### 1 PROCEDURAL BUSINESS

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<tr>
<td>1.1</td>
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<td>Note</td>
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<tr>
<td>1.8</td>
<td>Chair’s Report (verbal)</td>
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<td>1.9</td>
<td>Chief Executive’s Report</td>
<td>Note</td>
<td>D Chin</td>
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<td></td>
<td>1.9.1 Financial Summary, August 2017</td>
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<td>1.10</td>
<td>Clinical Council Report</td>
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<td>A McCance</td>
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<td>Appendix 1 Terms of Reference</td>
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<td></td>
<td>Appendix 2 Summary of Discussions</td>
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### 2 ADVISORY COMMITTEE

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<tr>
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<td>Sub Regional Disability Advisory Group</td>
<td>Note</td>
<td>B Francis</td>
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<td></td>
<td>Patient Story</td>
<td>Note</td>
<td>P Boyles</td>
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### 3 FOR DECISION

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### 4 FOR DISCUSSION

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<td>Health and Safety Monthly Report</td>
<td>Note</td>
<td>T Davis</td>
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<tr>
<td>4.2</td>
<td>3DHB MHAIDS Report</td>
<td>Note</td>
<td>N Fairley</td>
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### 5 OTHER

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<td>5.1.1 Community Networks Wellington and WCC Meeting</td>
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<td>5.2</td>
<td>Resolution to Exclude the Public</td>
<td>Approve</td>
<td>A Blair</td>
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**DATE OF NEXT MEETING 22 NOVEMBER 2017 – KAPITI DISTRICT COUNCIL CHAMBERS, 175 RIMU ROAD, PARAPARAUMU**

**APPENDICES**

<table>
<thead>
<tr>
<th>ITEM</th>
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|   | • Te Haika Data August 2017  
|   | • Buckle Fellowship for MHAID Service staff programme  
|   | • Buckle Fellowship for Public lecture  
|   | • Balanced Score Care – September 2017  
|   | • Wairarapa Pre Admission and Post Discharge contact – September 2017 | 188  
|   |  | 198  
|   |  | 199  
|   |  | 200  
<p>|   |  | 201 |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
</tr>
</thead>
</table>
| Mr Andrew Blair        | Chair, Hutt Valley District Health Board (from 5 December 2016)  
Chair, Southern Partnership Group (appointed jointly by Ministers of Finance and Health to provide governance for the redevelopment of Dunedin Hospital)  
Advisor to the Board, Forte Health Limited, Christchurch  
Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector  
Former Member of the Hawkes Bay District Health Board (2013-2016)  
Former Chair, Cancer Control (2014-2015)  
Former CEO Acurity Health Group Limited |
| Dame Fran Wilde        | Ambassador Cancer Society Hope Fellowship  
Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims  
Chair, Remuneration Authority  
Chair Wellington Lifelines Group  
Chair Wellington Culinary Events Trust  
Chair National Military Heritage Trust  
Co-Convenor 2018 NZ Population Health Congress  
Deputy Chair, Capital & Coast District Health Board  
Deputy Chair NZ Transport Agency  
Director Museum of NZ Te Papa Tongarewa  
Director Business Mentors NZ Ltd  
Director Frequency Projects Ltd  
Member Whittirea-Weltec Council |
| Mr Roger Jarrold       | Member, Capital & Coast District Health Board  
Chair, Capital & Coast DHB FRAC committee  
Trustee, Auckland District Health Board Charitable Trust  
Employee CFO, Downer New Zealand Ltd  
Director, Downer New Zealand Ltd  
Director, Works Infrastructure Cortex Resources JV Ltd  
Director, Works Infrastructure Harker Underground Construction JV Ltd  
Director, Works Finance (NZ) Ltd  
Director, DGL Investments Ltd  
Director, TSE Wall Arlidge Ltd  
Director, Waste Solutions Ltd  
Employer (Downer NZ) subcontracts to Spotless  
Director, Underground Locators Ltd  
Member, Finance and Risk Committee, Health Research Council  
Past member, Ministry of Health Audit and Risk Committee (resigned 6 December 2013) |
<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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</thead>
</table>
| Mr Darrin Sykes | • Member, Capital & Coast District Health Board  
• Deputy Chair, Capital & Coast District Health Board, FRAC committee  
• Trustee, Wellington Regional; Sports Education Trust (trading as Sports Wellington)  
• Member, Sport and Recreation New Zealand (trading as Sport NZ)  
• Chief Executive, Crown Forestry Rental Trust                                                                                     |
| Ms Sue Kedgley  | • Member, Capital & Coast District Health Board  
• Member, CCDHB CPHAC/DSAC committee  
• Member, Greater Wellington Regional Council  
• Member, Consumer New Zealand Board  
• Deputy Chair, Consumer New Zealand  
• Environment spokesperson and Chair of Environment committee, Wellington Regional Council  
• Stepson works in middle management of Fletcher Steel                                                                                           |
| Dr Roger Blakeley | • Member of Capital and Coast District Health Board  
• Deputy Chair, Wellington Regional Strategy Committee  
• Councillor, Greater Wellington Regional Council  
• Director, Port Investments Ltd  
• Director, Greater Wellington Rail Ltd  
• Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council  
• Member, Harkness Fellowships Trust Board  
• Independent Consultant  
• Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland  
• Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington  
• Invited to join the Board of the Wesley Community Action Group.                                                                                       |
| Ms Kim Ngarimu | • Member of Capital and Coast District Health Board  
• Member, Medical Council of New Zealand (MCNZ)  
• Member, Māori Heritage Council  
• Board Member, Te Māngai Pāhō (Māori Broadcasting Agency)  
• Board Member Eastern Institute of Technology  
• Board Member Heritage New Zealand  
• Alternate Crown Trustee, Crown Forestry Rental Trust  
• Director, Taaua Ltd (Public policy and management consulting company)  
• Trustee, Judith and Taina Ngarimu Whānau Trust (has shareholdings in various health related companies – share acquisition and sale is independently managed) |
| Ms ‘Ana Coffey  | • Member of Capital & Coast District Health Board  
• Councillor, Porirua City Council                                                                                                                |
<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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<tbody>
<tr>
<td>Ms Eileen Brown</td>
<td>• Director, Dunstan Lake District Limited&lt;br&gt;• Trustee, Whitireia Foundation&lt;br&gt;• Member of Capital &amp; Coast District Health Board&lt;br&gt;• Board member (until Feb. 2017), Newtown Union Health Service Board&lt;br&gt;• Employee of New Zealand Council of Trade Unions&lt;br&gt;• Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union.&lt;br&gt;• God daughter/family friend employed as a solicitor at specialist health law firm, Claro.</td>
</tr>
<tr>
<td>Dr Kathryn Adams</td>
<td>• Member, Capital &amp; Coast District Health Board&lt;br&gt;• Fellow, College of Nurses Aotearoa (NZ)&lt;br&gt;• Reviewer, Editorial Board, Nursing Praxis in New Zealand&lt;br&gt;• School Nurse Vaccinator (casual) Regional Public Health, HVDHB&lt;br&gt;• Workplace Health Assessments and seasonal influenza vaccinator, Artemis Health&lt;br&gt;• Secretary, National Party Ohariu Electorate&lt;br&gt;• Director, Agree Holdings Ltd, family owned small engineering business, Tokoroa</td>
</tr>
<tr>
<td>Ms Sue Driver</td>
<td>• Community representative, Australian and NZ College of Anaesthetists&lt;br&gt;• Board Member of Kaibosh&lt;br&gt;• Daughter, Policy Advisor, College of Physicians&lt;br&gt;• Former Chair, Robinson Seismic (base isolators, Wgtn Hospital)&lt;br&gt;• Advisor to various NGOs</td>
</tr>
</tbody>
</table>
## EXECUTIVE LEADERSHIP TEAM

### 20 SEPTEMBER 2017

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Interests</th>
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</table>
| Debbie Chin           | Chief Executive Officer                       | • DHB lead CE for sector performance frameworks  
                        |                                 | • Trustee, Wellington Hospitals Foundation  
                        |                                 | • Member, Rotary  |
| Chris Lowry           | General Manager Hospital and Healthcare Services | • Trustee on Life Flight Trust Board  
                        |                                 | • Son works at HVDHB  |
| Rachel Haggerty       | General Manager, Strategy Innovation & Performance | • Chair, Takanini Care Ltd  
                        |                                 | • Director, Haggety & Associates  
                        |                                 | • Partner is an employee of CCDHB  |
| Donna Hickey          | General Manager, People and Capability         | • Sister is a nurse, working for Plunket  |
| Thomas Davis          | General Manager, Corporate Services            | • None  |
| Nigel Fairley         | General Manager of 3DHB Mental Health, Addictions and Intellectual Disability Services | • President, Australian and NZ Association of Psychiatry, Psychology and Law  
                        |                                 | • Trustee, Porirua Hospital Museum  
                        |                                 | • Fellow, NZ College of Clinical Psychologists  
                        |                                 | • Director and shareholder, Gerney Limited  |
| Mr John Tait          | Chief Medical Officer                         | • Vice President RANZCOG  
                        |                                 | • Chair, National Maternity Monitoring Group  
                        |                                 | • Co-Chair Maternity Morbidity Working Group  
                        |                                 | • Member, ACC taskforce neonatal encephalopathy  
                        |                                 | • Member, Waikato Women’s service taskforce  
                        |                                 | • Board member, Wellington Hospitals Foundation  
                        |                                 | • Board member Asia Oceanic Federation of Obstetrician and Gynaecology  |
| Catherine Epps        | Executive Director of Allied Health, Technical & Scientific | • Deputy Chair, National DHB Directors Allied Health  
                        |                                 | • Expert Advisor (Leadership) to New Zealand Speech-Language Therapists Association  
                        |                                 | • Brother is employed at Waikato and Waitemata DHBs  
                        |                                 | • Partner is the Programme Manager for the Children’s Hospital project  |
| Andrea McCance        | Executive Director of Nursing & Midwifery      | • Trustee, Mary Potter Hospice  |

20 September 2017
<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Details</th>
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<tbody>
<tr>
<td>Roger Palairet</td>
<td>Chief Legal Counsel</td>
<td>• Chair and Trustee of Carers NZ (non-profit organisation promoting the interests of family carers; funders include MoH, MSD and Waitemata DHB)</td>
</tr>
<tr>
<td></td>
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<td>• Sister-in-law is a paediatric nurse at CCDHB</td>
</tr>
<tr>
<td>Shayne Hunter</td>
<td>Chief Information Officer Technology, 3 DHB</td>
<td>• Currently in transition from a role at the Ministry of Health and assisting Rillstone Wells on the RHIP/CRISP review</td>
</tr>
<tr>
<td>Dr Pauline Boyles</td>
<td>Director of Disability Strategy and Performance</td>
<td>• Member on the Ministry of Health National Advisory Group for Review of Behaviour Support Services</td>
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<td>• Managing Director, Dream Achievers Ltd</td>
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<td>• Past President/ Advisor to Board, Wellington Riding for the Disabled</td>
</tr>
<tr>
<td>Arawhetu Grey</td>
<td>Director Māori Health Services/Manager Planning &amp; Funding Mental Health and Addiction Services</td>
<td>• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group</td>
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<td></td>
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<td>• Director, Gray Partners</td>
</tr>
<tr>
<td>Taima Fagaloa</td>
<td>Director of Pacific Peoples’ Health/Manager Planning &amp; Funding, Child &amp; Population</td>
<td>• Cousin works as a community health worker for Ora Toa Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Director, TCF Consulting Limited</td>
</tr>
<tr>
<td>Jannel Fisher</td>
<td>Communications Manager</td>
<td>• Mother-in-law and sister-in-law are a Bureau nurse and Healthcare assistant respectively</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Another sister-in-law is a nurse at CCDHB</td>
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<tr>
<td>Robyn Fitzgerald</td>
<td>Board Secretary</td>
<td>• Daughter is a nurse at HVDHB</td>
</tr>
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PUBLIC SECTION

PRESENT:  
Mr A Blair (Chair)  
Dame F Wilde (Deputy Chair)  
Dr K Adams  
Ms E Brown  
Mr R Blakeley  
Mr R Jarrold (arrived 12.25pm)  
Mr D Sykes  
Mrs S Driver  
Ms K Ngarimu  
Ms A Coffey (arrived 1.10pm)  
Ms S Kedgley (arrived 1.20pm)

IN ATTENDANCE:  
Mrs D Chin (Chief Executive)  
Mrs R Fitzgerald (Board Secretary)

STAFF:  
Mr T Davis (General Manager, Corporate Services)  
Ms J Fisher (Communications Officer)  
Ms C Lowry (General Manager Hospital and Healthcare Services)  
Ms R Haggerty (Director, Strategy Innovation and Performance) (arrived 12.20pm)  
Mr N Fairley (General Manager, 3DHB MHAIDS) (arrived 12.10pm)  
Mr M McCarthy (Chief Financial Officer)  
Ms C Epps (Executive Director, Allied Health and Scientific) (arrived 1.20pm)  
Ms A McCance (Executive Director, Midwifery and Nursing) (arrived 1.20pm)

GENERAL PUBLIC:  
Five members of the general public – Four of whom were Health students from Victoria University (left 1.13pm); other member of public left 1.20pm.

1  PROCEDURAL BUSINESS

Item 1.1   
PROCEDURAL  
Karakia was led by Darrin Sykes. Chair, Andrew Blair, welcomed the general public, Board members and Executive team.

Item 1.2   
APOLOGIES  
‘Ana Coffey, Roger Jarrold and Sue Kedgley registered their apologies and will be arriving late.
Item 1.3 INTERESTS

1.3.1 REGISTER OF INTERESTS
Roger Jarrold informed the Board that he soon will be taking up a new position with Fletcher Construction.

