutively in support of, or in opposition to, any motion the Chairperson may call for a speaker to the contrary. If no such speaker is forthcoming the motion shall be put. Any member speaking shall, if called upon by the Chairperson to do so, announce whether they are speaking in support of or against the motion or amendment.

2.20.5 When any member objects to words used and desires them to be recorded in the minutes, the Chairperson may so order them to be recorded; provided such objection be made at the time the words were used and not after any other members have spoken.

2.20.6 Members shall not read their speeches, except with the permission of the Chairperson, but may refresh their memory by reference to notes.

2.20.7 The following time limits shall apply to members speaking at meetings, unless extended by a majority vote of members present:

(i) Movers of motions when speaking to the motion, 10 minutes;

(ii) Other members, not more than 5 minutes;

(iii) Movers of motions, when expressing their right of reply, 5 minutes.

2.20.8 Except pursuant to orders 2.21.10, 2.21.13 and 2.21.14 a member may not speak more than once to a motion.

2.20.9 Members may request the Chairperson to restate the motion for their information at any time during the debate, but not so as to interrupt.

2.20.10 The mover of an original motion shall have the right of reply. After the mover has commenced such reply, or has intimated the wish to forego this right, or the Chairperson has intimated his or her intention to put the motion, no other member shall speak on the motion. Movers in reply shall not introduce any new matter and shall confine themselves strictly to answering previous speakers.

2.20.11 The right of reply shall be governed as follows:

(a) Where no amendment has been moved, the mover may reply at the conclusion of the discussion on the motion; or

(b) If there is an amendment, the mover of the original motion may make such reply at the conclusion of the debate on such amendment, and this reply shall exhaust the right thereto as mover of the original motion (see 2.21.10). The mover may, however, take part in the discussion upon subsequent amendments.

2.20.12 Members may speak to any matter before the meeting or upon a motion or amendment to be proposed by themselves, or upon a point of order arising out of debate, but not otherwise.

2.20.13 Notwithstanding order 2.21.8, members may make a personal explanation with the permission of the Chairperson, but such matters may not be debated.

2.20.14 With the permission of the Chairperson, a member who has already spoken may give explanation of some material part of a previous speech in the same debate, but new matter may not be introduced.

2.21 Conduct of meetings

2.21.1 The Chairperson shall decide all points of order and any member who refuses to obey any order or ruling of the Chairperson may be directed by the Chairperson to withdraw from the meeting. Upon such direction, any such member shall withdraw and shall not be permitted to return during the meeting, or any period thereof of that meeting that the Chairperson may determine.

2.21.2 Whenever the Chairperson rises or raises a hand during a debate any member then speaking or offering to speak shall be seated, and members shall be silent so that the Chairperson may be heard without interruption.

2.21.3 Members desiring to speak shall indicate accordingly and address the Chairperson, and shall not leave their place while speaking without the leave of the Chairperson.

2.21.4 When two or more members rise to speak, or raise a hand the Chairperson shall name the member who has the right to speak first, provided that the following members shall have precedence, where in order, when they rise and state their intention to:

(a) Raise a point of order (see order 2.22), including any request to obtain a time extension for the previous speaker;

(b) Move a motion to terminate or adjourn the debate (see order 2.14); or

(c) Make a point of explanation or request an indulgence of the Chairperson (see orders 2.20.3 or 2.20.14).

2.21.5 Members called to order by the Chairperson shall resume their seats and/or stop speaking, as the case may be. Should any member refuse to obey, such member may be directed by the Chairperson to withdraw from the meeting. Upon such direction, any such member shall withdraw and shall not be permitted to return during the meeting, or any period thereof of that meeting that the Chairperson may determine.

2.21.6 No member shall at any meeting, be disrespectful in speech or use offensive or malicious language, including in reference to:

(i) the Board, or
(ii) any other member, or
(iii) any officer or employee of the Board.

In addition, no member shall impute improper motives, or make offensive remarks about

the private affairs of any other member of the Board or its staff.

2.21.7 The Chairperson may call upon any member to withdraw any offensive or malicious expression and require the member to apologise for the expression. The Chairperson may require any member, who refuses to withdraw the expression and/or apologise, to withdraw from the meeting for a time specified by the Chairperson.

2.21.8 The Chairperson may require a member to withdraw immediately, from the meeting if their conduct is, in the opinion of the Chairperson, disorderly or creating a nuisance.

2.21.9 No member may use, or be associated with the use of, a recording device without the knowledge of the meeting and the consent of the Chairperson.

2.22 Points of order

2.22.1 Any member may rise to speak to a point of order upon any breach of these standing orders and the member previously speaking shall be seated and stop speaking.

2.22.2 The member rising shall state without explanation precisely the subject matter of the point of order.

2.22.3 No point of order shall be raised during a division except by permission of the Chairperson.

2.22.4 The following shall be recognised as substance for points of order:

(a) Discussion of a question not before the Board, or

(b) Use of offensive, disrespectful, or malicious language, or

(c) The breach of any standing order, or

(d) Misrepresentation of any statement made by a member or by an officer or employee of the Board, or

(e) Request that the words objected to be recorded in the minutes (see order 2.21.5)

2.22.5 Rising to express a difference of opinion or to contradict a statement of a speaker shall not be construed as rising to speak to a point of order.

2.22.6 The Chairperson may decide on any point of order immediately after it has been raised by any member, or may first hear further argument before deciding. The ruling of the Chairperson upon any point of order shall not be open to any discussion and shall be final.

2.23 Voting *(See also clause 29 of Schedule 3 and clause 30 of Schedule 4 of the Act)*

2.23.1 All questions arising at any meeting must be decided by a majority of the votes cast by the members present and entitled to vote.

2.23.2 The Chairperson or member presiding at the meeting shall have a deliberative vote but if the vote is tied the Chairperson or member presiding has no second or casting vote and the motion is not carried.

2.23.3 Every question coming before the Board shall be decided by open voting.

2.23.4 Any member may abstain from voting and shall have their abstention recorded in the minutes where requested.

2.23.5 The method of voting at meetings of the Board meetings and committee meetings shall be as follows:

(a) The Chairperson in putting the motion shall call for an expression of opinion on the voices or take a show of hands, the result of either of which, as announced by the Chairperson, shall be conclusive unless such announcement is questioned immediately, in which event the Chairperson shall call a division;

(b) The Chairperson may call for a division instead of or after receiving opinion on the voices and taking a show of hands;

(c) Any member may alternately call for a division immediately the Chairperson has declared the result of a vote on the voices or by a show of hands.

2.23.6 When a division is called for the Chief Executive shall take down the names of the members voting for and against respectively, and shall hand the list to the Chairperson who shall declare the result.

2.23.7 In case of confusion or error in taking the division, unless the same can be otherwise corrected, a second division shall be taken.

2.23.8 A member of the Board or a committee who has any interest in a transaction must fully disclose that interest. The member must not take part in any deliberation or decision of the Board or committee relating to the transaction. However, the member may take part in any deliberation (but not decision) relating to the transaction if a majority of the other members of the Board or committee permits the member to do so. The member must not be included in the quorum required for any such deliberation or decision. *(See also clause 36 of Schedule 3 and clause 38 of Schedule 4 of the Act)*

2.23.9 Any disclosure of interest and the subsequent abstention of the member from deliberation and/or voting on the item shall be recorded in the minutes.

2.23.10 If the member is not able to take part, after the disclosure, in any deliberation relating to the transaction the member should consider leaving the meeting room for the full duration of the deliberation.

2.24 Qualified privilege *(See clauses 23 and 24 of Schedule 3 of the Act)*

2.25 Maintenance of public order at meetings *(See clause 35 of Schedule 3 and clause 37 of Schedule 4 of the Act)*

3 PUBLIC ACCESS

3.1 Public at meetings

3.1.1 All meetings of the Board and its statutory committees (and other committees that have authority to make decisions or resolutions on behalf of the Board) shall be open to the public and news media except as provided in clauses 32 and 33 of Schedule 3 of the Act and in clauses 34 and 35 of Schedule 4 of the Act.

3.1.2 The agenda and associated reports circulated to members of the Board or committee (with the exception of public excluded information) shall be available to the public and news media and will be available at least two working days before the meeting. *(See clause 19 Schedule 3 and clause 21 Schedule 4 of the Act).*

3.2 Public notification of meetings and access to agendas, reports and minutes of the board and to committees that have authority to make decisions or resolutions on behalf of the Board

3.2.1 Public notification of ordinary meetings *(See clause 16(1) of Schedule 3 and clause 18(1) of Schedule 4 of the Act)*

3.2.2 Public notification of ordinary meetings held on or after the 21st day of any month *(See clause 16(2) of Schedule 3 and clause 18(2) of Schedule 4 of the Act)*

3.2.3 Public notification of special meetings *(See clause 16(3) of Schedule 3 and clause 18(3) of Schedule 4 of the Act)*

3.2.4 Public notification of emergency meetings *(See clause 16(4) of Schedule 3 and clause 18(4) of Schedule 4 of the Act)*

3.2.5 Public notification – additional requirements
The Chief Executive shall make any additional arrangements for the notification of meetings including special meetings and emergency meetings as the Board may from time to time determine.

3.2.6 Meetings not publicly notified are not invalid
No meeting of the Board or a committee is invalid just because it was not publicly notified in accordance with clause 16 of Schedule 3 or clause 18 of Schedule 4 of the Act.

3.2.7 Retrospective public notice *(See clause 17(2) of Schedule 3 and clause 18(2) of Schedule 4 of the Act)*

3.2.8 Public availability of agendas and reports
All agendas and reports, with the exception of public excluded information, shall be made available to the public in accordance with clauses 19 and 20 of Schedule 3 and clauses 21 and 22 of Schedule 4 of the Act. Information may be withheld from the publicly available agendas and reports in accordance with clauses 19(2) and 20(2) of Schedule 3 and clauses 21(2) and 22(2) of Schedule 4 of the Act.

3.2.9 Agenda etc to be made available at meetings
The public shall be entitled to copies of the order paper and agenda (including copies of any documents deemed to be part of the agenda) to be considered at that part of the meeting which is open to them. The part of the order paper that relates to a resolution to exclude the public shall also be available to the public. *(See also clause 34 of Schedule 3 and clause 36 of Schedule 4 of the Act)*

3.2.10 Public notification of resolution passed at an emergency meeting *(See clause 22 of Schedule 3 and clause 24 of Schedule 4 of the Act)*

3.2.11 Public access to minutes
The public shall be entitled to inspect, take notes from or receive copies of minutes of any meeting or part of a meeting from which the public was not excluded. *(See clause 21 of Schedule 3 and clause 23 of Schedule 4 of the Act)*

3.2.12 Access to minutes of meeting from which the public were excluded *(See clause 21(5) of Schedule 3 and clause 23(5) of Schedule 4 of the Act)*

3.3 Exclusion of the public from meetings

3.3.1 Lawful reasons to exclude the public from Board and committee meetings *(See clause 32 of Schedule 3 and clause 34 of Schedule 4 of Act)*

3.3.2 Form of resolution to exclude the public *(See clause 33 of Schedule 3 and clause 35 of Schedule 4 of Act)*

3.4 Application of standing orders to public excluded sessions

These standing orders apply to meetings or parts of meetings from which the public has been excluded.

3.5 Use of public excluded information

Subject to the provisions of the Official Information Act, no member, officer or other person shall disclose to any person other than a member or officer, any information which has been presented to, or is to be presented to any meeting from which the public is properly excluded, or where it is proposed that the public be properly excluded, nor shall any discussion, deliberations or decisions be divulged following any such meeting except by way of release of information by the Board

4 MISCELLANEOUS

4.1 Questions at meetings

4.1.1 Any member of the Board may at any ordinary meeting of the Board at the appointed time, put a question to the Chairperson, or through the Chairperson of the Board to the Chairperson of any committee, or to any officer of the Board concerning any matter relevant to the role or functions of the Board about any matter that does not appear on the order paper, nor arises from any committee report or recommendation submitted to that meeting.

4.1.2 Before putting a question, a member shall, in the first instance, endeavour to obtain the relevant information from the appropriate Board officer or the Chairperson of the committee concerned. In the event of the information sought not being forthcoming, or the member not being satisfied with the answer, the member then has the right to raise the matter by way of a question at an ordinary meeting of the Board provided that the Chairperson may refer a question to an appropriate committee.

4.1.3 Wherever applicable, such questions shall be in writing and handed to the Chairperson prior to the commencement of the meeting at which they are to be asked.

4.1.4 If an answer to the question cannot be given at that meeting it shall, at the discretion of the Chairperson, be placed on the order paper for the next Board meeting.

4.1.5 Questions and answers shall be submitted as briefly and concisely as possible. No discussion shall be allowed upon any question or upon the answer.

4.2 Questions to officers during debate

In the course of any debate at any Board meeting, any members may, at the Chairperson's discretion, ask any question of the relevant officer on any matter under debate. Such questions shall be directed through the chair.

4.3 Obligation to provide members with information

4.3.1 Public excluded information required by members in the performance of their particular duties as members shall be supplied to them by the Chief Executive. Where the Chief Executive is uncertain that public excluded information should be supplied in any particular case, the matter shall be referred to the Chairperson for direction.

4.3.2 No information obtained by any member, including information obtained pursuant to order 4.3.1, shall be used for any purpose other than for the proper discharge of duties as a member.

4.3.3 Where the Chairperson of the Board has reasonable grounds for believing that information provided to any member has been misused, the Chairperson may report this and any proposed action to the Board.

4.3.4 The requirements of 4.3.1 are in addition to the rights of members to make separate and individual requests for information in terms of the Official Information Act 1982. Such requests for information may include requests for information that had previously been supplied to that member as public excluded information to be released as publicly available information. Where such information is made available to that member as publicly available information the member has the right to use such information in the same way as if that member were a member of the public.

4.4 Recording or filming of meetings

Filming or recording of meetings may only be done by prior arrangement and with the consent of the Chairperson. Any recording or filming of meetings must not be intrusive or interfere with the conduct of the meetings.

These revised Standing Orders were adopted by the **Waitematā District Health Board** at a meeting of the Board on **21 August 2019**

……..
Judy McGregor, Chairperson, Waitematā District Health Board

……..
Dale Bramley, Chief Executive, Waitematā District Health Board

Appendix 3: Committee Terms of Reference

(To be inserted once the incoming Board has confirmed its Committee structure and delegations following the 2019 DHB elections.)

Appendix 4: Board Member Fees set by the Minister of Health

Waitematā DHB fees approved by the Minister of Health by letter dated 26 July 2013, effective from 1 July 2013:

Annual rates: Board Chair - $52,500
Deputy Board Chair - $31,875
Board Members - $25,500

In addition meeting allowances payable for attending meetings of the three statutory advisory committee and the Audit and Finance Committee are $312.50 per meeting for Committee Chairs and $250 per meeting for Committee members.

Advice has been received that the Minister will be reviewing fees as part of the incoming Board appointments around the 2019 DHB elections.

Appendix 5: Waitematā DHB Member Remuneration, Fees and Expenses Policy

RELATED DOCUMENTS
Crown Entities Act 2004
New Zealand Public Health and Disability Act 2000.
Cabinet Fees Framework for Members Appointed to Bodies in which the Crown has an Interest [CO(19)1].

OVERVIEW/SUMMARY

The purpose of this Policy 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 the procedures to be followed for payment of fees and reimbursement of expense claims.

Remuneration and Committee fees are paid in accordance with the Cabinet Fees Framework for Members of Statutory and Other Bodies Appointed by the Crown, and at the levels indicated in that framework and/or set by the Minister of Health.

Reasonable travel costs 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 of 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 we have applied the DHB's own travel and expenses policy to Board members.

Where travel or other costs are incurred for the purposes of both Waitematā DHB and another organisation, a fair apportionment shall be made between organisations, and only that part attributable to Waitematā DHB 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 for non-standard items of expenditure by the Board Chair requires sign-off by the Chair of the Waitematā DHB Audit and Finance Committee.

BASE REMUNERATION *(effective 1 July 2013)*

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: $52,500 p.a.
Deputy Chair $31,875 p.a.
Board Member $25,500 p.a.

COMMITTEE FEES

In addition to the base remuneration, the following fees are payable to members of certain committees:
For the three Statutory Committees (Hospital Advisory Committee, Community and Public Health Advisory Committee and Disability Support Advisory Committee) each member is paid $2,500 pa. If a member

attends less than 10 meetings per annum the fee is pro-rated. Effectively, this equates to $250 per meeting and the fees are paid in this way, with a check at the end of the year to ensure that total payment does 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 pa or $312.50 per meeting.
[These Committee fees were most recently confirmed as part of the Cabinet Office Circular CO (19)1: Fees Framework for Members Appointed to Bodies in which the Crown has an interest (issued on 17 June 2019)].

2. Fees are also payable to members of the Board's Audit and Finance Committee on the same basis as the above three Statutory Committees. [Approved by the Minister of Health for Waitematā DHB on 11 September 2003 – since applied to all DHB Audit, Risk and Finance Committees nationally].

3. No additional fees are payable to Board members involved in other formal Committees such as Manawa Ora.

LEAVE
Where an individual receives an annual fee and is absent from board business for a period of greater than two months, then the annualised fee should be pro-rated to take account of this absence. [Fees Framework clause 90].

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 per kilometre rate set by the IRD (normally reviewed by the IRD annually).

Taxis and Rental Cars
Where appropriate or more economical, taxis or public transport may be used. Waitematā 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, and rental car bookings must be made via the Board Administrator (from the WDHB preferred supplier).

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: Waitematā DHB provides a mobile phone for Board Chair and pays 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 from 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 Auckland
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.

Wherever practicable bookings for air travel, accommodation and training courses should be made through Waitematā DHB (via the Board Administrator) so as to obtain the best discounted rates.

Where travel or other costs are incurred for the purposes of both Waitematā DHB and another organisation, a fair apportionment shall be made between organisations, and only that part attributable to Waitematā DHB shall be claimed.

The following applies:
- Under normal circumstances air travel will be by economy class.
- An authorised airfare for business travel must not be exchanged or part exchanged for lower fares to enable a partner to accompany the Board member.
- Waitematā DHB travel does not accrue air points and Waitematā DHB does not re-imburse airline lounge subscriptions.
- Accommodation is to be at an acceptable level and reasonable rates having regard to the public service nature of the office. Waitematā DHB has preferred rates with a number of hotels and these should be used wherever possible.
- Waitematā DHB will meet reasonable personal telephone expenses but hotel phone usage should be kept to a minimum.
- Waitematā DHB will meet reasonable daily expenses for items associated with travel out of Auckland 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.
- Waitematā DHB will not pay for or reimburse personal expenses e.g 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 used for training relating to the legislative requirements for DHB members (which cover "obligations and duties of a member of a board, Māori health issues, Treaty of Waitangi issues, or Māori groups or organisations in the district of the DHB"). Such training is paid for in full (and in most cases organised by) Waitematā DHB 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

Waitematā DHB 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 Audit and Finance Committee. Expenditure above $500 should have the prior approval of the Chair of the Audit and Finance Committee.

Wherever practicable/appropriate Waitematā DHB 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 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 Audit and Finance Committee) who will determine how to respond.

Gifts or donations to the WDHB Board, accepted on the Board's behalf by individual Board members, are the property of the Waitematā DHB Board. The only exceptions are small gifts (eg a bottle of wine; a diary) worth less than $50.

Board members are governed by the WDHB Corporate policy on Koha. (There are relevant sections on Koha in the Travel Policy and the Engagement and Consultation Financial Recognition Policy.)

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 purposes of sections 105 and 105A of the Crimes Act 1961 relating to bribery and corruption.

"Company" Credit Card

Under no circumstances will any Board member or the Board Chair be provided with or have personal use of a Waitematā DHB Credit Card.

Note: Waitematā DHB has a "company" credit card which is used for booking travel and accommodation through its preferred travel agent. This arrangement is used when bookings are made for Board members for work related travel.

PROCESS FOR CLAIMING AND PAYMENT OF FEES AND EXPENSES

1. Standard Payments

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 months payment in December of the year they are elected.

Additional meeting fees and mileage allowance for meetings in Auckland are regarded as standard payments to be claimed monthly using the Board and Committee Members' Meeting and Travelling Expenses Claim Form. Fees for Statutory Advisory Committee and Audit and Finance Committee meetings are based on attendance. Attendance is checked against the minutes of the meeting. A register of attendance is maintained by the PA Board Support and in December each year there is a check to ensure that no members receives payment for more than 10 meetings for each committee for that year (ie 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.

In accordance with IRD rules, withholding tax is deducted from the base remuneration and committee fee payments.

The Board Chair will review the standard payments made to members each month, including mileage claims. (Note, this may be on a retrospective basis.)

The Chair of the Audit and Finance Committee will review the standard payments made to the Board Chair each month. (Note, this may be on a retrospective basis.)

2. Non –Standard Items

For other, non-standard, items (travel outside Auckland, meals, accommodation, courses etc) the standard Waitematā DHB forms should be used: the Form for Approval of Air Travel and Accommodation, and the 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, reimbursement for non-standard expense claims are to be signed off by the Chair of the Board's Audit and Finance Committee.

Unrecorded cash funds

The Board (i.e the Board members collectively, as opposed to the organisation) must not pen or maintain a bank account that is not consolidated into Waitematā DHB's financial accounts. (Note: this prohibition was recommended by the Board's external auditors, Audit N.Z, August 2010).

5.2 Power of Attorney for the Board Chair

Recommendation:

That the Board approve the Waitematā DHB Board Chair, Judith McGregor, being given power of attorney to execute deeds on behalf of Waitematā District Health Board *provided* the arrangement reflected in such a deed is within the delegated authority of the staff member seeking the deed's execution or has been approved by the Board. The duration of power of attorney is for the appointed term of the current Board Chair, Judith McGregor.

Prepared by: Amanda Mark, General Counsel
Endorsed by: Dr Dale Bramley, Chief Executive Officer and Robert Paine, Chief Financial Officer

Glossary

CEO – Chief Executive Officer
CFO – Chief Financial Officer
Chair – Chair of Waitemata District Health Board
DHB – Waitemata District Health Board

1. Executive Summary

This paper seeks the Board's approval to grant the Board Chair power of attorney to execute deeds on behalf of Waitematā District Health Board *provided* the arrangement reflected in such a deed is within the delegated authority of the staff member seeking the deed's execution or has been approved by the Board.

Approval is sought because difficulties and inefficiencies arise when the DHB needs to sign leases or licences or tenancy agreements[1] as lessee, licensee or tenant[2].

2. Background

Section 3.7.8 of the Delegated Authority policy permits leases, licences and tenancy agreements where Waitematā DHB is the lessee to be entered into by:

- the **CFO** if the rental is less than $100K per annum and the term of the lease is up to 5 years (total term including any rights of renewal)
- the **CEO** if the rental is less than $250K per annum and the term of the lease is up to 5 years (total term including any rights of renewal)
- the **Board** if the rental exceeds more than $250K per annum and the term of the lease is more than 5 years

All leases are in the form of deeds and therefore, must be signed by two Board members if there is no power of attorney in place.

Note 4 to Section 3.7.8 states that if the CEO has delegated authority to, enter into a lease where Waitematā DHB is the lessee, and approve subsequent rent reviews, the Board Chair will have the authority to execute the lease under the Power of Attorney granted to the Chair by the Board without the need for the Board to first approve the lease.

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[1] From here on the term "lease" should be read as including leases, licences and tenancy agreements.
[2] From here on the term "lessee" should be read as including licensee and tenant

Note 4 is intended to operate so that if a lease is within the CEO or CFO's delegated authority, the Board Chair could sign the lease under a Power of Attorney. It was also expected that it would reduce the number of low value, short term leases going to the Board for approval and enable arrangements for such leases to be finalised quickly and efficiently.

With the change in Chairs in 2018, it is necessary for the Board to grant the Chair Power of Attorney to sign leases which are within the CEO and CFO's delegated authority to approve. The Chair will then be able to sign leases within these delegations without the need for prior approval by the Board.

Section 3.7.8 of the Delegated Authority policy appears below:

	Delegated Authority	Board	CEO	CFO	GM Facilities	Facilities Manager
3.7.8		*>$250k p.a. Up to and* beyond 5 years	$250k p.a.	$100k p.a.	Nil	Nil

Notes

1. Maximum term 5 years including rights of renewal. The dollar limit applies to the total commitment over the term of the contract including rights of renewal. Any contract that results in a total commitment of more than $1 million or that is for longer than 5 years must be put to the Audit & Finance Committee which will make a recommendation to the full Board.
2. The total term including all rights of renewal must not exceed 5 years. See Section 2.10 for terms greater than 5 years.
3. Neither the initial term nor any renewal term may exceed 5 years.
4. Where the CEO has delegated authority to:
   (a) grant a lease, licence or tenancy agreement over WDHB land or buildings and approve subsequent rent reviews under 3.7.7; or
   (b) enter into a lease, licence or tenancy agreement where WDHB is the lessee, licensee or tenant and approve subsequent rent reviews under 3..7.8 ;

the Board's Chair shall have the authority to execute any such lease, licence or tenancy agreement under the Power of Attorney granted to the Chair by the Board without need for the Board to first approve the lease, licence or tenancy agreement.

The proposed power of attorney is attached as Schedule 1

3. Other Issues

Leases where Waitemata DHB is a lessee worth more than $250K per annum or for a term of more than 5 years will continue to be submitted to the Board for approval.

Leases executed by the Chair under the proposed Power of Attorney will be reported to the Audit and Finance Committee to ensure the Board is aware of them.

4. Consultation/Engagement

The Leasing team welcome the prospect of the Chair holding power of attorney.

5. Conclusion

This paper seeks the Board's approval for the Chair to be granted a power of attorney to execute deeds on behalf of the DHB. This will enable the Chair to execute leases which are within the CEO's and CFO's delegated authority.

There are sufficient safeguards in the caps on the rentals and terms which the CEO and CFO can agree to and the requirement to report leases executed under the Chair's power of attorney to Audit and Finance Committee.

6. Authorities/Sign-offs

Approved by Dr Dale Bramley, Chief Executive Officer, Robert Paine, Chief Financial Officer

Schedule 1

Proposed Power of Attorney

Limited Power of Attorney

Given by: Waitemata District Health Board

To: Judith Helen McGregor

Details

Date	2019

Parties

Name	**Waitemata District Health Board** as donor
Short Name	**Waitemata District Health Board**
Name	**Judith Helen McGregor** as attorney
Short Name	**Attorney**

Background

A Waitemata District Health Board is a Crown Entity established under Part 3 of the New Zealand Health and Disability Act 2000.

B Waitemata District Health Board believes it is expedient that an attorney be appointed by it for the purposes referred to in this Limited Power of Attorney.

Agreed terms

1. Appointment

Waitemata District Health Board appoints Judith Helen McGregor to be its attorney (**Attorney**) with and limited to the powers respectively described as follows.

2. Powers

2.1 Execute documents and take actions in respect of Waitemata District Health Board's Property Portfolio

(a) Waitemata District Health Board gives the Attorney power, in Waitemata District Health Board's name, and on Waitemata District Health Board's behalf, to execute and deliver all documents and to take any action necessary or considered desirable in respect of all of Waitemata District Health Board's property portfolio interests and rights in real property (**Property Portfolio**).

(b) Without limitation to the foregoing, the Attorney is authorised to sign any of the following documents on Waitemata District Health Board's behalf:

(i) any leases, licences, agreements, assignments, variations, sub-grants, extensions, surrenders and renewals, easements, caveats or any other document, registered or otherwise, in relation to any part of Waitemata District Health Board's Property Portfolio;

(ii) any documents required in relation to the acquisition or divestment of any part of Waitemata District Health Board's Property Portfolio;

(iii) any transfer, lease, licence, grant of easement, caveat or any other document or instrument relating to or connected with the occupation, use or demise of any real property or building by Waitemata District Health Board; and

(iv) in connection with the exercise of such powers any other document required by, or made under the Conservation Act 1987, the Land Act 1948, the Land Transfer Act 1952, the Land Transfer Act 2017, the Land Transfer (Computer Registers and Electronic Lodgement) Amendment Act 2002, the Property Law Act 2007, the Unit Titles Act 2010, Public Works Act 1981, Overseas Investment Act 2005, or the Resource Management Act 1991.

3. Dealings with Attorney

3.1 No Need to Enquire

No person or body corporate or other entity dealing with the Attorney need enquire as to the propriety or expediency of anything which the Attorney may do or purport to do or agree to do in Waitemata District Health Board's name by virtue of this deed.

3.2 Execution of Documents

The Attorney's execution of any document referred to in this deed shall be conclusive evidence of the Waitemata District Health Board's approval of that document.

4. Ratification

Waitemata District Health Board declares that all acts, matters and things done by the Attorney in exercising powers under this Limited Power of Attorney will be as good and valid as if they had been done by Waitemata District Health Board. Waitemata District Health Board agrees to ratify whatever the Attorney lawfully does or causes to be done by virtue of this Limited Power of Attorney.

5. Indemnity by Waitemata District Health Board

Waitemata District Health Board will indemnify and keep indemnified the Attorney against any loss, claim, damage, expense, liability or proceeding suffered or incurred at any time by the Attorney and resulting from the Attorney's exercise, or purported exercise, in good faith, of the powers conferred by this deed.

6. Duration

This Limited Power of Attorney continues to operate and is effective until expressly revoked and notice of that revocation is given to the Attorney. For the avoidance of doubt, the rights, powers and authorities conferred or vested by this deed on the Attorney shall be deemed to be revoked and determined once they cease to be the appointed Board Chair of Waitemata District Health Board.