CONFLICTS RELATED TO ITEMS ON THE AGENDA
No other conflicts were foreshadowed in respect of items on the current agenda but there would be an additional opportunity at the beginning of each item for members to declare conflicts of interest.

Item 1.4 MINUTES OF PREVIOUS MEETING 23 August 2017

RESOLVED THAT:
The minutes of the CCDHB Board meeting held on 23 August 2017, taken with the public present are confirmed as a true and correct record.

Moved: Seconded: CARRIED

Item 1.5 MATTERS ARISING UPDATE
Nil.

Item 1.6 ACTION LIST
The reporting timeframes on the other open action items were NOTED.

Item 1.7 CCDHB WORK PLAN 2017
Changes noted.

Actions:
1. Add to 2018 CCDHB Board workplan a report back to the Board on the feasibility study of the development of a primary birthing unit closer to Wellington Regional Hospital – February 2018
2. Management to arrange for ‘Staff stories’ to be added to workplan or Board site visits.

Item 1.8 CHAIR’S REPORT
The Chair’s verbal report was noted.

Inward Mail:
- Hon Dr Jonathan Coleman re PHARMAC and procurement
- Compass Health re appointment process for a new CEO
- Sub-Regional Pacific Strategic Health Group re appointment for new CEO
- TAS re Annual General Meeting
- Hon Dr Jonathan Coleman re Quarter 4 2016-17 Health Target Performance
- Wellington Hospital Foundation re Child Development Service
  - 2 x sets of TREAX Pads & TREAX Wall Mounting boards ($7,212.15)
- Wellington Hospital Foundation re Paediatric Theatre – Endoscopic equipment
  - Paediatric Colonvideoscope Flexible Endoscope ($42,377.09 excl. gst)
  - Gastrointestinal Flexible Endoscope (GIF) ($36,933.33 excl. gst)
- Wellington Hospital Foundation re Women’s Health, Ward 4N
Outward Mail:
- Wellington Hospital Foundation thanking them for their various donations
- Compass Health and the Sub-Regional Strategic Pacific Health Advisory Group re appointment for new CEO
- NZ Hospital’s Association re additional theatre and hospital bed capacity.

Meetings:
- One on one meeting with Director-General of Ministry of Health
- CCDHB Board workshop on Long Term Investment Plan
- Combined CCDHB and HVDHB Board workshop on 3DHB Shared Services stocktake and IDFs
- DHB Chair’s meeting (including discussions on NOS and Director Board member development)
- Children’s Hospital Portfolio Board

The verbal report was received.

The Board:
1. Thanked Russell Tregonning for his invitation to meet with the Board but declined as the discussion on this subject would best fit Wellington Regional Council

Item 1.9 CEO’S REPORT
The paper was taken as read.

The Board:
1. Noted the influenza vaccination rate of CCDHB staff (71%) and thanked staff involved
2. Noted the Chair or Co-Chair of the Clinical Council will be in attendance at Board meetings
3. Noted the contents of the report.

Action:
3. Management to report on the ASMS survey (SMO vacancies) and the Employment Engagement Survey (re workloads) and strategies that are being put in place to manage these matters.
The Chair congratulated Teresa Wall on her appointment as Chair of MPB.

The Board:
   a) **Noted** the use of ‘Trendly’, as a monitoring and reporting data tool that provides reports such as equity performance in our region
   b) **Noted** continual discussion with MPB and the Board on reaffirmation of the relationship; review of the use of Trendly for future years, monitoring and reporting of equity.

**Item 2.2 Maori Health Services**

*Cheryl Goodyear, Manager, Maori Health Services provided a patient’s story focusing on tissue return, consent, and communication with the patient pre- and post-operation.*

The Chair thanked Cheryl for providing the patient’s story.

---

**3 DECISION**

**Item 3.1 Refreshing the 3DHB CPHAC/DSAC Approach**

The paper was taken as **read**.

The Board:

   a) **Noted** that on 1 September 2017 CPHAC-DSAC discussed whether the current 3DHB model for these statutory committees is meeting the needs of individual DHBs and endorsed the following recommendations:
      i. **Noted** that CPHAC-DSAC as a combined 3DHB Committee is challenged to effectively fulfil its obligations to each of the DHBs in a meaningful way and concerns have been raised by members and DHB planning and funding teams
      ii. **Agreed** that DSAC is retained as a 3DHB Committee, meeting quarterly, with a focus on relevant areas managed and delivered across the sub-region being mental health and disability support services
      iii. **Agreed** that CPHAC is managed locally at an individual DHB level enabling a focus on the health needs of local populations including equity, enabling prioritisation of localised health strategies and investment requirements
      iv. **Invited** the three Chief Executives to consider how strategic planning across the sub-region can be advanced, and discussed and monitored at a Governance level, should Boards agree to implement three local Community and Public Health Advisory Committees.

   b) **Agreed** that any changes take effect from the start of the 2018 calendar year
   c) **Noted** that the meeting schedule for CPHAC and DSAC will be brought to the Board after discussions with Hutt Valley and Wairarapa.

**Moved:** Andrew Blair  
**Seconded:** Eileen Brown  
**CARRIED**

**Action:**

4. Chair of 3DHB CPHAC/DSAC committee to discuss dates with other DHBs and report back to board.
4 DISCUSSION

4.1 Health and Safety Monthly Report  
The paper was taken as read.

The Board:
   a) **Noted** the number of reported Health & Safety incidents has decreased slightly this month
   b) **Noted** that there were no reported Notifiable Events this month, continuing a ten month trend
   c) **Noted** the number of incidents resulting in lost time injuries has decreased for General incidents and slightly increased for MHAIDS
   d) **Noted** 71% of employees have received the annual influenza vaccination compared with only 58% last year.
   e) **Noted** the current Health and Safety Risks.

4.2 SIP Bi-monthly Report  
The paper was taken as read.

The Board:
   a) **Noted** that the Mental Health Strategy to be developed at the 3DHB level and added to the 2018 workplan
   b) **Noted** the contents of the report, which updated the Board on priority activity for the Strategy Innovation and Performance (SIP) Directorate.

4.3 Ministry of Health Quarter 4 Performance Report  
The paper was taken as read.

The Board:
   a) **Noted** the performance of CCDHB in the quarter four report against the seven priority health targets with two achieved and five partially achieved
   b) **Noted** that the Surgery, Woman’s and Children’s Directorate achieved the Better Help for Smokers to Quit (Maternity) and Improved Access to Electives targets
   c) **Endorsed** the revised action plan for CCDHB to achieve the remaining five priority health targets
   d) **Noted** that of the 55 non-financial performance indicators reported against 41 were achieved, 12 were partially achieved and 2 were not achieved.

**Moved:** Roger Blakeley  **Seconded:** Darrin Sykes  **CARRIED**
5. OTHER

Item 5.1 General Business

The paper was taken as read.

The Board:

a) Agreed to the 2018 Board and Workshop dates in the schedule attached
b) Agreed to the dates of the committee meetings as proposed in the 2018 schedule attached
c) Noted that the scheduled January 2018 workshop will focus on Annual Planning
d) Noted that there will be a Board meeting on the day of the workshop in January 2018 to focus on the financial results.

The Board noted the report.

Moved: Andrew Blair  Seconded: Darrin Sykes  CARRIED

Item 5.2 RESOLUTION TO EXCLUDE THE PUBLIC

The Board NOTED and RESOLVED to:

(a) AGREE that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>REASON</th>
<th>REFERENCE</th>
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<tbody>
<tr>
<td>Public Excluded Minutes</td>
<td>For the reasons set out in the respective public excluded papers</td>
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<tr>
<td>Public Excluded Matters Arising from</td>
<td>For the reasons set out in respective public excluded papers</td>
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<tr>
<td>previous Public Excluded meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chair’s report</td>
<td>Papers contain information and advice that is likely to prejudice or</td>
<td>9(2)(i)(j)</td>
</tr>
<tr>
<td>CEO’s report</td>
<td>disadvantage commercial activities and/or</td>
<td></td>
</tr>
<tr>
<td>FRAC report</td>
<td>disadvantage negotiations</td>
<td></td>
</tr>
<tr>
<td>National Oracle Solution Programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment in Alcohol and other drugs/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-existing problems (AODCEP) services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demolition of Riddiford House, Recreation Centre and Chapel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Hospital Development Project – Bulk and Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Hospital Project Status Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Litigation and Legal Risk Update</td>
<td>Maintain legal professional privilege</td>
<td>9(2)(h)</td>
</tr>
</tbody>
</table>

Moved: Andrew Blair  Seconded: Darrin Sykes  CARRIED

The meeting closed at 2.10pm.
7 DATE OF NEXT MEETING

25 October 2017, 1 pm, 11th Floor Board Room, Grace Neill Block, Wellington Regional Hospital.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting

DATED this ................................................day of...............................................2017

Andrew Blair
CCDHB BOARD CHAIR
### SCHEDULE OF ACTION POINTS – OCTOBER 2017 PUBLIC MEETING

<table>
<thead>
<tr>
<th>Action No</th>
<th>Date of meeting</th>
<th>Agenda item number</th>
<th>Topic</th>
<th>Action</th>
<th>Designated to</th>
<th>How dealt with</th>
<th>Delivery date</th>
</tr>
</thead>
<tbody>
<tr>
<td>P0017</td>
<td>3.1</td>
<td>Refreshing the 3DHB CPHAC/DSAC Approach</td>
<td>Chair of 3DHB CPHAC/DSAC committee to discuss dates with other DHBs and report back to Board on 2018 dates</td>
<td>Chair of 3DHB CPHAC/DSAC</td>
<td>Feedback</td>
<td>October 2017</td>
<td></td>
</tr>
</tbody>
</table>
### CLOSED since last meeting – 20 September 2017

<table>
<thead>
<tr>
<th>Action No</th>
<th>Date of meeting</th>
<th>Agenda item number</th>
<th>Topic</th>
<th>Action</th>
<th>Designate d to</th>
<th>How dealt with</th>
<th>Delivery date</th>
</tr>
</thead>
<tbody>
<tr>
<td>P0016</td>
<td>20 September 2017</td>
<td>1.7</td>
<td>CCDHB Work Plan 2017</td>
<td>Add to 2018 CCDHB Board workplan a report back to the Board on the feasibility study of the development of a primary birthing unit closer to Wellington Regional Hospital</td>
<td>Board Secretary</td>
<td>Place on 2018 CCDHB Work plan</td>
<td>February 2018</td>
</tr>
<tr>
<td>P0014</td>
<td>23 August 2017</td>
<td>3.1</td>
<td>Board schedule, workplan and committee memberships 2018</td>
<td>Provide feedback of draft 2018 CCDHB Meeting Schedule to Chair and Board Secretary</td>
<td>Board members</td>
<td>Feedback</td>
<td>September</td>
</tr>
<tr>
<td>P0015</td>
<td></td>
<td>3.3</td>
<td>Proposal for establishment of a Citizens Health Council</td>
<td>The Citizens Health Council to provide regular feedback to the Board.</td>
<td>Dir SIP</td>
<td>Place into CEO’s Report until Council established, then report direct to Board</td>
<td>September</td>
</tr>
</tbody>
</table>
## Capital & Coast Health District Health Board Workplan 2017

### Regular monthly items:
- (Public) Chair’s Report; CEO’s Report; Health & Safety Report; Resolution to Exclude
- (Public Excluded): Chair’s Report; CEO’s Report; FRAC recommendations; FRAC minutes.

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July - cancelled</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
</table>

### DECISION
- CPHAC/DSDAC membership and meeting timetable
- Insurance renewals
- Health System Plan
- Regional Services Plan
- Risk Management Policy and Framework
- FRAC:DSDAC membership
- Cognitive Institute Partnership
- 3DHB Mental Health electronic client management system
- Conflict of management plan

### DISCUSSION
- Quarterly performance report
- Quality and Safety
- Quarter 3 performance report
- SIP and stocktake
- SIP performance report

### INFORMATION
- Hospital and Health Services update
- 3D Mental Health Working Group Report
- 3D Mental Health Working Group Report
- SIP update
- 3D Mental Health Working Group Report

### WORKGROUP AND COMMITTEE BUSINESS
- Long Term Investment Plan (LTP) ICU and Surgery Business Case
- 2018 Board Schedule and workplan
- 3DHB Healthy Food and Beverage Policy
- External Audit

### REPORTS
- Annual Planning
- Draft Annual Plan Overview
- Draft Strategic Planning – Board ½ day planning workshop
- Sustainability Plan Options 16/17
- Sustainability Plan
- Workforce

### COMMISSION
- Consumer Council Terms of Reference and project
- Population Health update
- SIP Bi-monthly update
- SIP Bi-monthly update
- SIP Bi-monthly update
- SIP Bi-monthly update

### AGENDA ITEMS
- 3D Mental Health Integration Plan
- Comment [2830101]: Request to move to November

---

CCDHBR Public 25 October 2017 - Item 1.7 Work plan 2017
<table>
<thead>
<tr>
<th>Month</th>
<th>Health &amp; Safety</th>
<th>Health &amp; Safety</th>
<th>Health &amp; Safety</th>
<th>Health &amp; Safety</th>
<th>Health &amp; Safety</th>
<th>Health &amp; Safety</th>
<th>Health &amp; Safety</th>
<th>Health &amp; Safety</th>
<th>Health &amp; Safety</th>
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</thead>
<tbody>
<tr>
<td>April</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Legal update</td>
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<tr>
<td>May</td>
<td>Rheumatic fever</td>
<td>Rheumatic fever</td>
<td>Rheumatic fever</td>
<td>Rheumatic fever</td>
<td>Rheumatic fever</td>
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<td>Rheumatic fever</td>
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<td>June</td>
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<td>July</td>
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<td></td>
<td></td>
<td>CPHAC/DSAC update – Disability Strategy/Equity</td>
</tr>
<tr>
<td>August</td>
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<td></td>
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<td></td>
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<td></td>
<td>CPHAC/DSAC update – Disability Strategy/Equity</td>
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<tr>
<td>September</td>
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<td></td>
<td></td>
<td>CPHAC/DSAC update – Disability Strategy/Equity</td>
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<td>October</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>CPHAC/DSAC update – Disability Strategy/Equity</td>
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<td>November</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CPHAC/DSAC update – Disability Strategy/Equity</td>
</tr>
<tr>
<td>December</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CPHAC/DSAC update – Disability Strategy/Equity</td>
</tr>
</tbody>
</table>

**Staff engagement survey**

**3DHB ICT update**

**CPHAC/DSAC update – Disability Strategy/Equity**

**Primary Birthing Unit Initiative**

**3DHB Options paper**

**CPHAC/DSAC update – Public health, localities and social investment/equity**

---

**Health and Safety**

**Public Health Organisation – PHO**

**Wellington Hospital Foundation (WHF) update**

---

**Māori Partnership Board**

**SRDAG**

**SR/SHAG**

**Goals of Care**

**MPB**

**SR/SHAG**

---

**Health and Safety**

**Healthcare Homes**

**Children’s Facilities**

---

**Emergency Preparedness**

**Service Reviews**

**Māori’s patient story**

---

**Separate Presentation (David Moore)**

---

**Board Site Visits**

11.45am-12.30pm

**ICU**

**Te Maara**

**Visit Te Maara**

---

**Board only meeting 5.00pm-5.45pm**

---

Comment [28300102]: To be rescheduled in 2018

Comment [28300103]: Deferred until December
**RECOMMENDATION**

It is recommended that the Board:

a) Note the contents of this report.

**APPENDICES**

1. **Financial Summary.**

**1. FINANCIAL UPDATE**

**1.1 Financial overview**

The DHB has a board approved deficit target of ($21m) for the 2017/18 financial year.

The DHB result for the period ending August 2017 is $235k favourable to budget and a deficit of ($2.61m).

**Activity movement compared to last year**

<table>
<thead>
<tr>
<th></th>
<th>As reported in MoH MIF report</th>
<th>Aug-17</th>
<th>Aug-16</th>
<th>Variances Month</th>
<th>Months % change</th>
<th>YTD 17/18</th>
<th>YTD 16/17</th>
<th>Variances YTD</th>
<th>YTD % change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td></td>
<td>5,537</td>
<td>5,507</td>
<td>(30)</td>
<td>-0.5%</td>
<td>10,757</td>
<td>10,796</td>
<td>39</td>
<td>0.4%</td>
</tr>
<tr>
<td>Caseweights (Excl MH)</td>
<td></td>
<td>6,046</td>
<td>6,175</td>
<td>129</td>
<td>2.1%</td>
<td>11,989</td>
<td>11,994</td>
<td>5</td>
<td>0.0%</td>
</tr>
<tr>
<td>Bed Days (calculated from Hours)</td>
<td></td>
<td>13,623</td>
<td>13,643</td>
<td>20</td>
<td>0.1%</td>
<td>26,722</td>
<td>25,988</td>
<td>(735)</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Length of Stay (excluding day patients)</td>
<td></td>
<td>3.93</td>
<td>3.90</td>
<td>(0.03)</td>
<td>-0.8%</td>
<td>3.90</td>
<td>3.85</td>
<td>(0.06)</td>
<td>-1.4%</td>
</tr>
<tr>
<td>ED Presentations</td>
<td></td>
<td>5,521</td>
<td>5,390</td>
<td>(131)</td>
<td>-2.4%</td>
<td>10,997</td>
<td>10,726</td>
<td>(271)</td>
<td>-2.5%</td>
</tr>
<tr>
<td>ED Admissions</td>
<td></td>
<td>1,884</td>
<td>1,908</td>
<td>24</td>
<td>1.3%</td>
<td>3,813</td>
<td>3,785</td>
<td>(28)</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Theatre Throughput (Hospital)</td>
<td></td>
<td>1,416</td>
<td>1,331</td>
<td>(85)</td>
<td>-6.4%</td>
<td>2,595</td>
<td>2,628</td>
<td>33</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

**Financial Results**

<table>
<thead>
<tr>
<th></th>
<th>Aug 2017</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Result in $000s</td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>(2,605)</td>
<td>(2,840)</td>
</tr>
</tbody>
</table>
2 HEALTH TARGETS

2.1 Acute Flow – Shorter Stays in Emergency Department (SSIED)

Target: 95% of patients will be admitted, discharged, or transferred from the Emergency Department within six hours

2.1.1 SSIED and Flow Results

CCDHB SSIED performance for September 2017 was 90.3%. The result is a decrease from the result in Aug 2017 but an improvement compared to the same month last year which reported a performance of 85.8%. The improved result on the previous year is in part due to the successful winter strategies including flexi beds at Kenepuru and Wellington; the introduction of the Interventional Radiology Ward; introduction of the ED Observation Unit model changes, together with, a number of service improvements resulting from the acute flow programme of work.

ED volumes have increased by 286 in Sep 2017 as compared to Sep 2016 however we continue to see fewer patients leaving ED before being seen, a reduction in corridor patients and a reduction in complaints in ED. This was despite the increase in presentations, similar number of admissions and the same bed days as September 2016.

2.2 Elective Services

2.2.1 Elective Discharges Health Target

Performance against the electives health target is 14 favourable for the month and 15 behind target YTD.

<table>
<thead>
<tr>
<th>Total</th>
<th>Month</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Plan</td>
</tr>
<tr>
<td>Sep</td>
<td>Sep</td>
<td>Sep</td>
</tr>
<tr>
<td>TOTAL</td>
<td>940</td>
<td>926</td>
</tr>
</tbody>
</table>

2.2.2 Elective Services Performance Indicator (ESPI) compliance

September ESPI 2 and 5 results are not yet confirmed by MOH however our internal reporting shows we are within the threshold for compliance for both indicators.

2.3 Faster Cancer Treatment (FCT)

2.3.1 62 Day Cancer Target: Target 90%

The target is that patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and the triaging clinician believes the patient needs to be seen within two weeks.

The 62-day wait is measured from receipt of the referral to the date of the patient’s first cancer treatment (or other management). From June 2017, 90% of patients meeting the criteria should commence treatment within 62 days.
Approximately 25 per cent of newly-diagnosed cancer patients will be covered by the 62-day target. A large proportion of newly-diagnosed cancer patients will continue to access treatment through pathways not covered by the target.

The Ministry of Health have also made changes to 2017/18 target definitions. Under new definitions, FCT records breaching the 62 day timeframe with a delay code of patient reason or clinical consideration will be removed from the denominator when calculating DHBs achievement level.

Performance against the target for Q1 was 89%. There were three breaches for the month of September relating to capacity resulting in delay to FSA and cancellation of surgery due to no ICU beds. Work continues across the organisation focusing on the whole pathway to reduce the unnecessary delays.

2.4 ICU Extension Project

The ICU extension project is making good progress over the two phases with design progressing and a main contractor engaged for Phase 1.

2.4.1 Phase 1 - Department of Anaesthesia’s office reconfiguration and RMO relocation enabling works

Design of the space to make way for the new RMO accommodation is finalised and provides a like for like basis to the current accommodation. There will be some improvements from the current space in that the sleeping quarters are all located together, there will be a central dining area and the space will be light, bright and modern. The plans have been shared with the New Zealand Resident Doctor’s Association (RDA) with no major concerns raised. Staff relocations to free up space for the accommodation on level 3, CSB have commenced. The relocations will be phased to minimise impacts. Following an open market tender process, Naylor Love is being engaged as the main contractor for this phase of work. The tendered fee is within the approved project budget and has been validated by an external Quantity Surveyor. Building consent has been issued and work is expected to commence on site in early October. The phase is on track for completion in December 2017.

2.4.2 Phase 2 – ICU bed extension

Developed Design is complete and the project has moved into the final stage of design. A user group including clinical and operational staff have been informing the design. A working group to coordinate the medical equipment requirements has been established and includes a procurement representation to ensure the appropriate processes are followed. It is expected the Phase 1 main contractor will be engaged as the “Preferred contractor” for Phase 2. Works are on track for completion in July 2018.

3 COMMUNICATIONS ACTIVITY

3.1 Media

3.1.1 Media Enquiries and Releases

There were 64 media enquiries in September. Around 29 per cent related to patient condition updates. Key matters for the other media enquiries were:

- Mental health
- Staff shortages (SMO and nurse).
Four pitches and media releases were issued. Coverage includes:
- [Joining forces to empower Pacific families](#)
- [Wellington hosts palliative care nursing scholar](#)
- [Hospitals to gauge people’s snackisfaction](#)

### 3.2 OIA Requests

| Requests received in September | 12 |
| Requests sent in September     | 14 |
| Responses sent on time         | 86% |

### 3.3 Website

In September, the website was visited 58,296 times by 25,966 people.

The 5 most visited website pages in September were:

<table>
<thead>
<tr>
<th>Website page</th>
<th>Page views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff login</td>
<td>37,466</td>
</tr>
<tr>
<td>Homepage</td>
<td>31,693</td>
</tr>
<tr>
<td>Careers</td>
<td>4,949</td>
</tr>
<tr>
<td>Nursing and midwifery professional development</td>
<td>4,293</td>
</tr>
<tr>
<td>Wellington Regional Hospital</td>
<td>3,680</td>
</tr>
</tbody>
</table>

### 3.4 Social Media

The number of people following us on Facebook continues to increase and is now 2028. Our number of page likes rose by 3.4% during September.
3.5 Internal Communications

3.5.1 Health Matters Staff Newsletter

The latest copy of the Health Matters staff newsletter is attached as appendix 1.

The September edition includes articles about:

- Nurturing a home grown nursing workforce
- Identifying signs of fatigue
- Extra beds for cardiology patients improving patient journey
- Better patient information sharing
- Meet our new sustainability champion.
3.5.2 Internal Campaigns

This month our internal campaigns were promoting the onsite food survey, early voting for the elections and our new cyber safety intranet page.

4 COMMUNITY

(a) Pharmacy Anti-Coagulation Management Service (CPAMS)

There have been media reports this month about the CPAMS service with the Community Pharmacy sector presenting a perspective that it should be expanded. This is in the context of the current CPSA negotiations.

Most patients prescribed warfarin are supported by Community Laboratory Services in conjunction with their local GP.

CCDHB has contracts for CPAMS with 5 community pharmacies and the service is used to monitor patients prescribed Warfarin by performing a Point-of-Care coagulation test on patients in the pharmacy and then, if required, adjusting the dose of Warfarin they are
taking. Each Pharmacy may enrol up to 50 patients at $540 pa per patient. Overall CCDHB budgeted spend is $160k per annum.

The number of people able to access the service currently is fixed. Whilst there are advantages through improved patient experience and improved monitoring of their condition there would be a cost for expanding this service. This would be subject to a prioritisation of funding process outside of contract negotiations.

(b) Pharmacy Services
Capital & Coast District Health Board have a need to create a strategy for Pharmacists and Community Pharmacies so that changes in the CPSA (Community Pharmacy Services Agreement) contract structure can be implemented appropriately.

As part of the strategy development we are having a workshop with key stakeholders. These will include Clinical Pharmacists, GPs, Consumers, Community Pharmacist owners and DHB funders.

Key inputs into the workshops will be national documents such as the New Zealand Health Strategy, the Pharmacy Action plan, the Integrated Health Care Framework for Pharmacists and Doctors as well as the local DHB strategy as contained within the Capital and Coast Health System plan.

CCDHB are working with HVDHB on this strategy development with similar workshops on consecutive days. It is hoped that the resultant strategies will be closely aligned to each other, albeit within the context of the individual DHBs.

5 PATHWAY TO ‘PAPER LESS’ ENVIRONMENT

(a) New electronic template
Report of Concern (ROC) is a form template that has been created to replicate the Ministry of Vulnerable Children Oranga Tamariki Report of Concern paper document which currently needs to be filled out and faxed or scanned and emailed. The completed paper form is not visible in the Medical Applications Portal (MAP).

Now both Child Protection and Ministry of Vulnerable Children Oranga Tamariki will receive an electronic copy of the Report of Concern. Child Protection knows exactly who has been referred, and it is visible in MAP to those authorised to view this. This is another step on our journey to a paper-less environment.

(b) Point of Care Test Integration Project
The Capital & Coast District Health Board and Hutt Valley District Health Board Point of Care Test Integration Project has gone live. With the introduction of new software this adds functionality to glucose, ketone and lactate point of care testing.

The changes mean that staff can now positively identify patients on the point of care testing meters. This patient’s name and NHI appear onscreen when the patient barcode is scanned on the meter, instead of just the NHI displaying as was the case previously.

This ensures meter operators are testing and capturing results for the correct patient. The test results are now automatically saved to MAP instead of being manually entered thus
removing transcription errors or loss of results. This also means less paperwork and easier clinical review. A further plus is ketone and lactate meter operators can be recertified by doing an action on the meter instead of redoing eLearning. This means quicker recertification and is similar to how it’s done for glucose meters.

These efficiencies combined mean there’s a more time for clinicians to spend on patient care instead of administrating a point of care test system and paperwork, ultimately leading to a better and safer patient experience.