7. Governing Law and Jurisdiction

This deed shall be governed by, and construed in accordance with, New Zealand law.

8. Definitions

(a) "document" includes deed, agreement , contract, instrument or other writing and includes any record of information in electronic form;

(b) "persons" includes bodies corporate and other legal entities, as well as natural persons;

(c) "real property" includes any estate or interest, right or claim whether present or future and whether vested or contingent in land of any description and wherever situated (whether in New Zealand or elsewhere) whether solely, jointly or severally owned; and

(d) "sign" includes execute, sign, seal and deliver and sign whether by hand or by facsimile or by electronic means using a personal identification number or other means of electronic signature.

9. Interpretation

(a) **Headings:** headings appear as a matter of convenience and do not affect the construction of this deed;

(b) **Statutes and Regulations:** a reference to an enactment or any regulations is a reference to that enactment or those regulations as amended, or to any enactment or regulations substituted for that enactment or those regulations; and

(c) **Singular, Plural and Gender:** the singular includes the plural and vice versa, and words importing one gender include the other genders.

Signing page

EXECUTED as a deed

WAITEMATA DISTRICT HEALTH BOARD
by:

Signature of Board Member

Name of Board Member

Signature of Board Member

Name of Board Member

6.1 Financial Report for June 2019

Recommendation:

That the Board receives the report.

Prepared by: Simon Watts (Deputy Chief Financial Officer), David Dodds (Financial Planning Manager), Cliff La Grange (Deputy Chief Financial Officer - Funder)
Endorsed by: Robert Paine (Chief Financial Officer and Head of Corporate Services)

Glossary

ACC	-	Accident Compensation Commission
AIR	-	Advanced Interventional Radiology
DHB	-	District Health Board
ED	-	Emergency Department
FPIM	-	Financial and Procurement Information Management System
FTE	-	Full Time Equivalents
IDF	-	Inter District Flow
MECA	-	Multi-Employer Collective Contract
MHSOA	-	Mental Health Services Older Adults
MoH	-	Ministry of Health
MRI	-	Magnetic Resonance Imaging
NGO	-	Non-Government Organisation
NZNO	-	New Zealand Nurses Organisation
ORL	-	Otorhinolaryngology
PHO	-	Primary Health Organisation
RMO	-	Resident Medical Officer
SLA	-	Service Level Agreement
WDHB	-	Waitematā District Health Board

Background

The report summarises the financial performance of the DHB for the month of June 2019 and for the financial year 2018/19. The report covers all operating units of the DHB, being the Funder Arm, Provider Arm and Governance.

1. Executive Summary

The provisional operating deficit for the year ended 30 June 2019 was $6.84m, being $160k favourable to the Ministry approved budget deficit of $7m.

Subsequent late adjustments achieved by the Ministry of Health, including holiday pay and FPIM impairment, has increased the deficit for the year to $9.97m.

Work is progressing on the Holiday Pay Liability, which may result in an increased loss. The MoH has confirmed that the financial performance of the WDHB for the year ended 30 June 2019 will be assessed prior to any holiday pay increased charge.
The financial result is the outcome of significant efforts by everyone at the WDHB.

Our year end result reflects a significant improvement to the originally estimated loss of $20m. This amount has been reduced over the year as costs and revenues have crystallised. The final agreed budgeted deficit of $7m was agreed with the Minister of Health in April. As referred to above, the full impact of the Holidays Act was yet to be agreed at the time of writing this report. Advice to the Board on this matter will occur at the meeting, and also any impact this may have on the final result.

The DHB has submitted a break even budget for 2019/20, which will be challenging to deliver, but management is committed to do so without reducing services or patient care, nor increasing clinical risk. However, Holiday Pay matters may cause an unbudgeted cost in 19/20, which the MoH assumes will be met by increased revenue.

WDHB has a comprehensive multiyear financial sustainability programme to enable the DHB to live within its means.

1.1 Highlights

- Excluding extraordinary and one-off adjustments noted below, the operating deficit for the year was $6.84m, favourable by $0.16m against the ministry agreed budget deficit of $7.0m.

The $2.7m unfavourable variance in the month of June, and the $2.97m unfavourable variance for the full year include the following MoH authorised sector-wide year-end adjustments:

- FPIM impairment of $1.62m, representing the write down of its investment in the National Finance and Procurement Information System, and
- Holiday Pay Act provision of $1.5m, recognising potential costs of underpayment of holiday pay,

Key financial impacts on the Funder Arm Result (Surplus of $39.1m against a budgeted surplus of $14.7m) include:

- Lower than planned demand, especially in pharmaceuticals
- An assessment of certain provisions as at 30th June 2018, as recommended by Audit New Zealand
- Lower than forecast IDF outflow

Key financial impacts on the Provider Arm Result (Deficit of $51.5m against a budgeted deficit of $21.7m) include:

- FPIM impairment $1.62m
- Holiday Pay Act provision $1.5m
- Delays in the realisation of benefits in the sale of 44 Taharoto Road $6.0m
- Delays in the realisation of savings under the financial sustainability programme, $2.3m
- Timing and cost of MECA settlements
- Industrial action impacting elective surgery

On 26th June 2019, the Cabinet approved the business case for the Financial and Procurement Information Management System (previously known as National Oracle System (NOS)). On advice from NZ Health Partnerships on 5th July 2019, WDHB recognised an impairment in the value of FPIM

in June 2019 of $1.62m. This impairment is on top of the $1.3m impairment booked in June 2018, bringing the total impairment on FPIM to $2.9m.

The financial sustainability programme has contributed savings of $9.8m against a plan of $18.1m, a shortfall of $8.3m. This shortfall includes a $6.0m benefit from sale of Taharoto Road due to be realised in September 2019, and delays in the implementation of some initiatives. Updates on the programme are reported to the Audit and Finance Committee.

In the next financial year, the financial sustainability programme will be tracked via an enhanced project management solution (Daptiv) which went live in July 2019. A new programme manager was appointed in April 2019 to manage the programme, to provide guidance on individual projects and ensure momentum is maintained. At the time of writing, the 19/20 breakeven budget within the Provider Arm includes a savings target of $27.6m that has yet to be identified.

1.2 Financial Indicators

Table 1: Financial Indicators for June 2019

FINANCIAL PERFORMANCE									
$ millions	Month			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Funder Arm	16.3	2.0	14.3	39.1	14.7	24.4	39.1	14.7	24.4
Provider Arm	-11.3	6.5	-17.8	-51.5	-21.7	-29.8	-51.5	-21.7	-29.8
Governance Arm	0.8	-0.0	0.8	2.4	0.0	2.4	2.4	0.0	2.4
DHB Result : Surplus / (Deficit)	5.7	8.5	-2.7	-10.0	-7.0	-3.0	-10.0	-7.0	-3.0

FINANCIAL POSITION									
$ millions	Month			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Crown Equity (net worth)	604.9	606.1	-1.2	604.9	606.1	-1.2	604.9	606.1	-1.2
Capital Expenditure	1.9	2.9	1.0	23.0	34.5	11.5	23.0	34.5	11.5
Cash Flow Balance	36.7	7.5	29.2	36.7	7.5	29.2	36.7	7.5	29.2

CLINICAL ACTIVITY									
	Month			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
ED Attendances	9,741	9,771	30	114,643	111,222	-3,421	114,643	111,222	-3,421
Acute Volumes (WIES)	5,422	5,437	15	66,051	66,149	99	66,051	66,149	99
Elective Volumes (WIES)	1,452	1,529	-77	17,536	18,246	-711	17,536	18,246	-711

ED (emergency department) attendance figures are per the activity volume report (AVR) excluding primary care voucher attendances

A negative variance in ED Attendances reflects higher than planned presentations

A positive variances in Acute Volumes (WIES) reflects a lower than planned acute demand

A negative variance in Elective Volumes (WIES) reflects under delivery

2. Waitematā DHB Consolidated Financial Performance

2.1 Financial Result

Table 2: Waitematā DHB Consolidated Financial Result for the month ended June 2019

CONSOLIDATED FINANCIAL PERFORMANCE							
$ 000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Crown	154,058	147,444	6,614	1,809,511	1,769,451	40,060	1,769,451
Other	3,759	2,498	1,261	30,682	29,542	1,140	29,542
Total Revenue	157,817	149,942	7,875	1,840,192	1,798,993	41,199	1,798,993
EXPENDITURE							
Personnel	62,267	52,566	-9,701	689,004	660,287	-28,717	660,287
Outsourced Personnel	2,096	1,322	-774	21,693	15,936	-5,757	15,936
Outsourced Services	5,113	5,071	-42	63,218	62,120	-1,098	62,120
Clinical Supplies	10,070	10,783	713	127,453	126,344	-1,109	126,344
Infrastructure & Non-Clinical Supplies	14,065	3,368	-10,697	119,357	111,574	-7,783	111,574
Funder Provider Payments	58,474	68,369	9,895	829,432	829,732	300	829,732
Total Expense	152,086	141,480	-10,606	1,850,157	1,805,993	-44,165	1,805,993
DHB Result : Surplus / (Deficit)	5,732	8,463	-2,731	-9,965	-7,000	-2,965	-7,000

2.2 Financial Performance June 2019

Revenue - $7.9m favourable to budget

The favourable variance in revenue includes:

- MoH funding support for MECA settlements.
- Consolidation of income from Three Harbours Health Foundation.
- Revenue from PHARMAC rebates that are now accounted for as revenue relating to the new MoH Combined Pharmaceutical Budget (CPB) strategy. Up until December 2018, the rebates were accounted for and budgeted as an offset in pharmaceutical expenditure. From January 2019 onwards, the rebates have been accounted for as revenue (unbudgeted).

Expenditure - $10.6m unfavourable to budget

The unfavourable variance in expenditure includes:

- In-year additional FTE appointments approved after the formation of the annual plan necessitated in order to maintain safe clinical services.
- Higher personnel costs due to MECA impacts partially offset by additional funding support from the MoH.
- Year-end provisions for holiday pay, $1.5m.
- Impairment of FPIM as noted above, $1.6m.

Refer to section 3.0 for commentary on Funder Financial Performance.

2.3 Financial Performance YTD

Revenue - $41.2m favourable to budget

The favourable variance in the year to date revenue includes:

- Funder revenue $24.1m favourable
- Governance revenue $0.4m favourable
- Provider revenue $16.7m favourable

Expenditure - $44.2m unfavourable to budget

The unfavourable variance in the year to date expenditure includes:

- Funder expenditure $0.3m favourable
- Governance expenditure $2.1m favourable
- Provider expenditure $46.5m unfavourable

Refer to section 3.0 for Funder Arm commentary on YTD financial performance.
Refer to section 4.0 for Provider Arm commentary on YTD financial performance.

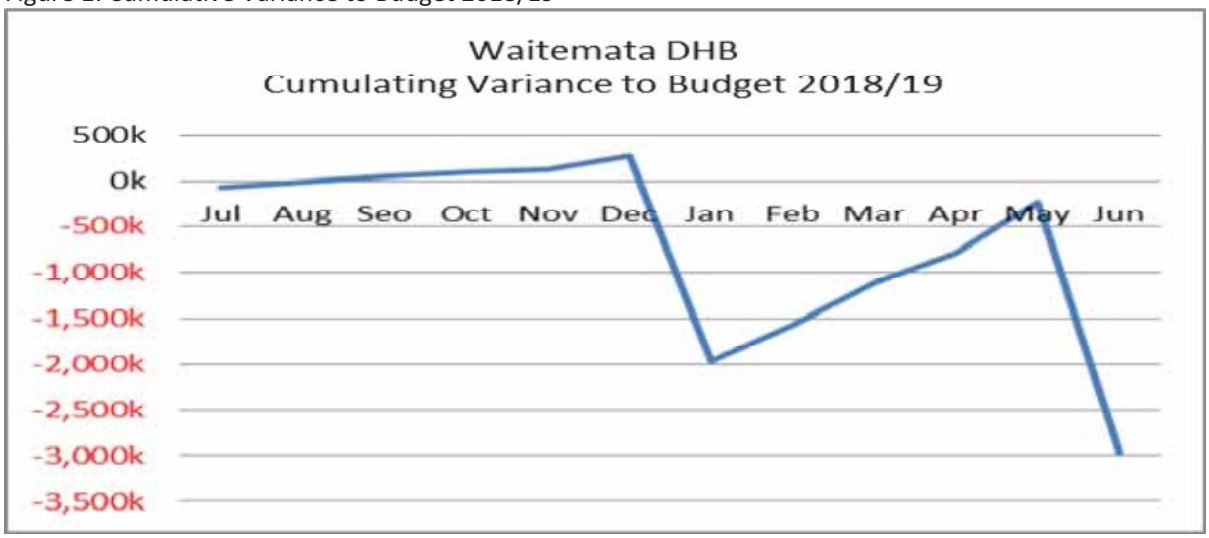
2.4 Trend in Financial Performance YTD

The financial performance of WDHB as at May 2019 supported a forecast deficit of $7m, which was in line with the MoH approved annual plan. However, in June 2019 the following year-end adjustments were recognised, resulting in an unfavourable variance to budget of $3.0m:

- FPIM impairment of $1.6m
- Holiday Pay Act provision of $1.5m

The negative movement in the cumulative variance to budget in January 2019 results from a revision of the 2018/19 Annual Plan deficit from $8.7m to $7.0m.

Figure 1: Cumulative Variance to Budget 2018/19



3. Funder Arm Commentary on Financial Performance

Funder Arm Financial Performance: June 2019

The Funder Total Core result variance was $14.29m favourable for the month and $24.42m favourable for the year. This is the net position across all four of the Funder divisions. The four Funder divisions are: Funder NGO, Funder Own Provider, Funder IDF and Funder Governance.

Funder NGO is the main focus of Funder performance and refers to contracted health services delivered by third party providers consisting mostly of community services providers. Approximately 80% of such services are demand based delivered by means of a National Agreement with little or no opportunity to directly influence either the number of service providers and/or the number of patient presentations.

The Funder consolidated $24.42m favourable position for the year consists of a favourable Funder NGO variance of $16.27m, a favourable Funder Own Provider variance of $0.29m, a favourable Funder IDF variance of $7.86m and nil variance within Funder Governance. It is important to note that a significant component of Funder variances are, in effect, offsets resulting mostly from Ministry mandated strategies and changes introduced after DHB budgets have been confirmed. For example, the significant additional funding for MECA settlements was received after the final Ministry Funding advice which results in a large revenue variance and an equivalent large expenditure variance when paid over to the Provider as required.

The table below summarises the key components of the Funder Core Result from a Revenue and Expenditure perspective and across the four Funder Divisions.