7 PROJECT ENERGIZE

Project Energize actively works in 240 primary and intermediate schools within the Waikato District Health Board area, beginning in 2004. The Project works alongside teachers to deliver healthy eating and physical activity into the school setting and through into communities. Capital Coast DHB, through the Heart Foundation has been delivering the project since 2016 into Wellington schools and is already seeing good results in their 16 schools.

The first CCDHB Project Energize AUT evaluation is showing significantly improved results, with AUT indicating that compared to other reports they have completed, CCDHB’s results are outstanding. The highlight summary includes (statistically significant improvement from 2016 to 2017):

- more children are eating breakfast every day of the week and more children are usually eating breakfast at home
- one third fewer foods purchased from a fast food place or takeaway
- one third fewer fizzy or soft drinks consumed in 2017 compared to 2016
- more children (9%) drinking four or more glasses of water a day
- a marked (10%) decrease in the proportion of children having fizzy drinks. Almost half (48%) had no fizzy drinks in the last week
- slightly (3%) more children drinking fruit juice three or fewer times in the last week. 39% had no fruit juice in the last week
- the overall average time spent each day in physical activity in class time increased from 20 minutes in 2016 to 25 minutes in 2017
- overall, exceeding the goal of 20 minutes of quality physical activity in class time each day
- at all ages and for both genders Capital Coast children were faster in 2016 than 2017.

8 PEOPLE STRATEGY

The recent staff engagement survey gives us the starting point and eight key areas to focus on to better support staff with work pressures and challenging behaviors. We are now looking in more detail at these areas. From 16 October to 3 November, a series of workshops are occurring with staff to develop a People Strategy.

A People Strategy will mean we have a coordinated approach to support and develop our people. It is also about making sure our people are prepared for the future and the changes in health care we expect to see in the next 10 years.
Growing our people is one of our three organisational priorities. Our goal is for our staff to feel safe, happy, and able to perform at their best. The chief executive and executive leadership team have restated their on-going commitment to making this the best place to work.
Capital & Coast DHB
Board Financial Overview
August 2017

Debbie Chin, Chief Executive Officer
Michael McCarthy, Chief Financial Officer
FINANCIAL PERFORMANCE RESULT AND OVERVIEW

Summary

The DHB has a board approved deficit target of ($21m) for the 2017/18 financial year.

The DHB result for the period ending August 2017 is $235k favourable to budget and a deficit of ($2.61m). The year to date (YTD) result was $411k favourable to budget with deficit of ($3.13m) YTD.

Result for Period ended Aug 2017

<table>
<thead>
<tr>
<th>Account Type in $000s</th>
<th>Aug 2017</th>
<th>Year to Date</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>Revenue</td>
<td>91,416</td>
<td>89,889</td>
<td>1,527</td>
</tr>
<tr>
<td>Labour Costs</td>
<td>40,905</td>
<td>39,945</td>
<td>(960)</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>2,053</td>
<td>2,044</td>
<td>(8)</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>10,369</td>
<td>10,255</td>
<td>(114)</td>
</tr>
<tr>
<td>Infrastructure &amp; Non-Clinical</td>
<td>9,673</td>
<td>9,703</td>
<td>30</td>
</tr>
<tr>
<td>Other Providers</td>
<td>31,022</td>
<td>30,782</td>
<td>(239)</td>
</tr>
<tr>
<td>Total</td>
<td>(2,605)</td>
<td>(2,840)</td>
<td>235</td>
</tr>
</tbody>
</table>

YTD Variances against Budget

Revenue – Favourable $1.53m against budget for the month due to recognition of $1.0m of additional IDF revenue in August. Further there was $125k of quarterly wash-up revenue in clinical genetics, revenues from other DHBs ($82k) and adjustment to other MOH contracts. Year to date the DHB is favourable $1.28m only, due to the unfavourable variance in July relating to the timing of savings target achievement.

Labour Costs- Unfavourable $960k against budget, made up of medical ($800k), Allied ($215k) and Support ($77k), offset by underspend in nursing and management /admin $77k. The overspent was as a result of increased overtime and call backs and adverse annual leave movement. In addition there were fewer vacancies than projected. Year to date, the variance is only ($256k) due to favourable timing variance in the previous month.

Clinical Supplies - Unfavourable ($114k) for the month due to increased volumes.

Infrastructure & Non Clinical - The DHB is on target for the month. YTD the result is unfavourable ($212k) against budget, due to spend on consulting costs related to various projects, such as ED 6 hour rule improvements and site master planning.
## External Providers Review

The external provider payments are as per plan. The main drivers for these variances are:

- Capitation costs are ($100k) adverse for the month, mainly due to MOH unbudgeted programmes (mainly Care-Plus Services, VCLA and free under 13). These will be offset by MoH additional revenue for new contracts.

- The balance of the variance is related to timing of contract renewals and costs for 2017/18.

### Capital & Coast DHB - Funder Ext Provider Payments - $000s

<table>
<thead>
<tr>
<th>Month - August 2017</th>
<th>Year to Date</th>
<th>Capital &amp; Coast DHB - Funder Ext Provider Payments - $000s</th>
<th>Variance</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
<td>Last year</td>
<td>Actual vs Budget</td>
<td>Actual vs Last year</td>
</tr>
<tr>
<td>5,863</td>
<td>5,888</td>
<td>5,686</td>
<td>25</td>
<td>(177)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5,176</td>
<td>5,076</td>
<td>4,760</td>
<td>(100)</td>
<td>(416)</td>
</tr>
<tr>
<td>1,673</td>
<td>1,692</td>
<td>1,432</td>
<td>19</td>
<td>(241)</td>
</tr>
<tr>
<td>3,731</td>
<td>3,794</td>
<td>3,703</td>
<td>63</td>
<td>(28)</td>
</tr>
<tr>
<td>1,626</td>
<td>1,629</td>
<td>2,720</td>
<td>3</td>
<td>1,093</td>
</tr>
<tr>
<td>1,878</td>
<td>1,839</td>
<td>1,899</td>
<td>(39)</td>
<td>22</td>
</tr>
<tr>
<td>760</td>
<td>697</td>
<td>689</td>
<td>(64)</td>
<td>(71)</td>
</tr>
<tr>
<td>2,318</td>
<td>2,171</td>
<td>2,093</td>
<td>(147)</td>
<td>(226)</td>
</tr>
<tr>
<td>7,995</td>
<td>7,995</td>
<td>6,844</td>
<td>(0)</td>
<td>(1,151)</td>
</tr>
<tr>
<td><strong>31,021</strong></td>
<td><strong>30,782</strong></td>
<td><strong>29,825</strong></td>
<td><strong>(239)</strong></td>
<td><strong>(1,195)</strong></td>
</tr>
</tbody>
</table>

The external provider payments are as per plan. The main drivers for these variances are:

- Capitation costs are ($100k) adverse for the month, mainly due to MOH unbudgeted programmes (mainly Care-Plus Services, VCLA and free under 13). These will be offset by MoH additional revenue for new contracts.

- The balance of the variance is related to timing of contract renewals and costs for 2017/18.
Employee FTE Financial Reporting to Ministry of Health (MOH Accrued FTE)

For financial accounting purposes MOH require an accrued FTE measure (as shown in the table below). This measure includes all hours on an accrual basis including leave accruals, overtime and casual hours. As an FTE measure this is highly volatile for a 24/7 facility due to the divisor being set based on the number of working days in the month. The Year to Date total is an average for the year. The average $ per FTE is impacted by MECA increases year on year.

<table>
<thead>
<tr>
<th></th>
<th>Month - August 2017</th>
<th>Capital &amp; Coast DHB MOH Accrued FTE</th>
<th>Year to Date</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Last year</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>FTE</td>
</tr>
<tr>
<td>Actual FTE</td>
<td>902</td>
<td>833</td>
<td>885</td>
<td>(68)</td>
</tr>
<tr>
<td>Medical</td>
<td>2,161</td>
<td>2,166</td>
<td>2,100</td>
<td>5</td>
</tr>
<tr>
<td>Nursing</td>
<td>714</td>
<td>692</td>
<td>703</td>
<td>(23)</td>
</tr>
<tr>
<td>Support</td>
<td>141</td>
<td>143</td>
<td>135</td>
<td>2</td>
</tr>
<tr>
<td>Management &amp; Administration</td>
<td>854</td>
<td>803</td>
<td>857</td>
<td>(51)</td>
</tr>
<tr>
<td>Total FTE</td>
<td>4,773</td>
<td>4,637</td>
<td>4,680</td>
<td>(136)</td>
</tr>
<tr>
<td>Average $ per FTE</td>
<td>15,022</td>
<td>15,352</td>
<td>14,586</td>
<td>330</td>
</tr>
<tr>
<td>Medical</td>
<td>15,022</td>
<td>15,352</td>
<td>14,586</td>
<td>330</td>
</tr>
<tr>
<td>Nursing</td>
<td>15,022</td>
<td>15,352</td>
<td>14,586</td>
<td>330</td>
</tr>
<tr>
<td>Allied Health</td>
<td>15,022</td>
<td>15,352</td>
<td>14,586</td>
<td>330</td>
</tr>
<tr>
<td>Support</td>
<td>15,022</td>
<td>15,352</td>
<td>14,586</td>
<td>330</td>
</tr>
<tr>
<td>Management &amp; Administration</td>
<td>15,022</td>
<td>15,352</td>
<td>14,586</td>
<td>330</td>
</tr>
</tbody>
</table>
## CCDHB STATEMENTS OF FINANCIAL POSITION

### Balance Sheet

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual At Aug 2016</th>
<th>Actual At June 2017</th>
<th>Variance At Aug 2016 vs Budget</th>
<th>Variance At Aug 2016 vs Actual At Aug 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>26,082</td>
<td>22,087</td>
<td>8,919</td>
<td>2,821 (13,168)</td>
</tr>
<tr>
<td>Bank NZHP</td>
<td>8,664</td>
<td>8,409</td>
<td>7,713</td>
<td>424 (1,120)</td>
</tr>
<tr>
<td>Trust funds</td>
<td>43,335</td>
<td>44,690</td>
<td>45,407</td>
<td>2,603 (2,886)</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>8,108</td>
<td>8,602</td>
<td>7,397</td>
<td>8,602 (215)</td>
</tr>
<tr>
<td>Inventory/Stock</td>
<td>7,543</td>
<td>5,632</td>
<td>4,255</td>
<td>5,632 (784)</td>
</tr>
<tr>
<td>Prepayments</td>
<td>93,833</td>
<td>86,701</td>
<td>73,785</td>
<td>87,009 (6,418)</td>
</tr>
<tr>
<td>Fixed assets</td>
<td>463,417</td>
<td>465,314</td>
<td>475,251</td>
<td>456,419 (17,115)</td>
</tr>
<tr>
<td>Work in progress - CRISP</td>
<td>6,715</td>
<td>10,503</td>
<td>14,158</td>
<td>15,472 (2,495)</td>
</tr>
<tr>
<td>Work in progress</td>
<td>479,991</td>
<td>485,816</td>
<td>499,423</td>
<td>481,750 (20,673)</td>
</tr>
<tr>
<td>Total fixed assets</td>
<td>6,468</td>
<td>6,468</td>
<td>6,468</td>
<td>6,468 (0)</td>
</tr>
<tr>
<td>Investments in New Zealand Health Partnership</td>
<td>1,150</td>
<td>1,150</td>
<td>1,150</td>
<td>1,150 (0)</td>
</tr>
<tr>
<td>Investment in Allied Laundry</td>
<td>7,618</td>
<td>7,618</td>
<td>7,618</td>
<td>7,618 (0)</td>
</tr>
<tr>
<td>Total investments</td>
<td>581,442</td>
<td>579,700</td>
<td>580,426</td>
<td>576,377 (686)</td>
</tr>
<tr>
<td>Bank overdraft HBL</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accounts payable, Accruals and provisions</td>
<td>69,171</td>
<td>68,709</td>
<td>65,809</td>
<td>64,440 (13,168)</td>
</tr>
<tr>
<td>Loans - Current portion</td>
<td>326</td>
<td>326</td>
<td>62,244</td>
<td>62,000 (2,654)</td>
</tr>
<tr>
<td>Capital Charge payable</td>
<td>2,057</td>
<td>4,800</td>
<td>1,245</td>
<td>777 (2,868)</td>
</tr>
<tr>
<td>Insurance liability</td>
<td>593</td>
<td>593</td>
<td>0</td>
<td>593 (0)</td>
</tr>
<tr>
<td>Current Employee Provisions</td>
<td>19,984</td>
<td>20,969</td>
<td>18,965</td>
<td>20,969 (2,404)</td>
</tr>
<tr>
<td>Accrued Employee Leave</td>
<td>45,034</td>
<td>45,507</td>
<td>41,869</td>
<td>45,507 (3,251)</td>
</tr>
<tr>
<td>Accrued Employee salary &amp; Wages</td>
<td>14,077</td>
<td>11,819</td>
<td>6,470</td>
<td>11,815 (2,200)</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>151,241</td>
<td>152,813</td>
<td>196,611</td>
<td>145,654 (44,668)</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>302</td>
<td>302</td>
<td>277,628</td>
<td>302 (277,326)</td>
</tr>
<tr>
<td>Loans - current portion</td>
<td>8,746</td>
<td>8,488</td>
<td>8,891</td>
<td>8,488 (427)</td>
</tr>
<tr>
<td>Restricted special funds</td>
<td>605</td>
<td>605</td>
<td>229</td>
<td>605 (0)</td>
</tr>
<tr>
<td>Insurance liability</td>
<td>5,868</td>
<td>5,868</td>
<td>5,765</td>
<td>5,868 (0)</td>
</tr>
<tr>
<td>Long-term employee provisions</td>
<td>15,521</td>
<td>15,263</td>
<td>291,513</td>
<td>15,263 (427)</td>
</tr>
<tr>
<td>Total non-current liabilities</td>
<td>166,762</td>
<td>167,833</td>
<td>168,076</td>
<td>160,917 (6,927)</td>
</tr>
<tr>
<td>Total Liabilities</td>
<td>414,680</td>
<td>411,919</td>
<td>415,460</td>
<td>320,291 (25,021)</td>
</tr>
<tr>
<td>Capital repaid</td>
<td>769,822</td>
<td>769,567</td>
<td>769,751</td>
<td>425,132 (344,435)</td>
</tr>
<tr>
<td>Capital repaid</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital injection</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Deficit support</td>
<td>23,351</td>
<td>23,677</td>
<td>23,677</td>
<td>23,677 (240)</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>(378,494)</td>
<td>(381,099)</td>
<td>(381,509)</td>
<td>(356,078) (377,968)</td>
</tr>
<tr>
<td>Total Equity</td>
<td>414,680</td>
<td>411,919</td>
<td>415,460</td>
<td>320,291 (25,021)</td>
</tr>
</tbody>
</table>
## Capital & Coast DHB

### Statement of Cashflows

<table>
<thead>
<tr>
<th>Actual</th>
<th>Budget</th>
<th>Last year</th>
<th>Actual vs Budget</th>
<th>Actual vs Last year</th>
<th>Notes</th>
</tr>
</thead>
</table>

**Operating Activities**

<table>
<thead>
<tr>
<th>YTD August 2017</th>
<th>Actual</th>
<th>Budget</th>
<th>Last year</th>
<th>Actual vs Budget</th>
<th>Actual vs Last year</th>
</tr>
</thead>
</table>

| Receipts | 184,057 | 182,107 | 177,274 | 1,850 | 6,783 |

<table>
<thead>
<tr>
<th>Payments</th>
</tr>
</thead>
</table>

| Payments to employees | 75,997 | 76,139 | 74,191 | 142 | (1,806) |
| Payments to suppliers | 103,824 | 101,517 | 101,075 | (2,307) | (2,749) |

| Capital Charge paid | 0 | 0 | 0 | 0 | 0 |

| GST (net) | (666) | 517 | 1,217 | 1,183 | 1,883 |

| Payments - total | 179,154 | 178,172 | 176,483 | (982) | (2,671) |

| Net cash flow from operating Activities | 4,902 | 3,935 | 791 | 967 | 4,111 |

**Investing Activities**

| Receipts - Interest | 174 | 174 | 248 | 65 | 74 |

| Receipts - Other | 0 | (140) | 0 | (140) | 0 |

| Receipts - total | 174 | 99 | 248 | (75) | 74 |

<table>
<thead>
<tr>
<th>Payments</th>
</tr>
</thead>
</table>

| Investment in associates | 0 | (140) | 710 | (140) | (710) |
| Purchase of fixed assets | 2,869 | 5,000 | 5,123 | 2,131 | 2,254 |

| Payments - total | 2,869 | 4,860 | 4,413 | 1,991 | 1,544 |

| Net cash flow from investing Activities | (2,695) | (2,695) | (2,695) | (2,695) | (2,695) |

**Financing Activities**

| Receipts - Interest | 0 | 17 | 0 | 17 | 0 |

| Receipts - total | 0 | 17 | 0 | 17 | 0 |

<table>
<thead>
<tr>
<th>Payments</th>
</tr>
</thead>
</table>

| Interest payments | 0 | 8 | 0 | 8 | 0 |

| Payments - total | 0 | 8 | 0 | 8 | 0 |

| Net cash flow from financing Activities | 0 | (71) | 0 | 71 | 0 |

| Net inflow/(outflow) of CCDHB funds | 2,208 | (1,036) | (3,374) | 2,954 | 5,729 |

### Year to Date

| Opening cash | 28,812 | 28,812 | 20,100 | 0 | (8,712) |

| Net inflow funds | 154,231 | 182,153 | 177,522 | 1,292 | 6,857 |

| Net (outflow) funds | 182,023 | 183,189 | 180,896 | 1,025 | (1,127) |

| Net inflow/(outflow) of CCDHB funds | 2,208 | (1,036) | (3,374) | 2,954 | 5,729 |

| Closing cash | 31,020 | 27,776 | 16,726 | 3,244 | 14,294 |
Notes to the Balance Sheet and Cashflows

A) Notes to Balance Sheet:

1. The DHB’s cash balance at the end of August is higher than budget mainly due to timing differences. All surplus funds are invested by New Zealand Health Partnerships in short term investments;

2. Accounts receivable is higher than budget due to timing differences. Some of the main customers include Ministry of Health $3m, Hutt Valley DHB $1.6m, Clinical training agency $1.6m;

3. Total non-current assets is less than budget due to less than expected capital spend;

4. Accounts payable, accruals and provisions is in line with the budget. Some main suppliers include Healthcare Logistics $1.1m, Baxter Healthcare $0.4m, various SIDU related accruals $27.1m;

5. Accrued employee salary & wages is in line with the budget.

6. Crown loans and equity are in line with budget. The comparative previous year balances are different due to the conversion of all Crown loans to equity in February 2017.

B) Notes to Cash flow statement:

7. The net cash flow from operating activities is less than budget due to timing differences;

8. The net cash flow from investment activities is less than the budget due to less than expected capital spend;

C) Ratios

9. Current Ratio – This ratio determines the DHB’s ability to pay back its short term liabilities. DHB’s current ratio is 0.61 (June 17: 0.62);

10. Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base. DHB’s total liability to equity ratio is 29.71 (June 17 27.73).
Cash Forecast

We have projected our cash position based on the proposed capital budget and a forecast deficit of $21m for 2017/18. However, any deterioration in these forecasts may put the facility limit at risk and we continue to monitor this closely. The working capital facility limit is approximately $55m.
**BOARD DISCUSSION**

**Date:** 2 October 2017

**Author**
- Catherine Epps, Executive Director, Allied Health, Scientific and Technical
- Andrea McCance, Executive Director, Nursing and Midwifery
- John Tait, Chief Medical Officer

**Endorsed by**
- Debbie Chin, Chief Executive Officer, CCDHB
- Executive Leadership Team, and Clinical Council, CCDHB

**Subject**
CLINICAL COUNCIL – SIX MONTH UPDATE

**RECOMMENDATIONS**

It is **recommended** that the Board:

a) **Note** the contents of the Update on the Clinical Council

b) **Note** the plan for further development and alignment with the ‘Even better healthcare plan’.

**APPENDICES**

1. Terms of Reference for Clinical Council

---

**1. INTRODUCTION**

**1.1 Purpose**

This paper responds to a Board request for a more thorough update on the work of the Clinical Council following its establishment six months ago. It also informs the Board about experience to date on how best to deliver the functions of the Clinical Council.

**1.2 Previous Board Discussions/Decisions**

The formation and implementation of the Clinical Council was highly supported by the Board, during the course of 2017.

**2. BACKGROUND AT CCDHB**

The incoming Board members and Chair recommended a Clinical Council model at CCDHB to enable the Board to receive more explicit advice from Clinical Leaders across the health continuum (primary, secondary, and tertiary care) about clinical issues relevant to Board level decisions. The Clinical Council was formed as an advisory group who report to the Chief Executive Officer, who in turn reports to the Board.

Clinical Leadership across the health system is recognised as a crucial driver in the continuous improvement of a safe and effective health system. A clinical leadership organisational structure exists for all health professions (Medicine, Nursing, Midwifery, Allied Health, Scientific and Technical) across CCDHB, albeit in different structures and configurations to meet local service need.
CCDHB has also had a comprehensive Clinical Governance model in place for some years with a number of committees spanning key areas of clinical risk and complexity. There is also a Clinical Governance Committee structure within each of the Directorates, and at a service level too (where needed), within CCDHB. These committees between them provide on-going support and oversight to ensure that our complex systems and services provide safe and high quality healthcare. Mechanisms such as certification audits, by the Ministry of Health, ensure that these processes meet best practice standards. Over time, the model at CCDHB has continued to be refined.

3. CLINICAL COUNCIL - THE FIRST SIX MONTHS

The Clinical Council constructed their Terms of Reference (ToR) in the knowledge of the role and functions of other Clinical Governance committees within CCDHB. In contrast to many of the other committees, the Clinical Council’s role is to provide advice to the Board via the CEO rather than to provide feedback to health practitioners and services within the CCDHB. The Terms of Reference for the Clinical Council were agreed by the Executive Leadership Team, and endorsed by the Board. (Please see Appendix 1).

The Clinical Council has met monthly since commencing in March, apart from July where there was no Board meeting. The primary purpose of the Council is to review papers with a clinical focus, to ensure the Board receives robust advice on clinical matters. Most papers are presented to the Council by the clinical leader(s) with the subject matter expertise about the issue being considered. The range of papers considered and the recommendations made are listed in Appendix 2.

The Clinical Council members have from time to time reflected on how they can add the most value to the Board and wider organisation. Currently by the time papers and issues reach the Clinical Council they have been thoroughly researched and debated in the relevant local services. Additionally, many issues and papers are not raised to the Clinical Council and in turn the Board, where the issue raised is not considered a priority by others in the various teams and services. Alternatively, the investment required may be sufficiently small that the proposal does not require Board (and therefore Clinical Council) sign-off. This means the Clinical Council is not presented with the full spectrum of clinical decisions and issues arising within the DHB.

The other two larger district health boards that use a Clinical Council (Southern and Canterbury) have also indicated that they are having similar discussions about the role and function of their Clinical Council. So there is agreement to share findings and learning together, particularly as Canterbury DHB are planning an overseas visit to look at work in America. At CCDHB, there has been a mix of clinical issues discussed at the Clinical Council. As per appendix two, they have spanned new clinical practice, new services, and replacement of current capital equipment.

4. DISCUSSION

4.1 Analysis and Recommendation

Each paper presented tends to stand up on its own merit as an important area of the health system to invest in. So the Clinical Council has favoured towards endorsing each proposal, and adding additional recommendations for the Board to consider, where appropriate. This has also been done in the knowledge that the Clinical Council does not have sight of the whole. The work done to consider the financial implications, the economic case, opportunity costs, and alignment to priorities does not wholly sit within the parameters of the Clinical Council.

The partnerships that we as health practitioners and clinical leaders have with our operational, financial, and strategic planning colleagues, mean that the joint decision making forums, such as the Executive Leadership Team, (where the professional heads are members and represent the clinical workforces,) continue with their decision making function.
From the learning and feedback to date, the Clinical Council could be seen as using its advisory role to consider more long term and strategic issues. It could perform a useful role within the DHB’s framework to inform investment choices and plans and prioritise the many options for the population from a clinical perspective. In the future the remit of the Clinical Council could align with that of the Citizens’ Council so that both Councils can (report via the CEO) to enable the Board to clearly consider the relative benefits of different proposals from multiple perspectives.

5. NEXT STEPS

A summary of the discussion from the Clinical Council will be included as a separate agenda item on the Board Agenda on a monthly basis. Any questions can be directed to the professional head who chaired the meeting that month.

Further work is being undertaken to identify an appropriate prioritisation approach for organisational investment decisions, which the Clinical Council could utilise when considering the relative clinical merits of proposals. Broadly speaking prioritisation should consider factors such as clinical risks and benefits, health needs of the population including equity issues, cost-effectiveness and financial/budgetary constraints.

There is work underway reviewing the role of clinical input into strategic decision-making across the DHB. Reviewing the role of clinical input intends to support the objectives of the “Even better healthcare” plan so that whole of system investment decisions are informed by high quality clinical evidence. Any changes to the Clinical Council will be aligned to the work of the above plan.
# CCDHB Clinical Council

## Terms of Reference

| Purpose | The CCDHB Clinical Council’s purpose is to ensure optimum health for its CCDHB population. This will be achieved through clinical engagement, and a strong focus on an innovative and integrated quality health system. The Clinical Council will be responsible for informing the Board, via the Chief Executive (CE), on issues and solutions that span the CCDHB clinical governance framework across the primary, secondary and tertiary health services in relation to the triple aim:  
- Improved quality, safety and experience of care  
- Improved health and equity for all populations  
- Best value for public health system resources |
| Functions | The functions of the Clinical Council are to:  
- provide advice on key proposed service changes and measures to use resources more effectively and equitably  
- provide a forum for formal clinical engagement in decision-making  
- to communicate these decisions openly to clinicians and Board members.  

The Clinical Council’s advice must ensure:  
1. service changes are introduced across primary, secondary and tertiary care services to address both clinical and cost effectiveness  
2. excellence and innovation in education, training and research  
3. recommendations align with the DHBs Strategic Objectives. |
| Level of Authority | The Council has the authority to give advice, and make recommendations / endorsements to the Board via the CE.  
To assist it in this function the Clinical Council may:  
- request reports and presentations from particular groups  
- establish sub-groups to investigate and report back on particular matters  
- commission audits or investigations on particular issues  
- co-opt people from time to time as required for a specific purpose.  

The Clinical Council’s role is primarily one of advice to the Board, aiming at service improvements, not operational or line management. |
| Membership | Members of the Clinical Council will be initially appointed for a one year and may be re-appointed for up to a further two year term.  
The Clinical Council will consist of informed clinicians focused on working towards an integrated, quality health system for the CCDHB population. They will be expected to consider the whole health system when forming views and advising on decisions rather than representing or advocating for their particular profession, service or department. |
**Members by Position:**
- Chief Medical Officer (Co-Chair)
- Executive Director of Nursing and Midwifery
- Executive Director of Allied Health, Scientific and Technical

**Members by Appointment:**
Up to twelve other clinicians. This will include:
- clinicians from a variety of professional groups and settings across the health system who between then have expertise in primary care, community work, hospital services and population health. Currently this includes:
  - Medical Director MHAIDS
  - three Clinical Directors, HHS
  - two GPs
  - two Nurse Leaders from across the health system
  - one Community Allied Health
  - one clinician early in career / developing leadership.