Funder Arm Financial Performance

FUNDER ARM FINANCIAL PERFORMANCE							
$'000	Month Jun-19			Full Year 2018-19			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Funder NGO	48,639	44,218	4,421	553,231	530,614	22,617	530,614
Funder Own Provider	72,707	72,437	270	881,754	869,244	12,510	869,244
Funder IDF	26,726	26,152	575	315,032	313,818	1,214	313,818
Funder Governance	1,285	1,281	4	15,499	15,371	129	15,371
Total Funder Revenue	**149,357**	**144,087**	**5,270**	**1,765,515**	**1,729,047**	**36,469**	**1,729,047**
EXPENDITURE							
Funder NGO	37,933	42,218	4,285	522,259	515,914	(6,345)	515,914
Funder Own Provider	73,313	72,437	(876)	881,467	869,244	(12,223)	869,244
Funder IDF Outflows	20,541	26,152	5,610	307,172	313,818	6,646	313,818
Funder Governance	1,285	1,281	(4)	15,499	15,371	(129)	15,371
Total Funder Expenditure	**133,072**	**142,087**	**9,015**	**1,726,397**	**1,714,347**	**(12,051)**	**1,714,347**
CORE RESULT							
Funder NGO	10,706	2,000	8,706	30,971	14,700	16,271	14,700
Funder Own Provider	(606)	0	(606)	287	0	287	0
Funder IDF	6,185	(0)	6,185	7,860	0	7,860	0
Funder Governance	0	0	0	(0)	0	0	0
FUNDER RESULT Surplus/(Deficit)	**16,285**	**2,000**	**14,285**	**39,118**	**14,700**	**24,418**	**14,700**

FUNDER TOTAL REVENUE

The Funder consolidated total revenue variance was $5.27m favourable for the month and $36.47m favourable for the year. Most of this variance is a consequence of new and/or changes in Ministry initiatives introduced after budgets had been set and have equivalent expenditure variances that offset.

The Funder NGO Revenue

Funder NGO revenue variance was $4.42m favourable for the month and $22.62m favourable for the year. The variance for the year consists of $4.91m favourable in baseline revenue, $3.05m favourable in CFA variations/contracts revenue and $14.66m favourable in Other Government revenue.

The $4.91m favourable variance for the year in baseline revenue is mainly due to the post budget funding by the Ministry for the Mental Health Pay Equity Settlement and the 2017-18 In Between Travel wash up, partially offset by a reduction in the 2018-19 In Between Travel wash up revenue.

The $3.05m favourable variance for the year in CFA/Contracts revenue is a result of additional revenue for funding new Primary Health Initiatives relating to Zero Fees for Under 14s, Community Service Card holders and reduction in First Contact Care.

The $14.66m favourable variance for the year in Other Government revenue is mainly due to revenue received from PHARMAC relating to the new Ministry Combined Pharmaceutical Budget (CPB) strategy. DHBs are now receiving revenue from PHARMAC that is being funded out of what was previously budgeted and funded as CPB Drug rebate. This had been accounted for as a rebate offset in pharmaceutical expenditure as was budgeted, but has now been accounted for as revenue (unbudgeted).

Funder Own Provider Revenue

The Funder Own Provider revenue variance was $0.27m favourable for the month and $12.51m favourable for the year. The variance for the year consists of a $3.50m favourable variance in baseline revenue, a $5.54m favourable variance in CFA variations/contracts revenue and a $3.47m favourable variance in Other Government revenue.

The $3.50m favourable YTD variance in baseline revenue is mainly due to the Mental Health component of MECA settlements.

The $5.54m favourable YTD variance in CFA variations/contracts revenue is mainly due to the Personal Health component of the MECA settlements and the Safe Nursing funding.

The $3.47m favourable YTD variance in Other Government revenue is related to the CPB policy change mentioned earlier and results from the unbudgeted Hospital Medicines rebate component of the CPB rebate received as a combined rebate to the Funder rather than separately to the Provider Arm.

Funder IDF Revenue

The $1.21m favourable variance for the year in Funder IDF relates to the 2017-18 National MOH IDF wash-up process which was settled in October 2018 for $534k, as well as the 2018-19 National MOH IDF position wash up which was advised by the Ministry and will be settled in October 2019 for $593k. There was $83K of 2018-19 wash up variances for PHO capitation and FFS Deduction.

FUNDER TOTAL EXPENDITURE

The Funder total net expenditure variance was $9.02m favourable for the month and $12.05m adverse for the year. The full year expenditure variance consists of a $6.35m adverse in Funder NGO expenditure, $12.22m adverse variance in Funder Own Provider expenditure, $6.65m favourable in Funder IDF outflow expenditure and $0.13m adverse in Funder Governance expenditure.

Of note and as previously explained, the most significant variance drivers within Funder have a converse and equivalent offset either between Funder divisions and/or between Funder revenue and Funder expenditure. As a consequence, Funder revenue and expenditure variances can be relatively large but with little or no impact on the Funder Core Result. The main and underlying cause of such offsetting variances are Ministry funded strategies that are implemented after budgets have been finalised.

Funder NGO Expenditure

The $6.35m adverse variance for the year in Funder NGO expenditure is the net consolidated position across all services. The key adverse component of the variance is a consequence of Pharmaceutical expenditure and mostly driven by the previously explained PHARMAC/MOH CPB strategy. Budgeted CPB drug rebate funding, which was budgeted as an offset (reduction) against Community Pharmacy expenditure, is now accounted for as revenue. This is a post budget change which results in a significant favourable revenue variance, offset by an equivalent significant adverse expenditure variance.

This notwithstanding, the month and year to date variances are contributed to by the normally expected variations in business as usual factors across Funder NGO services. The business as usual variances mostly arise out of variations in demand/utilisation within Community Pharmacy, GP Demand, Age Related Residential Care (ARRC) and Primary Health Organisations (PHO) noting that these services constitute the most substantial component of Funder NGO expenditure.

As previously explained there are also the standard variances related to new Ministry Funded Initiatives expenditure (initiated after budgets had been set) that are offset by equivalent revenue variances and have a nil net impact on the core result. Funded initiatives variances include the variations in Pay Equity and new expenditure for Primary Health Initiatives relating to Zero Fees for Under 14s, Community Service Card holders and reduction in First Contact Care. Conversely there is also the favourable impact relating to budgeted Funder NGO initiatives not yet contracted. Other factors influencing the NGO variances include adjustments in PHO expenditure related to patients and GP practices moving between DHBs with the equivalent offsetting variances in IDF Outflows.

Funder Own Provider Expenditure

The $12.22m adverse variance for the year in Funder Own Provider expenditure mostly relates to the additional funding allocated (paid) to the Provider Arm for the NZNO Nursing Settlement, the PSA Nurses MECA Settlement, the PSA Allied MECA Settlement, Safe Nursing Funding and Capital Charge Revaluation 2018-19.

Funder IDF Expenditure

The net total $6.65m favourable variance for the year in Funder IDF expenditure mostly results from IDF wash-up processes between DHBs. These include a favourable variance of $6.62m relating to the 2018/19 National Ministry IDF wash-up process, a favourable variance of $1.02m relating to prior year wash-up processes, a favourable variance of $5.12m resulting from 2018-19 PHO expenditure

adjustments related to patient and GP practices moving between DHBs and an unfavourable variance of $6.05M relating to 2018/19 PHO capitation quarterly wash-ups.

4. Provider Arm Commentary on Financial Performance

4.1 Financial Statement

Table 4: Summary of Provider Arm Financial Performance for June 2019

PROVIDER ARM FINANCIAL PERFORMANCE							
$ 000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Crown	78,086	75,794	2,292	926,018	909,648	16,370	909,648
Other	2,864	2,493	371	29,808	29,482	327	29,482
Total Revenue	80,950	78,287	2,663	955,826	939,130	16,696	939,130
EXPENDITURE							
Personnel	61,391	51,440	-9,951	678,182	646,775	-31,407	646,775
Outsourced Personnel	1,810	1,074	-736	19,022	12,955	-6,066	12,955
Outsourced Services	4,846	4,607	-239	57,941	56,555	-1,385	56,555
Clinical Supplies	10,070	10,783	713	127,420	126,343	-1,078	126,343
Infrastructure & Non-Clinical Supplies	14,140	3,920	-10,220	124,786	118,201	-6,584	118,201
Total Expense	92,257	71,824	-20,433	1,007,350	960,830	-46,521	960,830
Provider Result : Surplus / (Deficit)	-11,307	6,463	-17,770	-51,524	-21,700	-29,824	-21,700

The deficit in June 2019 was $11.3m, unfavourable by $17.8m against a budget surplus of $6.4m.

The full year deficit for 2018/19 was $51.5m, unfavourable by $29.8m against a budget deficit of $21.7m.

4.2 Service Commentary on YTD result

Table 5: Provider Arm Financial Performance for June 2019 by Service

$000's	Direct Revenue YTD			Direct Expenditure YTD			Total
	Actual	Budget	Variance	Actual	Budget	Variance	Variance
PROVIDER ARM FINANCIAL PERFORMANCE YTD							
Acute & Emerg Medicine	4,032	3,578	454	150,889	144,913	-5,975	-5,522
Sub Specialty Med HOPS	8,626	9,150	-524	98,790	96,227	-2,564	-3,088
Surgical Services	9,418	8,274	1,144	182,306	180,900	-1,406	-262
ESC	0	0	0	27,749	27,988	239	239
Child, Women & Family	7,204	7,190	13	95,240	95,000	-240	-226
Mental Health	8,278	5,775	2,504	142,144	137,008	-5,136	-2,632
Corporate & Provider Support	918,268	905,162	13,106	310,233	278,794	-31,439	-18,333
Total Provider	955,826	939,130	16,696	1,007,350	960,830	-46,521	-29,824

Acute and Emergency Medicine – YTD $5.5m unfavourable to budget

The unfavourable variance was driven by:

- Premium cover costs for medical staff
- Additional sessions to shorten the patient waiting lists
- RMO strike cover cost for senior medical officers

The service has a number of initiatives to get back on track in the next financial year including flexing beds, managing staff turnover, a review of patient watches, nursing models of care in ED.

Specialty Medicine and Health of Older Persons Services – YTD $3.1m unfavourable to budget

The unfavourable variance was driven by:

- Increased patient watches in the Kingsley Mortimer Unit
- Increased demands in district nursing
- Increased demand for mobility aids

The service has a number of initiatives to get back on track in the next financial year including a review of ACC events, and enhanced services for mobility aid managements.

Surgical and Ambulatory Services – YTD $0.3m unfavourable to budget

While tracking close to budget overall, the service continues to benefit financially from additional revenues from orthopaedic ACC cases. In the financial year lower volumes were attributed to the impact of industrial action, acute bed encroachment from medical services, and a shortfall in discharges due to vacancies in the AIR and ORL services. Offsetting this, additional costs have been incurred with over-allocations of registrars, outsourced skin lesions, and unplanned repairs and maintenance costs. The service has absorbed cost pressures in the last few months to ensure Elective Services Performance Indicators (ESPI) compliance, plans to deliver to plan on outsourced MRI and ultrasound scans, and unbudgeted outsourced costs to meet Interventional Radiology demands that exceed internal capacity.

Elective Surgery Centre (ESC) – YTD $0.2m favourable to budget

Three factors have reduced the capacity to deliver to plan:

- Industrial action
- Acute bed encroachment at North Shore Hospital impacting ESC
- Holiday closure

The under delivery has resulted in a favourable financial variance from lower costs. Offsetting this, the service has realised higher than budgeted non-volume related clinical supplies e.g. repairs and maintenance and minor purchases.

Child, Women and Family Services – YTD $0.2m unfavourable to budget

The unfavourable variance was driven by:

- On-going patient demand driven cost increases across predominately Maternity (antenatal assessments and caesarean section activity) and Neonatal services involving use of external staffing resource and overtime to cover vacancies and roster gaps
- Cleaning outsourced costs
- Patient food
- Increased maintenance costs in the mobile dental units and fixed dental facilities.

These cost increases have been partly mitigated by service wide vacancies and an improved revenue position. The service remains focused on achieving its identified cost reduction initiatives in the next financial year. Examples of these being: the Auckland Regional Dental Services' transition to an electronic based patient communication platform as part of the overarching Outpatient Flow Tool initiative (traditional postage to email); renegotiation of service contracts and product pricing reviews.

Specialist Mental Health and Addiction Services – YTD $2.6m unfavourable to budget

The unfavourable variance was driven by:

- Use of locums and overtime to cover medical vacancies
- Increasingly acute caseloads

This is particularly the case in the Rodney region, both for adult and child and youth specialist psychiatrists. There remains a difficulty recruiting to nursing vacancies, again specifically in more specialist areas such as child and youth as well as intellectual disability. In addition, vacancies in both the adult inpatient units and forensics are covered with overtime rates which are paid at a premium. To minimise vacancies, a Retention and Recruitment Committee continues to explore and implement initiatives to attract and retain staff.

Corporate and Provider Arm Support Services – YTD $18.3m unfavourable to budget

Revenue is favourable $13.1m due to:

- Additional revenue from MoH for Care Capacity and Demand Management (CCDM)
- Capital Charge and MECA settlements
- Consolidated revenue from Three Harbours Health Foundation
- Additional cost recoveries from other DHBs
- Interest income

Expenditure is unfavourable $31.4m due to:

- Holiday Pay Act and other employee related provisions
- Lag in implementing some of the financial sustainability initiatives, including $6.0m budgeted benefit from the sale of Taharoto Road.

5. Waitematā DHB Financial Position

5.1 Summary of Financial Position

Table 6: Summary financial position as at June 2019

$000's	30th Jun 2019			May-19	Variance to	Jun-18
	Actual	Budget	Variance	Actual	Last Month	Actual
Crown Equity	**604,899**	**606,125**	**(1,226)**	**598,147**	**6,752**	**613,126**
Represented by:						
Cash & Bank Balances	36,685	7,526	29,159	36,685	0	29,078
Other Current Assets	88,399	82,967	5,432	89,109	-710	63,872
Current Liabilities	-254,822	-231,125	-23,697	-268,577	13,755	-241,042
Net Working Capital	**-129,738**	**-140,632**	**10,894**	**-142,783**	**13,045**	**-148,092**
Fixed Assets	727,526	735,655	-8,129	727,526	0	751,387
Long Term Investments in Associates	42,958	44,578	-1,620	44,582	-1,624	43,277
Term Liabilities	-35,848	-33,476	-2,372	-31,179	-4,669	-33,446
Total Employment of Capital	**604,899**	**606,125**	**-1,226**	**598,146**	**6,752**	**613,126**

5.2 Financial Position Commentary

The negative Net Working Capital balance of $129.7m at 30th June 2019 is expected, due to the nature of current liabilities including annual leave provisions and the current portion of other staff entitlements, such as continuing medical entitlements (CME). While these liabilities are considered current, any significant draw down is considered unlikely as accrued entitlements tend to offset leave claims over time.

The Cash and Bank balance of $36.7m at 30th June 2019 was favourable by $29.2m, against the budgeted cash balance of $7.5m, and represents an increase in cash during the year of $7.5m. The favourable variance in cash is driven primarily by timing of capital expenditure being incurred of $6.5m.