**Requirements for appointed members**
All appointed members will:
- have a current practicing certificate
- understand and be committed to clinical governance
- have recognised credibility as a clinician in their own field
- demonstrate commitment to organisational goals and strategic development
- are prepared to devote time to participate in the work of the Clinical Council.

**Chairperson**
The Clinical Council will be co-chaired on a rotational basis by the Professional Heads. The Chairperson is expected to report back verbally to the Board meetings.

**Quorum**
A quorum will be 8, and must include at least two representatives based outside the hospital.

**Meetings**
Meetings will be held monthly.

**Reporting**
The Clinical Council will report through the CE to the Board. The Clinical Council may also provide reports to the stakeholders of the CCDHB Health System to ensure transparency and free flow of information as needed.

**Minutes**
Minutes will be circulated to all members of the Clinical Council.

**Support**
The Clinical Council will be supported with secretarial, analytical, project management and improvement advisor support as needed.
## 15 March 2017 – initial meeting

<table>
<thead>
<tr>
<th>Item</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Clinical Council Structure Attached</td>
</tr>
<tr>
<td>2.0</td>
<td>Terms of Reference Attached</td>
</tr>
</tbody>
</table>

## 12 April 2017

<table>
<thead>
<tr>
<th>Item</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Capacity Planner Carey Virtue <strong>Endorsed</strong> the concept of Capacity Planner</td>
</tr>
<tr>
<td>2.0</td>
<td>TAVI Carey Virtue &amp; Anna Ranta <strong>ENDORSED</strong> the implementation of TAVI services at CCDHB with a recommendation to re-present in 12 months</td>
</tr>
</tbody>
</table>
| 3.0  | ICU Expansion Derek Snelling **Discussed** and everyone agreed there was no other realistic option  
  - Data revealed ICU short of 6 beds  
  - Business Case is a work-in-progress  
  - Draft Building Plan in progress – extension in to RMO Unit |

## 11 May 2017

<table>
<thead>
<tr>
<th>Item</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| 1.0  | Operating – theatres, spinal & neurosurgery Chris Hoffman **Discussed** significant CAPEX purchase.  
  The Council **SUPPORTED** the case. |
| 2.0  | Child Strategy – Children’s Hospital Simon Harding **Update** regarding the case for Treasury. **ENDORSED & SUPPORTED** the direction. |

## 8 June 2017

<table>
<thead>
<tr>
<th>Item</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| 1.0  | Health System Planning Rachel Haggerty The Clinical Council **ENDORSED** the approach and direction of the health system plan. They acknowledge that this is a significant shift in thinking and models of service delivery, particularly for some parts of the health system. The Clinical Council members also expect to be part of the team that design the detail of the plan going forward. **Discussed**  
  - Significant shift in our thinking  
  - Discussed equality versus equity  
  - Approach to changing mode of operating  
  - Expect to lead the implementation and design of the detail  
  - Direction of travel supported |
| 2.0  | Cognitive Institute Donna Hickey **Information**  
  - In principle we need this or similar  
  - A one year investment with a view to longer term investment is needed with agreed KPIs  
  - What does success look like?  
  - Unable to comment on ‘value for money’ |
| 3.0  | Clot Retrieval Anna Ranta **ENDORSED**  
  - Highly efficacious  
  - Ethically needs to occur  
  - System savings rather than hospital |

## 13 July 2017 – No meeting held
### 10 AUGUST 2017

| 1.0 | The Maori Perspective  
**Arawhetu Gray** | **Information**  
Arawhetu Gray - questions to be considered from a bicultural perspective when reviewing papers for the Board (as per our earlier agreed action)  
- bi-cultural practice & clinical governance  
- Health equity  
- Ax tool – tool to be circulated |

| 2.0 | Birthing Unit paper (draft) | **Considered**  
- Home births data and Models of Care  
- Impact of Melling Unit  
- Opportunity of on-going use of Kenepuru  
- Perinatal mortality data seems high  
- Primary Unit could be more of a place of sanctuary and place of cultural expertise  
- Rate of people having LMC seems low at 73%. Potential to improve  
- Need good financial analysis  
**Clinical Council Supportive** of direction and **ENDORSED** the approach |

| 3.0 | Cranio-facial business case –  
**Kaye Hudson** | **Discussed**  
- Proposal to set up Cranio-facial Service  
- Business case not yet completed  
  - What is the NZ/National context and opportunities?  
  - Advised re importance of expertise needed – business analysis  
  - Will review the business case |

### 14 September 2017

| 2.0 | Verifying Death  
**Gabrielle Driscoll** | **Considered**  
- The extent of the consultation for the pilot (HHS, ICC, PHO, Mary Potter Hospice (MPH))  
- Council agreed no risks and consultation with GPs has improved communication about death verification  
- Unanimously supported the three month pilot  
**Clinical Council ENDORSED/SUPPORTED** the three month pilot. |

| 3.0 | Services for Young people with Alcohol and Other Drugs and Mental Health Problems  
**Arawhetu Gray** | **Discussed**  
- Council members agreed the need for such a service  
- Council discussed whether funding would be disinvested from Adult to Young People and were reassured, no  
- Council expressed concern around the lack of data, lack of qualified need for the service and what criteria funding was based on, which is already being addressed  
- There was also discussion about the need to build a capability and capacity with PHOs  
**Clinical Council ENDORSED/SUPPORTED** the service to proceed. |

**September additional items** – discussion carried out by email

| 4.0 | Replacement of the Heart-Lung machine | Both business cases were **ENDORSED & SUPPORTED** by the members of the Clinical council |

| 5.0 | Approval to proceed with e-Pharmacy investment | |
## Membership

<table>
<thead>
<tr>
<th>Designation</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Director Mental Health</td>
<td>Alison Masters</td>
<td><a href="mailto:Alison.Masters@ccdhb.org.nz">Alison.Masters@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Executive Director of Nursing and Midwifery</td>
<td>Andrea McCance</td>
<td><a href="mailto:Andrea.McCance@ccdhb.org.nz">Andrea.McCance@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Clinical Director MCC</td>
<td>Anna Ranta</td>
<td><a href="mailto:Anna.Ranta@ccdhb.org.nz">Anna.Ranta@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>RMO Representative</td>
<td>Ayman Khan</td>
<td><a href="mailto:Ayman.Khan@ccdhb.org.nz">Ayman.Khan@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Chair of Integrated Care Collaborative (ICC) &amp; GP</td>
<td>Bryan Betty</td>
<td><a href="mailto:Bryan.Betty@pharmac.govt.nz">Bryan.Betty@pharmac.govt.nz</a></td>
</tr>
<tr>
<td>Chair of Primary-Secondary Clinical Governance (PSCG) &amp; Executive Director of Allied Health</td>
<td>Catherine Epps</td>
<td><a href="mailto:Catherine.Epps@ccdhb.org.nz">Catherine.Epps@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Director of Nursing, Primary &amp; Community</td>
<td>Emma Hickson</td>
<td><a href="mailto:Emma.Hickson@ccdhb.org.nz">Emma.Hickson@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Clinical Director SWC</td>
<td>Grant Kiddle</td>
<td><a href="mailto:Grant.Kiddle@ccdhb.org.nz">Grant.Kiddle@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Nominated Community Allied Health</td>
<td>Grant Plumbley</td>
<td><a href="mailto:grant@willisstreetphysiotherapy.co.nz">grant@willisstreetphysiotherapy.co.nz</a></td>
</tr>
<tr>
<td>Clinical Director MCC</td>
<td>Grant Pidgeon</td>
<td><a href="mailto:Grant.Pidgeon@ccdhb.org.nz">Grant.Pidgeon@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Clinical Director CSS, &amp; Chair of Choosing Wisely</td>
<td>James Entwisle</td>
<td><a href="mailto:James.Entwisle@ccdhb.org.nz">James.Entwisle@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Nominated GP</td>
<td>Jeff Lowe</td>
<td><a href="mailto:Jeff.Lowe@kmc.co.nz">Jeff.Lowe@kmc.co.nz</a></td>
</tr>
<tr>
<td>Nominated ADON</td>
<td>Alison Rowe</td>
<td><a href="mailto:Alison.Rowe@ccdhb.org.nz">Alison.Rowe@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Chief Medical Officer (CMO)</td>
<td>John Tait</td>
<td><a href="mailto:John.Tait@ccdhb.org.nz">John.Tait@ccdhb.org.nz</a></td>
</tr>
<tr>
<td>Chair of Medical Reference Group (MRG)</td>
<td>Sinead Donnelly</td>
<td><a href="mailto:Sinead.Donnelly@ccdhb.org.nz">Sinead.Donnelly@ccdhb.org.nz</a></td>
</tr>
</tbody>
</table>

### 2017 Agreed Meeting Dates

To be held the 2nd Thursday every month from 4.30 – 5.30pm, GNB, Boardroom, Level 11 as follows:

- 11 May 17
- 8 June 17
- 10 August 17
- 14 September 17
- 12 October 17
- 9 November 17
- 14 December 17
ADVISORY COMMITTEE REPORT
Date: 7 October 2017

Author Dr Pauline Boyles, Director of Disability Strategy and Performance (SIP)
From Bob Francis, Chair of Sub Regional Disability Advisory Group
Rachel Haggerty, Director Strategy Innovation and Performance
Endorsed By Debbie Chin, Chief Executive, Capital and Coast DHB
Subject DISABILITY STRATEGY IMPLEMENTATION HIGHLIGHTS DASHBOARD FIRST QUARTER
UPDATE ON LOCAL AREA INITIATIVES – SRDAG MEMBERS REPORT BACK

RECOMMENDATIONS

It is recommended that Board members:

a) Note the development of the performance monitoring report sub-regional Dashboard of highlights (first quarter) against the sub-regional Disability Strategy and 17/18 commitments (including annual plan)
b) Note the co-production of electronic health passport currently occurring with the Ministry of Health, Health and Disability Commissioner and the three District Health Boards
c) Note the Capital & Coast and Sub-Regional Disability Advisory highlights.

1. PURPOSE

To present key achievements against sub regional strategic framework and recent progress updates on improving clinical and service responsiveness Capital and Coast District Health Board.

2. PERFORMANCE FRAMEWORK: SUB REGIONAL DISABILITY STRATEGY (2017-22)

The Sub Regional Disability Strategy was endorsed by the three District Health Boards in April 2017 and publically launched June 9 2017. The performance framework presented shows how this ambitious plan will begin and gradually unfold with annual developmental targets. The following summary will target two key strategic areas: the monitoring framework and the development of electronic resources.

2.1 Performance Framework and Structural Measures

Progress under the following two focus areas are described as progress highlights:

Focus Area 1: Leadership
The sub-regional DHBs, in partnership with disabled people, their families, Whanau and communities; plus, other relevant stakeholders, will provide leadership to achieve equity in health and wellbeing on an equal basis to others.

1.4 Ensure better accountability by creating a monitoring framework
The strategic framework was produced after significant inter-sectorial consultation by a sub-committee of SRDAG with the Disability Strategy team. The 72 actions underpinning the main areas
are documented and tracked within the wider framework. The front page highlights dashboard measures activity and early progress against each key focus area. This framework represents the most rigorous form of monitoring available nationally available within District Health Boards. It identifies progress and quality indicators yielding some contributory measures to overall service improvement.

The monitoring of improvement on disability access using structural/system measures remains problematic in health services. The lack of a consistent national and international data set that is agreed across all services is demonstrated by the lack of disability population analysis in each published health needs assessment report. Therefore a key deliverable of this strategy of interest nationally is the overall methodology including data collection using disability alerts. In total 9000 people now have registered disability alerts across CCDHB and Hutt Valley.

The SIP analyst team, two consumer/clinical members of SRDAG and Disability Strategy and Performance have formed an expert monitoring group to meet the requirements of strategic area 1.4.

Focus Area 2: Inclusion and Support
The sub-regional DHBs will improve and promote the full inclusion of disabled people and will ensure the best service for disabled people and their families is available on an equitable basis. The co-production of the electronic health passport is currently underway by the Ministry of Health, Health and Disability Commissioner, and Sub-Regional District Health Boards.

This project relates to the following strategic areas:

1.1 Encourage intersectoral leadership on disability issues across government organisations and community and public Health Services to Partner Work with local communities.

1.2 Practice positive partnerships to enhance collaboration and co-design

2.2 Ensure IT platforms accommodate disability responsiveness tools.

The sustained commitment by all sub regional DHBs to the health passport since 2011 has resulted finally in a significant milestone agreement with the Health and Disability Commissioner and the Ministry of Health to refresh and develop an electronic version of the health passport. The leadership of Bob Francis is recognized in this report as pivotal to gaining funding from the Ministry of Health for the first stage development. The agenda shows the extensive work required to meet the needs of a variety of stakeholders.

Considerable work has been done to achieve alliances with consumers and clinicians to identify testing environments and opportunities. At least 30 people from a variety of skill areas and experiences are engaged in the workshops and testing opportunities are planned over the next month.

Negotiation with the Ministry of Health and the Director General for further funding for the next stage will occur within the next few weeks supported by the Health and Disability Commissioner.

Focus Area 3: Access
Services are more accessible and meet the health, wellbeing and social needs of disabled people, their families and Whanau.