Offsetting the above favourable variances is a $19.1m unfavourable variance in personnel payments due to MECA impacts and in-year additional FTE appointments, approved after the formation of the annual plan, and necessary in order to maintain safe clinical services. The higher personnel payments have been partially offset by additional funding support from the MoH.

5.3 Detailed Statement of Cash Flow

Table 7: Detailed Statement of Cash Flow as at June 2019

$000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Cash flows from operating activities:						
Inflows						
Crown	160,171	147,442	12,729	1,803,450	1,761,753	41,697
Interest Received	184	133	51	2,267	1,803	464
Other Revenue	7,046	2,512	4,534	30,854	33,940	-3,086
Outflows						
Staff	57,095	53,861	-3,234	677,605	658,527	-19,078
Suppliers	35,859	20,562	-15,297	258,672	246,976	-11,696
Other Providers	58,474	70,089	11,615	829,431	841,425	11,994
Capital Charge	18,089	18,474	385	36,415	36,948	533
GST (net)	-1,113	0	1,113	159	639	480
Net cash from Operations	**-1,003**	**-12,899**	**11,896**	**34,289**	**12,981**	**21,308**
Cash flows from investing activities:						
Outflows						
Capital Expenditure	4,356	3,215	-1,141	28,069	34,533	6,464
Investments	-473	0	473	813	0	-813
Net cash from Investing	**-3,883**	**-3,215**	**-668**	**-28,882**	**-34,533**	**5,651**
Cash flows from financing activities:						
Inflows						
Equity Injections	2,200	0	0	2,200	0	0
New Debt	0	0	0	0	0	0
Deposits Recovered	10,000	0	10,000	0	0	0
Outflows			0			
Interest Paid	0	0	0	0	0	0
Funds to Deposit	0	0	0	0	0	0
Net cash from Financing	**12,200**	**0**	**10,000**	**2,200**	**0**	**0**
Net increase / (decrease)	**7,314**	**-16,114**	**23,428**	**7,607**	**-21,552**	**29,159**
Opening cash	**29,371**	**23,640**	**5,731**	**29,078**	**29,078**	**0**
Closing cash	**36,685**	**7,526**	**29,159**	**36,685**	**7,526**	**29,159**
Closing Cash Balance in HBL Sweep acco	**36,685**	**7,526**	**29,159**	**36,685**	**7,526**	**29,159**

6. Statement of Capital Expenditure

Expenditure on the development of major capital programmes is assumed to be recouped from the Crown, and as such, is being funded from cash reserves outside of the capital envelope. The Portfolio Investment Committee continues to robustly prioritise all investment requests to ensure that best value is achieved from the available capital budget.

Table 8: Summary of Capital Expenditure as at June 2019

$000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
Capital Expenditure							
Land	0	0	0	0	0	0	0
Buildings & Plant	1,244	1,204	-40	12,046	13,957	1,911	13,957
Clinical Equipment	169	1,103	934	5,594	13,227	7,633	13,227
Other Equipment	161	343	182	2,009	4,105	2,096	4,105
Information Technology	271	0	-271	2,819	400	-2,419	400
Motor Vehicles	73	230	157	521	2,844	2,323	2,844
Total Capital Expenditure	1,918	2,880	962	22,989	34,533	11,544	34,533

7. Clinical Activity

YTD ED attendances are 1.1% higher than this time last year.

YTD acute volume WIES are 1.0% higher than this time last year. The budget was set in anticipation of 2.9% increase. The lower than planned acute volumes (WIES) are despite the seasonal demands last winter.

YTD elective volume WIES are 5.3% less than this time last year.
Lower than planned volumes are attributed to a difficult and challenging year, directly influenced by nursing strikes and unprecedented acute surgery encroachment, especially within Orthopaedics. This was coupled with an inability to recruit in the AIR and ORL services, which has contributed to a further 350+ lost discharges.

7.1 Clinical Activity Scorecard

Table 9: Clinical Scorecard for June

CLINICAL ACTIVITY	Month			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
ED Attendances	9,741	9,771	30	114,643	111,222	-3,421	114,643	111,222	-3,421
Acute Volumes (WIES)	5,422	5,437	15	66,051	66,149	99	66,051	66,149	99
Elective Volumes (WIES)	1,452	1,529	-77	17,536	18,246	-711	17,536	18,246	-711

ED (emergency department) attendance figures are per the activity volume report (AVR) excluding primary care voucher attendances

A negative variance in ED Attendances reflects higher than planned presentations

A positive variances in Acute Volumes (WIES) reflects a lower than planned acute demand

A negative variance in Elective Volumes (WIES) reflects under delivery

7.1 The Wai 2575 - Health Services and Outcomes Waitangi Tribunal Inquiry Update

Recommendation:

The the Board receives the Wai 2575 Health Services and Outcomes Kaupapa Inquiry Pre-Publication Stage One Report, and in particular, consider the points as noted.

Prepared by: Riki Nia Nia (General Manager, Māori Health)
Endorsed by: Dr Dale Bramley (Chief Executive Officer)

1. Background

This paper has been put together at the requet of the Chief Executive to update the Board on the outcome of the Wai 2575 Health Services and Outcomes Kaupapa Inquiry Pre-Publication Stage One Report.

The Wai 2575 - Health Services and Outcomes Waitangi Tribunal Inquiry commenced in October, 2018. The inquiry is concerned with grievances relating to health services and outcomes of national significance. There were over 200 claims seeking to participate in the inquiry by December 2017.

The inquiry has been broken into three stages. Stage One (with hearings running from October to December 2018 and closed in March 2019) inquired into aspects of primary care. Stage two will cover three priority areas encompassing mental health (including suicide and self-harm), Māori with disabilities, and issues of alcohol, tobacco, and substance abuse.

Stage two will begin later in 2019 with a focus on Māori mental health, disabilities, and alcohol and substance abuse. There are a wide range of claims, including elders who are supporting people impacted by drug dependency, dentists, Māori health providers, professional bodies and personal claims to the Tribunal.

The Tribunal is also expecting to receive the following Crown funded research to aid its stage two inquiry:

- Māori Disability Statistical Status Report (due 30 June 2019); and
- Historical Health Overview Report 1840-1992 (due 20 August 2019).

Following the receipt of all research reports, the Tribunal anticipates holding a judicial conference, to discuss more detailed planning for the stage two inquiries.

It is intended that stage three will focus on further themes of national significance, including eligible historical claims, and will be refined pending the outcomes of stages one and two.

Outline of Stage One

The task of the Waitangi Tribunal in Stage One was to focus on the legislative and policy framework of New Zealand's primary health care system and its alleged flaws, when assessed against the principles of the Treaty of Waitangi. Four specific areas were focussed on: the Treaty-compliance of

the Act and framework; funding; accountability; and the nature of Treaty partnership arrangements in the primary health care sector.

The Hearings for Stage One have now been concluded by the Tribunal. This has resulted in the release of the *HAUORA: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Pre-publication Version*) by the Waitangi Tribunal.

The two claims considered in this stage were made on behalf of several individuals and groups and on behalf of all Māori. However, the official named claimants were Māori Primary Health Organisations and Providers claim (Wai 1315) and The National Hauora Coalition claim (Wai 2687).

At the core of collective claimants grievances, was the notion that Māori health inequities are so serious and persistent and the Crown's response so pitifully inadequate, that there can be no doubt that the Crown has breached its Treaty obligations to Māori. The claimants also felt that the structure and operation of the current primary health care system is failing Māori and is blighted by institutional racism (i.e. inaction in the face of need). There was a collective call to act now. There was limited support to give the Crown more time to try and fix the issues and a feeling expressed that tinkering with the current system will not be sufficient and radical reform is required.

2. Stage One – Findings and Recommendations

The Stage One Report of findings has now been released and has aimed to address claims concerning the way the primary health care system in New Zealand has been legislated, administered, funded and monitored by the Crown since the passing of the New Zealand Public Health and Disability Act 2000 (the Act).

In each of the areas investigated, the Waitangi Tribunal found that the Crown acted inconsistently with the principles of the Treaty. They found that the claims of the Māori Primary Health Organisations and Providers (Wai 1315) and the National Hauora Coalition (Wai 2687) are well-founded.

The Stage One report's discussion, analysis and conclusions on central aspects of the primary health care framework will provide a foundation for the remainder of the three stages of this Kaupapa Hauora inquiry.

Stage One Table of findings

The following table outlines the key findings made by the Waitangi Tribunal into Stage One of the Health Services and Outcomes Kaupapa Inquiry.

Summary of the Tribunal findings outlined in the Hauora report	
Findings on the legislative, strategy and policy framework	• The legislative, strategy and policy framework for primary health care has failed to state a commitment to achieving equity of health outcomes for Māori. • The Act does not work effectively in affording Māori consistent control of decision making in relation to health

	service design and delivery. • The omission of specific Treaty references in lower level documents has led to a concerning omission of the health sectors treaty obligations.
Findings on the funding framework for primary care	• The funding arrangements for primary health care disadvantage PHOs and providers that predominantly serve high need populations, particularly Māori PHOs. • The Crown has been aware of these failures and has failed to amend or replace the current funding arrangement.
Findings on accountability measures	• The Crown does not collect sufficient qualitative or quantitative data to fully inform how the primary health care system is performing in relation to Māori health, • The data collected is not used effectively and is not accessible and understandable by the public, • Te Puni Kōkiri has failed to carry out its statutory duty to monitor the health sector by failing to conduct agency reviews.
Findings on Māori governance, leadership and participation	• The Crown did not design the primary health care framework in partnership with Māori. • Māori are significantly under represented across the health sector and in the Ministry of Health. • DHB General Managers, Māori health, have very minimal budget holding functions. • DHB executive and DHB governance arrangements do not reflect the Treaty partnership. • DHB Māori relationship Boards do not have statutory recognition and the extent of their role and influence upon DHB operations is variable.

A key finding for DHBs

The Board should note a key finding made by the Waitangi Tribunal was that there were several breaches in relation to district health board governance and concluded that the governance arrangements for district health boards do not when taken together reflect the Treaty partnership. Māori members of district health boards are always in the minority and do not necessarily reflect mana whenua interests nor the Māori population or the district they serve. Ultimately, board members are appointed by and answerable to the Minister of Health, which does not reflect a true partnership model. While every district health board partners with a Māori relationship board, these arrangements do not have statutory recognition and the extent of their role and influence upon the operation of district health boards varies considerably throughout the country.

Wai 2575 - Health Services and Outcomes Waitangi Tribunal Stage One Recommendation:

In the Waitangi Tribunal report on Stage One there are a range of recommendations proposing interim, operational, structural and legislative change. There are operational recommendations which could be progressed within existing levers. There are interim recommendations, which while operational in their current intent, are likely to have big implications in the future and there are legislative and policy recommendations. The response to these is likely to be influenced by various inquiries and reviews currently underway. For example, the Health and Disability review currently underway.

It is important to note that Stage One is the first of a three stage process, as such, how the government responds to the Stage One recommendations is likely to set precedent for the later stages. It is also likely that the Government will give this matter serious consideration before responding formally to the Waitangi Tribunal Findings. It is also important to note that:

1. The current Government has a goal to achieve a strong public health care system and improved and more equitable outcomes for New Zealanders. This has led to both the Ministry of Health and the Health Quality and Safety Commission of New Zealand being more deliberate with their endeavours in the Health Equity space.

2. The New Zealand Health and Disability System is under a wide-ranging review, designed to future-proof our health and disability services and has appointed Ms Heather Simpson as Chair of the review. A final report is expected by 31 March 2020. The Review will focus on the future needs of New Zealanders and make recommendations on changes to the Health and Disability system, to ensure all New Zealander's have confidence that the system will assist them and their families to live well.

In 2018, the Ministry of Health initiated a work programme on achieving equity in health outcomes. Specifically, this programme aims to ensure that equity is at the heart of the way New Zealand's health and disability system operates and to promote the cultural shift needed to achieve that. The Ministry of Health recently released a report entitled '*Achieving Equity Work Programme: The Discovery Phase'*, which provides a brief summary of phase one of the 'Achieving Equity Work in Health Outcomes: summary of a Discovery Process'. The aim of the discovery phase was to identify where practical and coordinated effort could be undertaken to achieve a measurable shift in health equity in the next three to five years.

The Ministry has committed to 'delivering the Government's goals of a strong public health care system and improved and more equitable outcomes for New Zealanders'. The Ministry is now integrating a focus on achieving equity in health and wellness across its work programme and sector accountabilities. It has charged its new executive-led Outcomes and Equity Committee with governing on-going efforts in this area. The Committee's role includes oversight, accountability and key decision-making, in terms of the equity and outcomes components of the Ministry's stewardship role, at a system and organisational level (Ministry of Health 2018c). This report can be found at: **https://www.health.govt.nz/publication/achieving-equity-health-outcomes-summary-discovery-process**

The Health Quality Safety Commission (HQSC) has recently published a report entitled – '*A Window on the Quality of Aotearoa New Zealand's Health Care 2019*'. The report has been driven by the Minister of Health stating that the health sector should commit to achieving health equity for Māori across the life course and to meeting the obligations of Te Tiriti o Waitangi. 'A window on the quality of Aotearoa New Zealand's Health Care 2019' (Window 2019) – a view on Māori health equity aims to support the health system to meet these requirements. Window 2019 provides an evidence-

informed discussion, framed around three key questions: What are the health inequities between Māori and non-Māori? Why are there health inequities between Māori and non-Māori? How do we resolve health inequities between Māori and non-Māori and advance Māori health?

The consistent and key messages of Window 2019 are that the health system must acknowledge and understand inequities and commit to equity and Māori health advancement by enabling services where needed, identifying and removing institutional racism from our organisations and services, and arming our services, organisations and staff with the knowledge, tools and official sanction to do this work.

The view of the HQSC is that the health system requires Māori leadership and partnership to improve access, service and treatment quality and to make improvement efforts more successful. Māori are also needed in every sphere of the health system to ensure Māori strategic input is well implemented.

Te Tiriti o Waitangi provides a clear pathway to build the relationships between the Crown and Māori that are required to address institutional racism, advance Māori health and achieve health equity for Māori and non-Māori. The challenge is to implement the promise of Te Tiriti by tackling inequities through policies, programmes and services that work for Māori. By meeting our responsibilities in these areas, we prioritise wellbeing, promote Māori capability and advancement, and support the future health, education, cultural, social and economic aspirations of whānau. This report can be found at:

https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3721/

It is important that the Board note the above context when considering the Wai 2575 - Health Services and Outcomes Waitangi Tribunal Stage One Recommendation.