3.4 Improve access to New Zealand Sign Language interpreters and quality of care for Deaf community
Progress on electronic resource development (MSD funded) is on track developed with support and advice from a sub regional deaf task force group. It is expected the resources will be launched early 2018.
An article documenting research which took place in 2015 on the experiences of deaf people within health services has been accepted for publication by the New Zealand Medical Journal. It is expected to be released by the end of the year.

Co-writers are Jo Witko, Dr Pauline Boyles, Dr Kirsten Smiler (Post-doctoral fellow) and Rachel McKee (Victoria University post-doctoral fellow). This work is unique in New Zealand and is expected to attract considerable attention from media. An important outcome is the commitment that has now been made by Strategy Innovation and Performance and the Disability Strategy Team to a long term plan to improve access for deaf NZSL users. The plan also aims to benefit people who are also hard of hearing.

3. CAPITAL AND COAST DHB HIGHLIGHTS

The highlights of the work in Capital & Coast are:

- Work force Development: a review of work force needs with regard to disability competence as per the sub regional plan is big undertaken. Education sessions are being co led by consumers and staff across a range of disciplines with excellent evaluations.
- Interim Clinical Governance (ICG)\(^1\) is leading to timely decisions between and by needs assessment services. Seven patients were referred via the Disability Strategy team during September. Each referral was accepted but also referred on to the relevant agency which created immediate transparent and timely responses prior to the date of the panel indicating improved communications and responsiveness.
- Engagement in Health Consumer Council’s Annual Meeting.
- Whole of Life Strategic project on development of an integrated approach to needs assessment service delivery is progressing well with excellent cross systems engagement from community and hospital services.
- SRDAG involvement in Citizen’s Health Council development has been endorsed and supported by the group. Citizen’s Health Council follow-up workshop with all partners 27 October.

4. SUB REGIONAL DISABILITY ADVISORY GROUP UPDATE

The group has been actively engaged in the co-production of the health passport design as well as a range of local and national development areas. The following areas of activity were reported at the last meeting 29\(^{th}\) September 2017:

- People First\(^2\) member input and presentations on Health Passport to regional members.
- Wairarapa and Hutt Valley Healthy Ageing Expos were community driven and successful staff attendance.
- MOH Health and Disability Workforce Strategy, Consumer Working Group, 11 August.
- Engagement with Ministry of Health on Electronic record.
- Nursing Workforce Taskforce, meeting 25 August. Consumer representation from sub regional members.
- IHC Public Meeting on Enabling Good Lives (EGL), 29 August, St Joseph’s Church: report on Enabling Good Lives and Disability Support System Transformation demonstration (Mid Central).
- MOH NZ Health Strategy road show, half day 6 Sept, Pipitea Marae.
- Completion of Frequently Asked Questions website for the public.
- New Zealand Medical Journal has accepted article for publication (experiences of deaf people within health services).
- IHC/ DPA Election Forum, 7 Sept, ASB Arena, Kilbirnie.

\(^1\) ICG was established to address the needs of complex patients for whom clinicians struggled to discharge and/or place in the community due to the funding silos between age groups and diagnoses.

\(^2\) People First is the national group which advocates for people with learning disabilities and who have a representative on SRDAG.

Wairarapa, Hutt Valley and Capital & Coast District Health Board

CCDHB Public 25 October 2017 - 2 ADVISORY COMMITTEE

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Significant work is being done by each member in their local area as well as in raising the profile of disability and health within a range of other forums. This includes election forums, health forums and multiple workshops on Disability Support System transformation. Their ownership of and engagement with the work within each DHB and the Disability Strategy team is invaluable and much appreciated.
It is **recommended** that the Board:

a) **Note** that an amendment has been prepared to the current version of the Board Governance Manual

b) **Note** that the amendments include making the Governance Manual a standalone CCDHB document, reinserting the Iwi Partnership Board MOU and various other technical amendment

c) **Agree** to rescinding the current (2016) version of the Board Governance Manual and replacing it with the new version attached

d) **Agree** to the new version of the Governance Manual being published on the CCDHB website.

**APPENDIX**


1. **PURPOSE**

This report briefs the Board on the latest amendments to the CCDHB Board Governance Manual and seeks approval to replace the current Governance Manual with an updated version.

2. **BACKGROUND**

The CCDHB Board Governance Manual was first adopted by the Board in 2012. It was based on the State Services Commission *Resource for Preparation of Governance Manuals – Guidance for District Health Boards* publication (2010). The CCDHB Board Governance Manual is very similar to the Governance Manuals adopted by other DHB Boards.

The Governance Manual was amended in 2014 to be a “3D” document (and to reflect the changes being made to the governance and reporting regime in the Crown Entities Act at the time). The Governance Manual was also amended in 2016 to include new provisions relevant to the Health and Safety at Work Act 2015 and the Health and Safety Charter.

The 3D integration project is not being progressed at this time and it is no longer so appropriate to have a 3D Governance Manual. The latest amended version of the Governance Manual (attached) has therefore been “un-3D’d”. Various other refinements and minor corrections have also been made.

3. **BOARD GOVERNANCE MANUAL**

The most significant amendment to the Governance Manual is to reinsert the MOU between CCDHB and Iwi (see page 46 and Appendix 6). These provisions were included in the Governance Manual until 2014
when they were removed from the 3D Governance Manual because HVDHB and Wairarapa DHBs did not have Maori Partnership Boards.

The Iwi Partnership Board is in the process of revising the MOU. The revisions will need to be formally adopted and approved, and when that has happened it will be appropriate to include the new document in the Governance Manual. In the meantime the current MOU is the document that should be reinserted in the Governance Manual.

Other changes of note include:

1. The current Governance Manual says the SSC Code of Conduct is attached when the Code of Conduct actually attached to the Governance Manual is the CCDHB Code of Conduct specifically prepared for the Board and Board committees. The text is being corrected, and moved to page 32 (where Board conduct is more relevant).

2. The up-to-date version of the Board fees and expense reimbursement policy is referred to and attached to the Governance Manual (page 45 and Appendix 5).

3. The Standing Orders are amended to permit members to participate in Board and committee meetings by teleconference or video link. This is expressly permitted under the NZPHD Act (Schedule 3, clause 14), and it is not clear why it is not permitted under existing Standing Order 5.3.1 (page 74). There seems to have been some confusion between members passing resolutions by email (which is not permitted) and at real-time electronic meetings (which is permitted under the NZPHD Act and should not have been excluded by the Standing Orders).

4. DSAC is still a 3DHB committee, so their terms of reference are not being changed. CPHAC and HAC are no longer operating as 3DHB committees so the headings to their terms of reference are being amended. The HVDHB FRAC terms of reference are also being removed from the CCDHB Governance Manual.

5. Some new terms have been added to the (Ministry supplied) Glossary in Appendix 7.

There are also various detailed edits and corrections that are being made. Some of the edits are to references to other documents that need to be updated. None of these changes are material.

4. PROCESS

The Governance Manual is the Board’s document and it can only be amended by resolution of the Board. A PDF of the manual is available to the public among other Board documents on the CCDHB website.

We have shared the redraft of the Governance Manual with HVDHB and Wairarapa DHB.

Board members have been consulted on the changes to the Governance Manual, although the only comments were received from Board member Darrin Sykes.

The proposal is that the existing Board Governance Manual from 2016 be rescinded and replaced with the revised version.
It is recommended that the Board:

a) Note the number of reported Health & Safety incidents has decreased slightly this month

b) Note that there were no reported Notifiable Events this month, continuing an eleven month trend

c) Note the number of incidents resulting in lost time injuries has stayed the same for General incidents and slightly decreased for MHAIDS

d) Note: The current Health and Safety Risks.

All information accurate at time of report production – 04/10/2017

EXECUTIVE SUMMARY

1. RISK REGISTER

- There are currently 17 active health and safety risks identified on the risk register. Two new risks have been added:
  - 202: This encompasses the pressure staff feel under both in terms of workload and resourcing
  - 204: Inability to provide complete rosters or replace sick staff members is resulting in nursing staff working extended or double shifts that is resulting in increased nursing staff fatigue

- The H&S risk register is available in pages 4-5 (new risks) and 16-22 of the September Risk Report

2. INCIDENTS

Higher reporting indicates a stronger health and safety culture and provides a more realistic picture of the exposure to hazards experienced by our workers. It is the actual work injury claims that accurately reflect the level of harm that is occurring.

Verbal Abuse/Threatening behaviour was the highest category of reported incident, with physical assaults the second.
# 2.1 Performance Summary

## Performance Indicator

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Status</th>
<th>Trend (Past 12 months)</th>
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</thead>
<tbody>
<tr>
<td><strong>H&amp;S Incidents</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Total Number of Reported Incidents</td>
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<td>154</td>
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<tr>
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<td>Number of Incidents involving visitors</td>
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<td>Number of Incidents involving contractors</td>
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## H&S Incident Lag Indicators

- Blood or Body Fluid Exposure | 15 | 23 | Green |
- Slips, Trips, Falls | 6 | 11 | Green |
- Physical Assault of Workers - Excluding MHAIDS | 5 | 11 | Green |
- Physical Assault of Workers - MHAIDS | 23 | 20 | Green |
- Patient Handling | 7 | 11 | Green |
- Object Handling | 8 | 2 | Green |

## Performance Indicator

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Target</th>
<th>Status</th>
<th>Trend (Past 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Pre-Employment Health Screening completed prior to start*</td>
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<td>85%</td>
<td>100%</td>
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<tr>
<td>% of H&amp;S Fundamentals Managers completed</td>
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<td>81%</td>
<td>90%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>% of Managers – Injury Management completed</td>
<td>55%</td>
<td>49%</td>
<td>90%</td>
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</tr>
<tr>
<td>% of H&amp;S Incidents investigated within 14 days*</td>
<td>70%</td>
<td>57%</td>
<td>100%</td>
<td>Red</td>
<td></td>
</tr>
</tbody>
</table>

*Pre-employment Health Declarations being received with less than the required 2 weeks’ notice is the cause of this
*A two month lag in reporting is required to allow for accurate reporting

## Claims & Injury Statistics

### current period

- **Number of ACC45 Injury Claims**: 12, 2
- **Number of Medical Fees Only Claims**: 7, 1
- **Number of Lost Time Injuries**: 5, 1
- **Number of Lost Days**: 21, 7
- **Lost Time Injury Frequency Rate**: 10, 26

### Trend – General (Past 12 months)

### Trend – MHAIDS (Past 12 months)

- **Injury Claims**: Any work related injury resulting in an ACC claim
- **Medical Fee Only Claims**: Any work related injury which results in an ACC claim for treatment but with no lost time
- **Lost Time Injury**: Any incident which results in an ACC lost time injury
- **Lost Time Injury Frequency Rate**: The number of lost-time injuries (per million hours worked) within a given accounting period relative to the total number of hours worked in the same accounting period
2.2 Lost Time Injuries (LTI)

Current Month

<table>
<thead>
<tr>
<th>Category of Incident</th>
<th>Directorate</th>
<th>Department</th>
<th>Days Lost to Date</th>
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</thead>
<tbody>
<tr>
<td>Physical Assault</td>
<td>Medicine, Cancer &amp; Community</td>
<td>ORA - Ward 4 Kenepuru</td>
<td>7</td>
</tr>
<tr>
<td>Physical Assault</td>
<td>MHAIDS</td>
<td>Adult Community Mental Health and Addictions</td>
<td>7</td>
</tr>
<tr>
<td>Slip, Trip, Fall</td>
<td>Surgery, Women &amp; Children’s</td>
<td>Theatres - Wellington</td>
<td>5</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>Medicine, Cancer &amp; Community</td>
<td>Ward 6 East</td>
<td>3</td>
</tr>
<tr>
<td>Pain &amp; Discomfort</td>
<td>Medicine, Cancer &amp; Community</td>
<td>Kenepuru Surgical Unit</td>
<td>3</td>
</tr>
<tr>
<td>Slip, Trip, Fall</td>
<td>Medicine, Cancer &amp; Community</td>
<td>Transit and Patient Travel</td>
<td>3</td>
</tr>
</tbody>
</table>

Past 12 months

2.3 Notifiable Events
- No Notifiable Event incidents were reported in September 2017
- There has been only one Notifiable Event in the past 12 months.

2.4 Serious Injury Reduction
The Government has set a target of reducing serious injuries and fatalities in the workplace by at least 25% by 2020. As can be seen from 2.3 above, CCDHB has a very low incidence of Notifiable Events (serious injuries and fatalities).

3. EMPLOYEE ASSISTANCE PROGRAMME

3.1 EAP
Overall, the number of employees referring to EAP has decreased this month.

The number of referrals for work related reasons increased slightly from 33 the previous month to 38 this month. Non-work related issues accounted for 62% of all referrals.
3.2 Monthly Referrals to EAP:

**Reasons for Referrals (as stated by worker)**

- Workload, 3
- Trauma, 1
- Relocation, 1
- Bullying, 4
- Career, 4
- Conditions, 3
- Environment, 2
- Harassment, 1
- Performance, 5
- Relationship with Manager, 6
- Relationship with Co-Worker, 4
- Redundancy, 1
- Tell, 1

**by Directorate**

- Clinical & Support Services, 3
- Corporate Services, 1
- Medicine, Cancer & Community, 7
- MHAIDS, 12
- SIR, 2
- Surgery Women & Children's, 9
- Not Stated, 10

4. WORKPLACE INJURY MANAGEMENT

4.1 Cost Over Past Twelve Months

- Patient handling and object handling injuries continue to be the most common causes for claims, accounting for 49% of all claims
- Lumbar sprain injuries remain the most frequent type of injury reported
- There have been 288 injury claims in the past 12 months

**Statistics**

**Claims by Directorate – past 12 months**
5. EMPLOYEE PARTICIPATION AND ENGAGEMENT

5.1 Health & Safety Representatives (HSRs)

HSR training continues to be delivered using an external training provider. All planned courses up until October are currently full. Further sessions have been arranged and advertised for the rest of 2017.