Operational recommendations outlined in the Hauora report		
Chapter	**Focus area**	**Recommendation**
9.3.1	**Treaty of Waitangi principles**	9.3.1, a commitment to the Treaty is stated in all documents that make up the primary health system: the strategies, the plans and lower level documents reflecting the Treaty principles for the primary health care system (i.e. Tino rangatiratanga, equity, active protection, options, and partnership).
9.3.2	**Equity**	9.3.2, a commitment to achieve equitable health outcomes for Māori is expressed stated in all documents that make up the primary health system: the strategies, the plans and lower level documents.
9.5.2	**Accountability**	• 9.5.2, reviewing and strengthening accountability mechanisms and processes in the primary health sector which impact Māori • 9.5.2, co-design the Māori health action plan with Māori experts, including the claimants

		• 9.5.2 (a), co-design a primary health research agenda with Māori experts and claimants • 9.5.2 (b), collect robust quantitative and qualitative primary care data and information relevant to Māori health outcomes • 9.5.2 (c), measures specific to Māori and publically report against them in an accessible and easy to understand way, • 9.5.2 (d), DHBs and PHOs prepare and make available their annual Māori health plan, which have national minimum requirements that are set and monitored by the Ministry • 9.5.2 (e), all health sector contracting documents should reference the Treaty of Waitangi and its principles, reflecting the principles for the primary health care system
9.5.3	**A Treaty compliant framework**	9.5.3, the Crown review, with a view to redesign, its current partnership arrangements across all levels of the primary health care sector.
Structural, legislative and policy recommendations outlined in the Hauora report		
9.4	**Structural reform**	• 9.4, the Crown commits to exploring the concept of a stand-alone Māori primary health authority, and • 9.4 (a), an interim recommendation to design a draft terms of reference to explore the possibility of a stand-alone Māori health authority, by 20 January 2020.
9.3.1	**Treaty of Waitangi**	9.3.1, amendments to the New Zealand Public Health and Disability Act 2000 (the Act) to read *'this Act shall be interpreted and administered so as to give effect to the Treaty of Waitangi'*
9.3.2	**Equity**	9.3.2, the Crown commits to achieving equitable health outcomes for Māori, with amendments made to the Act to read: *'to achieve equitable health outcomes for Māori and other populations',*
9.5.1	**Funding**	9.5.1, conduct an urgent review of the funding for primary health care, to better align with the aim of achieving equitable health outcomes for Māori, and 9.5.1 (a), an interim recommendation for the Ministry and Claimants to agree upon a methodology for assessing historical underfunding since 2000, by 20 January 2020.
9.5.2	**Accountability**	• 9.5.2, amend section 8(4) of the Act to include

		reporting on progress against implementing He Korowai Oranga: the Māori health strategy
		9.5.2 (f), review, with a view to redesign, the current arrangements for the monitoring of the Ministry by external agencies, intended to ensure sufficiency of design and delivery of health services to Māori.
9.5.4	**Acknowledgment from the Crown**	9.5.4, acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health system to improve Māori health outcomes since the commencement of the Act.

Iwi Relationships in Our DHB Region

It is important to note that Auckland and Waitematā DHBs are working closely with Northland DHB to advance our relationships with iwi Māori. Each DHB has longstanding relationships with iwi. Our collective endeavour is to advance these relationships to a regional Treaty based partnership that recognises the mana of all partners for achieving Māori health outcomes. This partnership with iwi is an opportunity to enable the co-design, commissioning and delivery of hauora services that are valued by whānau Māori in our region. A further meeting is proposed for September 2019.

3. Summary

The purpose of this report was to update the Board on progress being made by the Waitangi Tribunal in relation to the Wai 2575 - Health Services and Outcomes Waitangi Tribunal Inquiry.

The report primarily focussed on updating the Board on:

a. Stage One Findings
b. Stage One Recommendations
c. The Government's Intentions to achieve a strong public health care system and improved and more equitable outcomes for New Zealanders by making changes to the Health and Disability system to ensure all New Zealander's have confidence that the system will assist them and their families to live well.

The Board should note that an important endeavour being progressed in our region presently is to advance relationships with Iwi. This endeavour provides the potential for the Board to front foot a joint response to Health Services and Outcomes Waitangi Tribunal Inquiry Stage One and future findings.

Regardless, the Stage One findings provide the Board an opportunity to assess whether its current approach can be improved upon.

Attachment: Appendix 1 - *Chronology of the New Zealand Health System 1840 to 2017*

Appendix 1
Chronology of the New Zealand Health System 1840 to 2017

OFFICIAL

1840–1849

Key Events

Signing of Te Tiriti ō Waitangi – Treaty of Waitangi (1840)

Discussions on subsidises for treating Māori (1840s)

Hospital institution (presumed to be military) established in Auckland (1841)

Official counting of the population began (1842)

Māori leaders petition government for hospital (1844)

New Zealand Land Wars began (1845)

Funding for Māori hospitals allocated (1846)

First hospitals commissioned (1846)

Funding granted for the erection of hospitals in Auckland, Wellington, Whanganui and Taranaki (1846)

First public hospital in New Zealand opened in Wellington (1847)

Māori use of hospitals evident from outset (1848)

Legislation

Municipal Corporation Act 1842 – to provide for 'the good order health and convenience of towns and their neighbourhoods'.

Harbour Act 1842 – to provide for the regulation of harbours for quarantine purposes

Coroners Act 1846

Lunatics Act 1846

Registration Act 1847

Medical Practitioners Act 1849

Public Health

First known case of smallpox via ship landed in Lambton Harbour (1840)

Release of a pamphlet on smallpox in Māori (1849)

Health Workforce

First Colonial Surgeon appointed (1841)

1850–1859

Key Events

Official national population census held (1851)

First meeting of Parliament in 1854

Medical assistance for Natives discussed in Parliament (1855)

Hospital in New Plymouth classed as tapu, leading to the hospital providing mainly outpatient service (1857)

First attempt to count Māori population (1857)

Legislation

Regulations gazetted amplifying provisions for quarantine 1854

Public Reserves Act 1854

Registration Act 1858

Coroners Act 1858

Public Health

Formation of Central Board of Vaccination for the Aborigines of New Zealand (1854)

Scarlet fever and measles outbreaks (1854)

Health Workforce

Appointment of qualified doctors solely as Native Medical Attendants (1857)

Policy

Funding assigned for Māori Medical Care under the New Zealand Constitution Act 1852 (UK)

1860–1869

Key Events

Influx of immigrants increases hospital demand (1861)

Return of George Grey as Governor (1862)

Land given in Te Awamutu for native hospital (1862)

Discussions about a hospital for Māori in Rotorua (1862)

New Zealand Government now responsible for Māori affairs (1863)

Legislation

Native Purposes Appropriation Act 1862

Marine Board Act 1863

Vaccination Act 1863

Lunatics Act 1866

Coroners Act 1867

Māori Representation Act 1867

Medical Practitioners Act 1867

Medical Practitioners' Registration Act 1867

Harbour and Quarantine Regulations for the ports of New Zealand 1868

Lunatics Act 1868

Contagious Diseases Act 1869

Medical Practitioners' Registration Act 1869

Public Health

Typhoid appeared as epidemic disease (1860)

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1870–1879

Key Events

Māori land wars ended (1872)

A central Board of Health for entire colony established under the Public Health Act 1876

Administrative and financial control of hospitals taken over by central Government (1876)

Control of asylums taken over by central Government (1876)

Legislation

Vaccination Act 1871

Public Health Act 1872

Registration of Births and Deaths Act 1875

Anatomy Act 1875

Public Health Act 1876

Public Health Act 1876 Amendment Act 1877

Tobacco Act 1879

Public Health

Smallpox outbreaks – Auckland and Wellington (1872)

Whooping cough epidemic (1873)

Cromwell has typhoid outbreak (1874)

Measles epidemic (1874)

Health Workforce

Otago Medical School established under Anatomy Act 1875

Chronology of the New Zealand Health System 1840 to 2017

1880–1889

Key Events

Native Schools Code teachers supplied with simple medicine (1880)

First report on New Zealand hospitals (1882)

Compulsory health education for Māori proposed (1884)

Discussion around hospitals for Ngāi Tahu (1887)

Legislation

Dentists Act 1880

Pharmacy Act 1880

Public Health Act 1876, Amendment Act 1881

Dentists Act 1880 Amendment Act 1881

Public Health Act 1876 Amendment Act 1882

Cemeteries Act 1882

Lunatics Act 1882

Public Health Act 1876 Amendment Act 1884

Hospitals and Charitable Institutions Act 1885

Pharmacy Act 1880 Amendment Act 1887

Public Health

Measles epidemic – Otago, Canterbury, Auckland, Wellington and Hawke's Bay (1881)

Typhoid epidemic (1888)

Health Workforce

First inspector of hospitals and asylums Dr Graham (1882)

Formation of New Zealand Medical Association (1886)

1890–1899

Key Events

First political party (Liberal Party) is formed (1890)

Native Department abolished (1892)

Women's suffrage movement (1893)

Police officers instructed to watch tohunga (1899)

Legislation

Lunatics Act Amendment Act 1891

Dentists Act Amendment Act 1891

Public Health Act 1876 Amendment Act 1893

Alcoholic Liquors Sale Control Act 1893

Lunatics Act Amendment Act 1894

Lunatics Act Amendment Act 1895

Alcoholic Liquors Inspections Act 1896

Pharmacy Act 1898

Public Health

Dr Walter Fell reviews quarantine regulations (1891)

Measles epidemic (1893)

Mrs Grace Neill appointed Assistant Inspector of Hospitals (1895)

Measles epidemic (1898)

Health Workforce

Tutere Wirepa and Peter Buck receive Māori medical scholarships (1898)

1900–1909

Key Events

Establishment of Department of Public Health (1901)

Suggestion to move matters pertaining to Māori health to Department of Public Health (1901)

Department of Public Health takes full responsibility for Māori health (1906)

Department of Native Affairs re-established (1906)

Native Department re-established (1906)

Establishment of Mental Hospitals Department (1908)

Māori medical services returned to Native Affairs (1909)

Legislation

Bubonic Plague Prevention Act 1900

Lunatics Act Amendment Act 1900

Public Health Act 1900

Māori Councils Act 1900

Hospital and Charitable Aid Boards Act 1900

Public Health Amendment Act 1901

Public Health Amendment Act 1901 (No.2)

Nurses Registration Act 1901

Public Health Amendment Act 1902

Public Health Amendment Act 1903

Juvenile Smoking Suppression Act 1903

Public Health Amendment Act 1904

Midwives Act 1904

Dentists Act 1904

Medical Practitioners Registration Act 1905

Habitual Drunkards Act 1906

Private Hospitals Act 1906

Infant Life Protection Act 1907

Public Health Amendment Act 1907

Tohunga Suppression Act 1907

Hospital and Charitable Institutions Act 1907

Public Health Act 1908 (consolidation Act)

Legislation continued

Medical Act 1908 (consolidation Act)

Quackery Prevention Act 1908

Dentists Act 1908 (consolidation Act)

Lunatics Act 1908 (consolidation Act)

Hospital and Charitable Institutions Act 1908 (consolidation Act)

Mental Hospitals Reserves Act 1908

Hospital and Charitable Institutions Act 1909

Public Health

First death from plague (1900)

Central Board of Health suggested establishment of Department of Public Health (1900)

Inquiry into the sanitary condition of the colony (1900)

Tangi by-law restricting public tangi in order to contain infectious disease (1900)

Measles epidemic (1902)

Smallpox spread from Tasmania to Christchurch (1904)

Measles epidemic (1907)

Health Workforce

A Māori chief appointed as a Sanitary Commissioner (1900)

Dr J M Mason appointed Chief Health Officer (1900)

Maui Pomare appointed Chief Native Health Officer (1901)

First District Health Officers appointed (1901)

Māori inspectors appointed (1903)

Sanitary inspectors working among Māori (1904)

Dr Pomare assisted by Dr Peter Buck in Department of Native Affairs (1905)

Plunket Society founded (1906)

Akenehi Hei, first Māori registered nurse and midwife (1908)

District nurses replace Māori Health Inspectors (1909)

6 September 2017

Chronology of the New Zealand Health System 1840 to 2017

1910–1919

Key Events

Control of Māori health returned to Department of Public Health (1910)

Māori Nursing Service established as part of Health Department (1911)

Reform Party becomes the government (1912)

Separate registration of Māori birth and deaths introduced (1913)

School Medical Inspection Service started (1913)

World War I (1914–1918)

Royal Commission of Inquiry into New Zealand medical services (1919)

Proposals for complete reorganisation of Department of Health (1919)

First Children's Health Camp established by Dr Elizabeth Gunn to help children malnourished or suffering from tuberculosis (1919)

Legislation

Dentists Amendment Act 1910

Public Health Amendment Act 1910

Census and Statistics Act 1910

Mental Defectives Act 1911

Aged and Infirm Persons Protection Act 1912

Medical Practitioners Act 1914

Public Health Amendment Act 1915

Miner's Phthisis Act 1915

Sale of Liquor Restriction Act 1917

Social Hygiene Act 1917

Public Health Amendment Act 1918

Public Health Amendment Act 1919

Public Health

Infectious diseases control transferred from local authorities to hospital boards (1910)

Typhoid fever outbreak (Ahipara, Te Puke, South Waikato) (1910)

Typhoid – Gisborne, Rotorua, Taranaki and Auckland (1911)

Plague – 11 cases in Auckland (1911)

Typhoid – Bay of Islands, Waiapu, Piako and Katikati (1912)

Typhoid (93 cases) in Waiapu (1913)

Smallpox epidemic (1913)

Poliomyelitis made a notifiable disease (1914)

Typhoid outbreak – Auckland, Raetihi and Bay of Plenty) (1914)

Typhoid among Māori in Bay of Plenty (1916)

Poliomyelitis epidemic (1916)

Influenza pandemic (1918)

Royal Commission Report to investigate in influenza pandemic (1919)

Health Workforce

Dr Pomare resigned from Native Medical Services (1910)

Lord Kitchener advised on the need for an army nursing service (1912)

Compulsory medical inspection of children in state schools (1912)

Establishment of New Zealand Army Nursing Service (1915)

1920–1929

Key Events

Division of Māori Hygiene created in Department of Health (1920)

Māori Health Councils revived (1920)

New Zealand divided into 12 Health Districts (1927)

United Party elected to power (1928)

Opening of Māori Hospital – Mahinarangi, Turangawaewae, Ngāruawahia (Kingitanga – Tainui) (1929)

Legislation

Health Act 1920

Nurses and Midwives Registration Act 1925

Hospital and Charitable Institutions Act 1926 Amended 1928, 29, 32, 36

Dangerous Drugs Act 1927

Opticians Act 1928

Mental Defectives Amendment Act 1928

Public Health

Four deaths in six cases of puerperal sepsis in a Auckland Hospital aroused public alarm (1923) Poliomyelitis epidemic (1925)

Introduction of diphtheria immunisation (1925)

Survey of goitre incidence in schoolchildren by Sir Charles Hercus (1925)

Dr Blake-McLagan determined endemicity of goitre in New Zealand as manifested by school population (1926)

Bacillary Dysentery epidemic (1929)

Health Workforce

Peter Buck replaced as Director of Division of Māori Hygiene by Dr Edward Pohau Ellison (1927)

1930–1939

Key Events

Māori Hygiene Department abolished (1931)

Reform Party and United Party form a coalition government (1931)

Worldwide economic depression begins to affect New Zealand and the Department of Health (1931)

Hawke's Bay earthquake (1931)

Labour Party elected to government (1935)

Publication of *Tuberculosis in the Māori: East Coast of New Zealand* (1935)

New Zealand Federation of Health Camps formed (1936)

Women's Health League formed by nurse Ruby Cameron in the Rotorua District (1937)

Māori death rate: crude rate per thousand population was 24.31 for Māori compared with Pākehā rate of 9.71 (1938)

World War II (1939–1945)

Legislation

Hospital and Charitable Institutions Amendment Act 1932

Dentists Act 1936

Social Security Act 1938

Pharmacy Act 1939

Nurses and Midwives Registration Amendment Act 1939

Public Health

Immunisation against diphtheria (1937)

Distribution of milk in schools began (1937)

Measles epidemic (1938)

Sanitation campaign for Waikato providing toilets for Māori homes (1939)

Health Workforce

Medical Research Council of New Zealand established (1937)

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Chronology of the New Zealand Health System 1840 to 2017

1940–1949

Key Events

General Medical Services Benefit established (1941)

Social Security extends to maternity benefits (1941)

Extension of Social Security benefits to physiotherapy (1942)

Publication of new edition of *The Māori Mother and Her Child* (1942)

Māori Councils abolished and Tribal Executives established (1945)

Extension of outpatients benefits (1945)

Health benefits extended to include artificial limbs (1947)

National Party elected (1949)

Legislation

Health Amendment Act 1940

Medical Advertisements Act 1942

The Social Security (District Nursing Service) Regulation 1944

The Social Security (Hospital Benefits for out-patients) Regulations 1944

Nurses and Midwives Act 1945

Māori Social and Economic Advancement Act 1945

Coroners Act 1846

Lunatics Act 1846

Social Security Amendment Act 1947

Food and Drug Act 1947

Health Amendment Act 1947

Tuberculosis Act 1948

Physiotherapy Act 1949

Social Security Amendment Act 1949

Medical Practitioners Act 1849

Public Health

Division of Tuberculosis set up (1942)

Poliomyelitis epidemic (1947)

1950–1959

Key Events

Medical Research Council established (1950)

Survey of goitre incidence in schoolchildren (1951)

Publication of report by the Consultative Committee on Hospital Reform (1954)

Labour Party elected (1957)

Major studies in the inequalities of health between Māori and Pākehā with regard to polio immunity and the incidence and treatment of bronchiectasis (1958)

Legislation

Medical Research Council Act 1950

Tuberculosis Amendment Act 1950

Dieticians Act 1950

Medical Practitioners Act 1950

Health Amendment Act 1951

Coroners Act 1951

King George the Fifth Memorial Children's Health Camps Act 1953

Physiotherapy Amendmant Act 1953

Medical Amentment Act 1954

Health Amentment Act 1954

Mental Health Amendment Act 1954

Health Act 1956

Hospitals Act 1957

Mental Health Amendment Act 1958

Public Health

Extension of the Bacille Calmette-Guérin (BCG) vaccination for tuberculosis (1951)

Poliomyelitis epidemic (1952)

Experiment in Hastings with fluoridation of water supplies (1954)

Poliomyelitis epidemic (1955)

Start made with immunising against poliomyelitis with Stalk Vaccine (1956)

1960–1969

Key Events

National Party elected (1960)

Publication of the Hunn Report (1960)

Publication of first Comparative Statistical Report, Māori-European Standards of Health (1960)

Department of Health sets up Māori Health Committee (1960)

United Nations Convention relating to the Status of Refugees, ratified by New Zealand (1960). Protocol of the Convention adopted in 1967 also ratified

New Zealand Māori Council established (1962)

Provisional grading of public water supplies by the Board of Health (1962)

Health Department reorganised into six divisions (1962)

Reconstitution of Medical Research Council, separated from Department (1965)

Alcoholism and Drug Addiction Act 1966

Replacement of eight hospital districts with two (1967)

Review of Hospital and Related services published (1969)

Legislation

Disabled Persons Employment Promotion Act 1960

Chiropractors Act 1960

Māori Social and Economic Advancement Amendment Act 1961

Mental Health Amendment Act 1961

Repeal of the Tohunga Suppression Act 1962

Māori Welfare Act 1962 (renamed Māori Community Development Act 1962)

Sale of Liquor Act 1962

Dental Act 1963

Burial and Cremation Act 1964

Legislation continued

Human Tissues Act 1964

Narcotics Act 1965

Medical Research Council Amendment Act 1965

Medical and Dental Auxiliaries Act 1966

Alcoholism and Drug Addiction Act 1966

Medical Auxiliaries Act 1966

Sale of Liquor Poll Act 1967

Mental Health Services Act 1969

Food and Drug Act 1969

Public Health

Provision of free vaccines for diphtheria, pertussis (whooping cough) and tetanus (1960)

Screening of newborn infants for phenylketonuria (1960)

Cervical cancer campaign (1963)

Distribution of milk in schools ended (1966)

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Chronology of the New Zealand Health System 1840 to 2017

1970–1979

Key Events

Labour Party elected (1972)

Psychiatric hospitals transferred to Hospital Board's control (1972)

International Convention on the Elimination of Racial Discrimination, ratified by New Zealand (1972)

ACC scheme started (1974)

Waitangi Tribunal established (1975)

National Party elected (1975)

A question on Māori descent (ethnicity) introduced in Census (1976)

International Covenant on Economic, Social and Cultural Rights, ratified by New Zealand (1978)

International Covenant on Civil and Political Rights, ratified by New Zealand (1978)

Legislation

Hospitals Amendment Act 1970

Medical Practitioners Amendment Act 1970

Pharmacy Act 1970

Health Amendment Act 1970

Alcoholism and Drug Addiction Amendment Act 1970

Nurses Act 1971

Hospital Amendment Act 1971

Hospital Amendment Act (No.2)1971

Accident Compensation Act 1972

Mental Health Amendment Act 1972

Children's Health Camps Act 1972

Mental Health Amendment Act 1975

Treaty of Waitangi Act 1975

Nurses Amendment Act 1975

Disabled Persons Community Welfare Act 1975

Disabled Persons Community Welfare Act 1975 (Part 2A)

Legislation continued

Misuse of Drugs Act 1975

Hospital Amendment Act 1976

Alcoholic Liquor Advisory Council Act 1976

Contraception, Sterilisation and Abortion Act 1977

Nurses Act 1977

Hospital Amendment Act 1977

Human Rights Commission Act 1977

Mental Health Amendment Act 1977

Nurses Act 1977

Health workforce

Nursing Council of New Zealand established (1971)

Policy

Department of Health, *A health service for New Zealand* White Paper, (1975)

1980–1989

Key Events

Population-based funding formulae introduced (1983)

Area Health Boards established (1983)

Hui Whakaoranga (1984)

Māori health identified as a health priority in the Ministry of Health (1984)

Standing Committee on Māori health set up by New Zealand Board of Health (1984)

Labour Party elected (1984)

Convention on the Elimination of all forms of Discrimination against Women, ratified by New Zealand (1985)

Health Benefits review (1986)

Formation of joint Treasury and Health Department Hospital and Related Services Taskforce (1987)

Oranga Māori/Māori Health team ceases function (1987)

New Zealand Board of Health promoted Treaty of Waitangi as a document that had relevance to health (1987)

Royal Commission on Social Policy report released (1988)

Mason Report published concerning procedures in psychiatric hospials in relation to admissions, discharge or release of patients (1988)

Report of the Cervical Cancer Inquiry (the Cartwright Report) released (1988)

Māori members appointed to Area Health Boards (1989)

Ministerial Advisory Committee on Māori Health (1989)

Legislation

Medical Research Council Amendment Act 1981

Medicines Act 1981

Health Benefits (Reciprocity with the United Kingdom) Act 1982

Area Health Boards Act 1983

Treaty of Waitangi Amendment Act 1985

State-Owned Enterprises Act 1986

Coroners Act 1988

Hospitals Amendment Act 1989

Sale of Liquor Act 1989

Health workforce

Hui of Māori Doctors (1981)

National Council of Māori Nurses (1983)

Policy

Guidance provided to hospitals and medical practices about working with Māori healers (1987)

Publication of *Partnership Perspective (He Tirohanga Rangapu)* published by Department of Māori Affairs (1988)

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Chronology of the New Zealand Health System 1840 to 2017

1990–1999

Key Events

National Party elected (1990)

Ministerial Committee on the Funding and Provision of Health Services established (1990)

Health Research Council established (1990)

Area Health Boards replaced by Commissioners (1991)

Green and White paper encouraged Māori to provide health care services (1991)

Ngai Tahu Waitangi Tribunal report (1991)

Te Roroa Waitangi Tribunal report (1991)

Ethnicity question reintroduced into the NZ Census (1991)

Implementation of Ka Awatea regime by Te Puni Kokiri (1991)

User charges introduced to public hospitals (1992)

Public Health Commission established (1993)

Crown Health Enterprises established (1993)

Regional Health Authorities (RHAs) – four established: Northern RHA: established three Māori coordinating and co-purchasing organisations called MAPOs funding Māori health providers; Midland RHA: established four joint Māori venture boards; Central RHA: established 50 health nests called 'Hauora Oranga' involving Māori health providers; and Southern RHA: worked with Ngai Tahu. (1993)

PHARMAC (Pharmaceutical Management Agency established (1993)

Te Kete Hauora, the Māori Health Directorate, established in Ministry of Health (1993)

Department of Health became Ministry of Health (1993)

Transitional Assistance Grant Scheme established (1993)

Introduction of Mixed Member Proportional (MMP) Representation (1993)

Health Research Council funded two Māori research units including establishing a Māori Health Committee (1993)

Key Events continued

Area Health Boards disestablished (1993)

United Nations Convention on the Rights of the Child, ratified by New Zealand (1993)

Public re-emergence of Māori healers including the establishment of Ngā Ringa Whakahaere ō te Iwi Māori (1993)

Introduction of Mixed Member Proportional (MMP) Representation (1993)

Health and Disability Commissioner established (1994)

Three major hui held to discuss Māori health: Te Ara Ahu Whakamua; Ma Te Miori E Puri Te Maimoatanga Māori; and Hui Whai Maramatanga Whai Oranga (1994/1995)

Public Health Commission disestablished (1995)

National Kaitiaki Group established – Māori control and protection of Māori women's cervical screening data (1995)

National Kaitiaki Group established – Māori control and protection of Māori women's cervical screening data (1995)

Mental Health Commission established (1996)

Hospital and Health Services established (1996)

Transitional Health Authority established 1997 and disestablished 1998

Vision 2020 project established to increase number of Māori doctors (1997)

Māori Health Commission established 1997 and disestablished 1999

Hospitals required to have a booking system for elective surgery (1998)

Health Funding Authority established (1998)

National Advisory Committee on Health and Disability Services established (1998)

Labour Party elected (1999)

Focus of Patients: Labour on Health policy released (1999)

Legislation

Smoke-free Environment Act 1990

Smoke-free Environment Amendment Act 1990

Nurses Amendment Act 1990

New Zealand Bill of Rights Act 1990

Health Research Council Act 1990

Mental Health (Compulsory Assessment and Treatment) Act 1992

Health Reforms (Transitional Provisions) Act 1993

Health Amendment Act 1993

Health Amendment Act (No.2) 1993

Health and Disability Services Act 1993

Human Rights Act 1993

Hospitals Amendment Act 1993

Privacy Act 1993

Cancer Registry Act 1993

Health Sector (Transfers) Act 1993

Health and Disability Commissioner Act 1994

Medicines Practitioners Act 1995

Health (Cervical Screening (Kaitiaki) Regulations 1995

Health and Disability Services Amendment Act 1995

Smoke-free Environment Amendment Act 1997

Health Amendment Act 1998

Health and Disability Services Amendment Act 1998

Mental Health Commission Act 1998

Menta Health (Compulsory Assessment and Treatment) Act 1999

Medicines Amendment Act 1999

Health Benefits (Reciprocity with Australia) Act 1999

Health Workforce

Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) established (1996)

Māori midwives meeting (1993)

Te Ao Mārama (Māori Dentists and Oral Health Workers Association) formed (1995)

Government approves health care provider purchaser of rongoā services in Napier (1995)

Māori Health Scholarships established (now known as Hauora Māori Scholarships) (1995)

Māori Provider Development Scheme introduced (1997)

Policy

Health Services Taskforce Report published (1991)

An Option for Māori released following the Green and White papers (1991)

Policy statement on Māori health released (1992)

Whaia te ora mo te iwi: strive for the good health of the people: government's response to Māori issues in the health sector – Health and Disability Services Bill (1992)

Te Ara Ahu Whakamua: Strategic Direction for Māori Health published by Te Puni Kokiri (1993)

Co-ordinated Care for Māori: Issues for Development released (1996)

Child Health Strategy released (1998)

Standards of Rongoā healing published (1999)

Rural Health Policy released (1999)

6 September 2017

Chronology of the New Zealand Health System 1840 to 2017

2000–2009

Key Events

National Health Committee established (2000)

Health Funding Authority and Hospital and Health Services disestablished (2000)

District Health Boards established (2001)

WAI 692 *Napital Hospital and Health* Report Services (2001)

Population-based funding formula introduced (2003)

Māori Party established (2004)

Labour Party elected (2005)

WAI 1315 Primary Health Organisations Claim lodged (2005)

Primary Health Organisation Performance Management Programme established (2005)

Very Low Cost Access (VLCA) scheme introduced (2006)

National health targets introduced (2007)

National Party elected (2008)

Ministerial Review Group established (2008)

Convention on the Rights of Persons with Disabilities, ratified by New Zealand (2008)

Free doctors' visits for under-6s (2008)

Whānau Ora Taskforce established (2009)

Meeting the Challenge: Enhancing Sustainability and the Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand report released by the Ministerial Review Group. (Also known as the Horn Report) (2009)

Māori Affairs Select Committee initiates an inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori (2009)

Legislation

New Zealand Public Health and Disability Act 2000

Health and Disability Services (Safety) Act 2001

Health and Disability Commissioner Amendment Act 2003

Health and Disability Commissioner Amendment Act 2003

Health Practitioners Competence Assurance Act 2003

Intellectual Disability (Compulsory Cover and Rehabilitation) Act 2003

Medicines Amendment Act 2003

Gambling Act 2003

Human Assisted Reproductive Technology Act 2004

Social Security (Long-term Residential Care) Amendment Act 2006

Epidemic Preparedness Act 2006

Coroners Act 2006

Disabled Persons Employment Promotion Repeal Act 2007

Human Tissue Act 2008

Health workforce

Ngā Maia (Māori Midwives Aotearoa) established (2000)

Tae Ora Tinana (Māori Physiotherapists Organisation) established (2001)

Health Workforce Advisory Committee (HWAC) established (2001)

Māori pharmacists meeting (2003)

Māori Health and Disability Committee (HWAC) established (2005)

Ngā Kaitiaki o Te Puna Rongoā o Aotearoa (Māori Pharmacists' Association) established (2006)

Health Workforce Advisory Committee disestablished (2006)

Health workforce continued

Māori Health and Disability Committee (HWAC) disestablished (2006)

Workforce Taskforce established Ministry of Health (2006)

Voluntary Bonding Scheme established (2008)

Health Workforce New Zealand established (2009)

Māori Workforce Development Programme Fund established (2009)

Public Health

Meningococcal B immunisation offered to anyone under age 20 due to epidemic (2004)

Policy

New Zealand Health Strategy released (2000)

New Zealand Disability Policy released (2001)

Improving Māori Health Policy released (2001)

Primary Health Care Strategy released (2001)

Kia Piki te Ora Māori Suicide Prevention Strategy released (2001)

The New Zealand Palliative Care Strategy released (2001)

A National Strategic Framework for Alcohol and Drug Services released (2001)

Minimum Requirements for Primary Health Organisations released (2001)

Publication *A Guide for Establishing Primary Health Organisations* published by the Ministry of Health (2002)

Health of Older People Strategy 2002 released (2002)

He Korowai Oranga: Māori Health Strategy released (2002)

Te Puawaitanga, Māori Mental Health National Strategic Framework released (2002)

Whakatātaka: Māori Health Action Plan 2002–2005 released (2002)

Policy continued

PHARMAC Māori Responsiveness Strategy launch (2002)

HIV/AIDS Action Plan Sexual and Reproductive Health Strategy released (2003)

Healthy Eating: Healthy Action: Oranga Kai: Oranga Pumau Implementation Plan: 2004–2010 released (2004)

Te Tāhuhu: Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan released (2005)

The New Zealand Cancer Control Strategy Action Plan 2005 – 2010 released (2005)

Tauawhitia te Wero: Embracing the Challenge: National mental health and addiction workforce development plan 2006-2009 released (2005)

Whakatātaka Tuarua: Māori Health Action Plan 2006–2011 released (2006)

Raranga Tupuake: The Māori Health Workforce Development Plan released (2006)

Treaty of Waitangi statements no longer included in Ministry of Health policies, action plans or contracts. Focus instead on improving Māori health outcomes and reducing health inequalities for Māori (2006)

New Zealand Suicide Prevention Strategy released (2006)

Te Rau Hinengaro: The New Zealand Mental Health Survey published (2006)

Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015 released (2006)

Good Oral Health for All, for Life – A strategic vision for Oral health in New Zealand strategy released (2006)

Publication *Review of Māori Child Oral Health Services* published (2006)

Te Uru Kahikatea: Public Health Workforce Development Plan released (2007)

E Ara a Tauwhaiti Whakarae – National Māori Public Health Workforce Development Plan released (2007)

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Chronology of the New Zealand Health System 1840 to 2017

2000–2009 continued

Policy continued

Te Puāwaiwhero the Second Māori Mental Health and Addiction National Strategic Framework 2008–2015 released (2008)

New Zealand Suicide Prevention Action Plan 2008–2012 released (2008)

Te Ao Auahatanga Māori Health Innovation Fund established (2009)

Better, Sooner, More Convenient policy (2009)

Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives released (2009)

2010–2017

Key Events

Māori Affairs Select Committee inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Maori report published (2010)

Health Quality and Safety Commission established (2010)

United Nations Declaration on the Rights of Indigenous Peoples, ratified by New Zealand (2010)

National Party elected (2011)

Canterbury earthquakes (2011)

Ko Aotearoa Tēnei: Wai 262 Fauna and Flora report released (2011)

Rheumatic Fever Prevention Programme started (2011)

Smokefree 2025 goal adopted (2011)

Prime Minister's Youth Mental Health Project announced (2012)

Better Public Services Targets announced (2012)

Mental Health Commission disestablished with a Mental Health Commissioner placed in the Office of the Health and Disability Commissioner (2012)

Whānau Ora Commissioning agencies established (2014)

National Party elected (2014)

Waka Houroa fund launched to support the prevention of suicide in Māori and Pacific communities (2014)

Ministry on the Move transformation programme commenced (2015)

Childhood Obesity Plan launched (2015)

Raising Healthy Kids Target introduced (2016)

Health Literacy Programmes introduced (2016)

National Health Board disestablished (2016)

National Health Committee disestablished (2016)

Te Kete Hauora disestablished (2016)

Waitangi Tribunal – Health Services and Outcomes Kaupapa Inquiry started (2016)

Kaikoura earthquake (2016)

Legislation

Health and Disability Amendment Act 2010

Health and Disability Amendment Act 2012

Psychoactive Substances Act 2013

The Vulnerable Children Act 2014

Radiation Safety Act 2016

New Zealand Public Health and Disability (Southern DHB) Elections Act 2016

Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016

Smoke-free Environments (Tobacco Standardised Advertising) Amendment Act 2016

Smoke-free Environments Regulations 2017

Substance Addiction (Compulsory Assessment and Treatment) Act 2017

Care and Support Workers (Pay Equity) Settlement Act 2017

Health Workforce

Kia Ora Hauora launched (2010)

Te Kāhui Rongoā Trust (National rongoā governance body) established (2011).

Policy

Uia Tonutia: Māori Disability Research Agenda released (2011)

The Māori Disability Action Plan for Disability Support Services 2012 to 2017 released (2012)

Children's Action Plan released (2012)

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 released (2013)

New Zealand Suicide Prevention Action Plan 2013 – 2016 released (2013)

New Zealand Cancer Plan: Better, faster cancer care 2015–2018 strategy released (2014)

Tikanga ā-Rongoā – Rongoā standard released (2014)

Policy continued

The Guide to He Korowai Oranga: Māori Health Strategy released (2014)

Zero fee doctors' visits for children aged under 13 introduced (2015)

Implementing Medicines New Zealand 2015 to 2020 – an action plan to the Medicines Strategy released (2015)

National Drug Policy 2015 to 2020 released (2015)

Living Well with Diabetes strategy released (2015)

The *New Zealand Health Strategy* refreshed (2016)

New Zealand Disability and Policy Strategy 2016–2026 released (2016)

Pharmacy Action Plan 2016 to 2026 released (2016)

Taking Action on Fetal Alcohol Syndrome Disorder: 2016 to 2019: An Action Plan released (2016)

National Healthy Food and Drink Policy released (2016)

Healthy Ageing Strategy released (2016

Mental Health and Addiction Workforce Action Plan 2017 to 2021 released (2017)

New Zealand Health Research Strategy 2017 to 2027 released (2017)

Increasing Decreasing Organ Donation and Transplantation: A National Strategy released (2017)

Transforming Respite: Disability Support Services Respite Strategy 2017 to 2022 released (2017)

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7.2 Patient Reported Outcomes Measures (PROMs) Programme

Recommendation:

That the Board notes the progress in developing a PROMs Programme.

Prepared by: Jarrard O'Brien (Associate Director, i3)
Endorsed by: Penny Andrew (Director, i3)

1. Executive Summary

A presentation (Appendix 1) is attached to update the Board on the development of system to collect and report Patient Reported Outcomes Measures (PROMs). The development of a PROMs measurement system has been a Leapfrog Programme project led by Jarrard O'Brien, Associate Director of the i3.

Patient Reported Outcome Measures (PROMs) are measures of patients' quality of life, functional outcomes, mental and emotional wellbeing, and other dimensions of health that matter to patients and which only patients can know. Patients are asked to complete PROMs questionnaires that are used to assess how health services and interventions have, over time, affected these outcomes and whether healthcare interventions actually make a difference to people's lives.

PROMs can be made electronic using our Patient Experience Reporting System (PERSy) and patients can be emailed a link to complete a PROMs survey, or can complete a survey in a clinic/on a ward using a device (e.g. tablet in outpatient clinics). PROMs results are now visible through the clinical portal (electronic clinical record) hence, once a patient completes a survey, the results are visible in their health record within five minutes.

An online 'playbook' which instructs clinicians on how to implement PROMs is being user-tested. Feedback, so far, has been positive. Our PROMs website (http://proms.waitematadhb.govt.nz/) has received international attention and we have been in contact with several agencies in Australia to discuss our PROMs programme.

PROMs are currently being collected in orthopaedics, ORL, diabetes and the Hyperbaric Unit. Other services commencing PROMs include urogynaecology, upper GI cancer, renal and Allied Health. A project is underway with the renal team to engage CALD patients. A renal PROMs survey for CALD patients will be translated into five languages and will include multimedia options such as welcome and thank you videos, and audio files so that survey questions can be spoken aloud to patients.

2. Strategic Alignment

Community, whānau and patient centred model of care	The measurement and reporting of PROMs will help ensure that models of care are centred on patient and whānau needs. PROMs will be used to inform service development and delivery
Emphasis and investment on both treatment and keeping people healthy	The measurement and reporting of PROMs will help ensure people receive high quality treatment, will support health literacy and will help people to keep themselves healthy through self-monitoring and self-management

	Intelligence and insight	A PROMs measurement system will enable systematic collection and reporting of outcomes that matter most to patients. The programme provides significant opportunities to empower patients, support clinical decision-making, guide funding and planning resource allocation, and enhance big data use eg predicting prognosis and early identification of at risk individuals
	Evidence informed decision making and practice	PROMs will enhance evidence-based decision by ensuring that what matters most to patients is understood and is part of the informed consent process, clinical decision making and practice
	Operational and financial sustainability	PROMs will enhance continuous improvement, service planning and delivery, efficiency, and effective resource allocation

Appendix 1

Patient-Reported Outcome Measures

Jarrard O'Brien
Associate Director i3

Mustafa Shaabany
Project Manager

PROMs
Patient Reported Outcome Measures
Outcomes that matter to patients

i3 institute for innovation + improvement

PROMs End-to-end

WEBSITE & RESOURCES

proms.waitematadhb.govt.nz

PROMS VISUALISATION

Portal 8

Qlik App – to be developped

PROMS COLLECTION

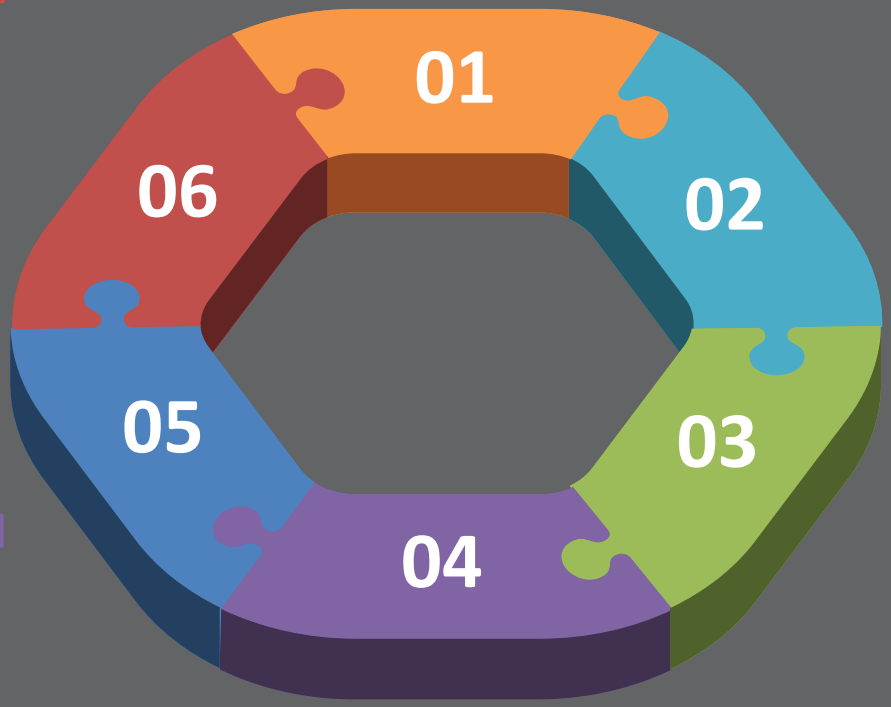
- iPads
- QR codes
- Emailed to verified patient emails – In progress

RESULT REPORT DESIGN

Orthopedics

Diabetes

EG-5D



ONLINE CHECKLIST

SURVEY DESIGN

Live & In-progress surveys

Service/Procedure	Lead	PROM	Checklist submitted	Converted	Approved	Published	Link to EQ-5D
Adolescent Diabetes	Carl Peters/Jo Naylor	PAID	No	Yes	Yes	Yes	Yes
ORL	Angus Shao	Septoplasty	No	Yes	Yes	Yes	Yes
ORL	Angus Shao	SNOT-22	No	Yes	Yes	Yes	N/A
ORL	Angus Shao	NOSE Scale	No	Yes	Yes	Yes	N/A
ORL	Angus Shao	Nasal Symptom Questionnaire - Pre-op	No	Yes	Yes	Yes	Yes
ORL	Angus Shao	Nasal Symptom Questionnaire - Post-op	No	Yes	Yes	Yes	Yes
Orthopedics	Robert Elliott	Oxford Hip/Knee Score	No	Yes	Yes	Yes	Yes
Orthopedics	Robert Elliott	Hip Replacement - Post Op PROMS	No	Yes	Yes	Yes	Yes
Orthopedics	Robert Elliott	Hip Replacement Questionnaire - Pre Op	No	Yes	Yes	Yes	Yes
Orthopedics	Robert Elliott	Hip: International Hip Outcome Tool (IHOT)	No	Yes	Yes	Yes	Yes
Hyperbaric Unit	Chris Sames	EQ-5D	No	Yes	Yes	Yes	N/A
Renal	Andy Salmon	IPOS-Renal	No	Yes	No	No	Yes
Upper GI	Megan Pemm	FACT- Hep v4.0	Yes	Yes	No	No	no
Urogynaecology	Eva Fong	ICIQ-FLUTS	Yes	no	No	No	no

Expression of interest

Service/Procedure	Lead	PROM
Anaesthetics	Lara Hopley/Jonathan Wallace	
Cardiology	Patrick Gladding	
Chronic Pain	Michal Kluger	
Haemodialysis	Andy Salmon/Janak De Souza	SONG-HD
Lymphedema	Amelia Koko	LLIS
Paediatrics	Tim Jelleyman	
Pelvic Pain	Fiona Connell	
Rheumatology	Mike Corkill/Peter van der Weijer	PROMIS
Spinal Surgery	Philip Insull	
Varicose Veins	John Bottomley	Aberdeen Varicose Vein Score
Stroke	Luke Skinner	
Dermatology	Deb Hogan/Bryony Drinkwater/Gill Rolfe	DQLI
CADS	Susanna Galea-Singer/Robert Steenhuisen/Emma Schwarcz	ADOM
Breast Surgery	Katherine Gale	Breast-Q

Q + A

Thank you

i3.waitematadhb.govt.nz