6. OTHER BUSINESS

6.1 Policies and Procedures

The updated Management of Workplace and Aggression and Lone and Community Worker Procedures are presently going through the final approval and sign off processes prior to implementation.

6.2 Online Hazard Reporting and Risk Assessment/Register System

Work has commenced on designing a risk assessment/register system potentially utilising the SQUARE reportable events system. This will replace the current hazard registers.

6.3 Workplace Violence and Aggression

The workplace violence & security steering committee is meeting on a monthly basis and is in the process of developing a work plan.

6.4 ACC Accredited Employer Partnership Programme Audit

An external audit of CCDHB’s safety and injury management programmes took place from the 29th-31st August 2017. ACC also undertook a monitoring visit in conjunction with the audit. A full report has been received and we have maintained our Tertiary level accreditation. A number of areas were identified for improvement and an action plan has been produced and communicated to the areas concerned.
### BOARD DISCUSSION

Date: 10 October 2017

<table>
<thead>
<tr>
<th>Author</th>
<th>Nigel Fairley, General Manager, MHAID Service 3DHB</th>
</tr>
</thead>
</table>
| Endorsed by | Adri Isbister, Chief Executive Wairarapa District Health Board  
Debbie Chin, Chief Executive Capital & Coast District Health Board  
Ashley Bloomfield, Chief Executive Hutt Valley District Health Board |
| Subject | MENTAL HEALTH, ADDICTIONS & INTELLECTUAL DISABILITY SERVICE 3DHB |

### RECOMMENDATIONS

It is **recommended** that the Board:

- **a)** Note the launch of the new MHAID Service website & Logo
- **b)** Note the progress update from MHAID Service Advisory Group
- **c)** Note update on the Work Plan
- **d)** Note appointment of Director of Consumer Involvement (acting)

### APPENDICES

1. Te Haika Data August 2017
2. Buckle Fellowship for MHAID Service staff programme
3. Buckle Fellowship for Public lecture
4. Balanced Score Card – September 2017
5. Wairarapa Pre Admission and Post Discharge Contact – September 2017

### 1 LAUNCH OF MHAID SERVICE WEBSITE AND LOGO

The new MHAID Service website went live on the 26th September; the website provides information about our services across the three DHBs, regionally and nationally.

The existing websites at [www.tekorowaiwhariki.org.nz](http://www.tekorowaiwhariki.org.nz) and [www.mentalhealthservices.org.nz](http://www.mentalhealthservices.org.nz) have been redirected to the new website. The mental health pages on Wairarapa, Hutt Valley and Capital & Coast DHB websites also link to the new website. The new website address is as follows; [www.mhaids.health.nz](http://www.mhaids.health.nz)

After all staff were given an option to vote, “logo C” was voted in as the preferred choice for MHAID Service. Templates are being designed by a Graphic designer and the roll out of the new and improved MHAID Service Logo will launch next month.
2 MHAIDS ADVISORY GROUP UPDATE

The MHAID Service 3DHB Advisory Group was established to provide oversight of the MHAID Service specifically service development and improvement in particular by focusing on quality and safety. The Advisory Group’s primary responsibility is to oversee the implementation and development of the recommendations from serious adverse event reviews associated with the service between October 2015 and April 2016.

The MHAIDS Advisory Group met again in September to review progress on the implementation of the 162 recommendations from various significant MHAIDS reviews previously advised to the 3 DHBs. The Group noted good progress continues to be made overall and the work was on track for completion this calendar year. A specific request was made of the project manager to review all the recommendations progress and provide a consolidated report to the Advisory Group noting how the various recommendations implementation is evidenced in practice for a stock take discussion at the November meeting.

Excellent progress is being made on the client pathway and ICT development. The associated work is on schedule.

With the recruitment of a new Quality and Risk Manager important activities related to a number of review recommendations have been initiated and are on track in line with the overall implementation programme. To ensure a process of continuous quality improvement is maintained, the Quality & Risk Manager will review the actions taken for the completed recommendations and where applicable will instigate further on going actions e.g. where an item needs to be added to the regular audit schedule, included in regular policy review, added to a regular clinical or management agenda for follow on oversight etc.

It is anticipated that following the November meeting the Advisory Group will be in a position to report a 30 November date for completion of most of the recommendations with a final 18 to be finalised by 31 December.

3 MENTAL HEALTH INTERGRATION UPDATE

A 3DHB Mental Health Working Group was established following a series of incidents involving current or former mental health service users. Based on this work, a subcommittee of the three Boards recommended to the June 2017 meeting of the Board that urgent progress be made to integrate the management of mental health, addiction and intellectual disability services (MHAIDS) across the 3DHBs. The intent underpinning further integration is to support service delivery that is “more seamless, higher quality and cost effective”.

Stage One of this work is now underway with a focus on identifying those services that could be best included in the provider arm integration of MHAIDS, and those which would be more suited to being managed and commissioned locally in each DHB. This work is also considering the funding impacts, including the financial implications of unbundling service funding from each DHB. Initial advice will be provided to Chief Executives on 3 October 2017. We will continue to keep you updated on progress through the regular SIP update.

Since the previous update work on the MHAIDS integration project has been moving rapidly. Good progress is being made on better understanding funding flows across the three DHBS, and there has been a workshop with Chief Financial Officers to discuss the financial implications of different structural arrangements on DHB balance sheets. A data model has also been created using encrypted NHI numbers and linking 17 databases that span mental health, primary care and pharmaceutical information. This will be invaluable for both the project and future analysis.

Two half day workshops have been held to test the range of possible structural options and service models. Options development has taken account of the needs of Tangata Whaiora (service users),...
consistency with goals of integration across the service continuum and effectiveness in addressing the considerable management challenges associated with the current financial, accountability and employment arrangements within MHAIDS. Workshop participants included the General Managers of Planning and Funding from across the three DHBs, the Manager of Mental Health for SIP, the Director MHAIDS, clinical leaders, PHO leaders and the General Manager People and Capability. Initial advice is due with Chief Executives in November.

Recognising the potentially significant impacts on our staff, Stage One of the project is being managed as a desktop exercise. Should work progress to Stage Two, planning is underway for staff and union engagement, along with engagement with provider, iwi and community stakeholders.

4 DIRECTOR OF CONSUMER INVOLVEMENT (ACTING)

Waiatamai Tamehana has started work with the Mental Health Addictions and Intellectual Disabilities Service as Director of Consumer Involvement (acting).

Waiatamai brings with her many qualities and attributes including strategic development, quality assurance and front-line service delivery. Waiatamai also has diverse experience and provided leadership throughout the consumer workforce of Aotearoa.

5 TE HAIKA SEPTEMBER 2017 DATA

Te Haika is the telephone call centre which triages crisis and acute calls 24 hours per day / 7 hours per week. Clients phone in on a specific phone number – 0800745477. The call centre is staffed by registered health professionals who manage referrals to MHAID Services for Wairarapa, Hutt Valley and Capital & Coast. Prior to July 2015, this service only covered CCDHB. In July 2015, the service was expanded to Wairarapa and Hutt during normal work hours, and from July 1, 2016 the service has covered the region 24/7.

See Appendix 1 for Te Haika September data (by DHB).

6 CHAD BUCKLE FELLOWSHIP

The Buckle Fellowship is set for the week of the 24th of October. There are various lectures located at Wellington, Porirua, Hutt and Masterton Hospitals. This year the fellow is Professor Peter Haddad. Professor Haddad is a consultant in community psychiatry at The Greater Manchester Mental Health NHS Foundation Trust. His main research interests are the management of affective disorders, schizophrenia and psychosis, with an emphasis on widening treatment choices and improving outcomes for people with these disorders.

Please see Appendix 2 for flyer with the various lectures for MHAIDS staff. Please see Appendix 3 for flyer on public lecture.

7 TE WHARE AHURU RECONFIGURATION PROJECT

The refurbishment of Te Whare Ahuru (TWA), the acute adult inpatient unit, is a priority for MHAIDS and Hutt Valley DHB.

The Board approved funding at its August 2017 meeting to procure services from a supplier to deliver an Adult Acute Services Plan. This will include the development of a model of care that will in turn inform the refurbishment.

Four organisations with the skills, expertise, knowledge and other attributes to deliver such a plan were invited to submit proposals as part of a closed tender process. Tenders closed on 28 September 2017 with
two organisations submitting proposals. These proposals are currently being assessed with the aim of having a preferred supplier engaged by late October 2017. The Board will be kept updated as the project progresses.

8 CORONERS SUICIDE STATISTICS

Chief Coroner Judge Deborah Marshall released the latest provisional suicide statistics for New Zealand for the year ending 30 June 2017. The latest statistics show a national increase in the number of suspected suicides (and highest on record over the last decade), with a total of 606 suspected suicides on record. The rate per 100,000 people is significantly higher for men at 19.36, while for women it is 6.12. The rate of suicide is highest among the 20 - 24 year-old age group (79 deaths) followed by the 25 - 29 year-old and 40 - 44 year-old age groups (each of which had 64 deaths). The rates for Maori were 86 (male) and 44 (female), similar to 2015/16 (83 and 46 respectively).

Last year the total number of recorded suicides was 579 (for 2015/2016), and the year before that the figure was 564 (2014/2015).

There has been an increase in the Wairarapa from the previous year; this continues to be a significant concern. The Wairarapa “Too Many” campaign, supported by the DHB, started in June 2017.

The following chart shows overall suspected suicides for the 3DHB region; along with how many were clients of MHAID Service.

![Suicide Statistics Chart]

9 ICAFS (INFANT, CHILD AND ADOLESCENT & FAMILY SERVICE) REVIEW UPDATE

An independent review of the ICAF service has now been completed and a management response provided to unions and staff for their feedback. The review made a series of recommendations that were either fully or in part supported as part of the management response. These recommendations included a combination of structural and practice changes.

Feedback was received from staff and unions after the July release of the Independent Review of ICAFS and corresponding proposed Management Response. This informed the development of Change Proposal to staff and unions which was released on 18 September 2017. Consultation on this closes on 10th October.

Once management has considered feedback from consultation, a document outlining final decisions will be released to staff, currently scheduled for 25 October 2017.

The Board will be kept updated of any significant decisions relating to the ICAF Service.
10 MHAID SERVICE SOCIAL WORK DAY

Social workers attended the annual education day for social workers of MHAID 3DHB. This is the second year that this day has been held and is seen as a good opportunity to network, learn new skills and put names to faces.

MHAID Service has approximately 90 mental health social workers throughout the service and this is the rare occasion that they have an opportunity to look at issues from a specific social work base. This day brings back to what it means to be a social worker and challenges they sometimes face.

This year the topic chosen was Culture. It was explored from three different perspectives:

- Biculturalism presented by Whetu Campbell
- LGBTQI presented by Bill Logan
- Refugees presented by Lucy Anderson and Yusuf from Red Cross

We are pleased to hear this event was a great success with lots of positive feedback from staff who attended.

11 MENTAL HEALTH AWARENESS WEEK

Mental Health awareness week NZ runs from 9th – 15th October. The theme is on the importance of connecting with nature to boost ones wellbeing.

There are various natured based activities arranged at Ratonga-Rua-o-Porirua such as volleyball (and soup), seedling planting and floral arrangements.

Dr Sally Davidson from our service has been part of a short social media clip talking about the importance of this and this is available to watch on the MHAID Service website and CCDHB Facebook page.

12 BALANCED SCORECARD

MHAID Service continues to invest in the Balanced Scorecard as a single portal for its performance indicators. There are a number of audits underway and data fixes are applied. Some measurements are still in draft until we can be confident about the data. As an interim measure Wairarapa DHB data is being collated manually and reported as an appendix to the BSC.

See Appendix 4 for August Balanced Scorecard.

See Appendix 5 for August Pre Admission and Post Discharge Contact Wairarapa.

13 ACTIVITIES SEPTEMBER 2017

<table>
<thead>
<tr>
<th></th>
<th>TWOM</th>
<th>Rangatahi</th>
<th>Ra Uta</th>
<th>Nga Taiohi</th>
<th>Purehuruhangipapa</th>
<th>Hikutia</th>
<th>Haumie</th>
<th>Tane M</th>
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<td>77%</td>
<td>67%</td>
<td>101%</td>
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<td>78</td>
<td>64</td>
<td>106</td>
<td>0</td>
<td>0</td>
<td>2248</td>
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</table>
Hutt Valley DHB
The directorate delivered a favourable variance of $53k to budget YTD August. Employee expense, $350k favourable YTD offset by $250k unfavourable in outsourced personnel expenses. Variances are Medical $55k, Nursing ($82k), Allied Health $115k in permanent FTEs. While there were 6.7 vacancies, utilisation of casual nursing in TWA and CREDS resulted in adverse variances in nursing cost. Wairarapa utilisation of TWA beds continue to be accounted for revenue in the provider arm. Allied health vacancies continue to be around 11 FTEs and advertising for these positions including the three new positions in TWA continue.

Wairarapa DHB
The directorate delivered a surplus of $77k which was a favourable variance of $48k to budget. The main contributor being reduced medical cost. Utilisation of TWA beds have been moved to the funder through the IDS process. Unbudgeted consultancy for National MH Improvement programme of $3k has been recorded with the provider arm. Both CCDHB and HVDHB are accounting for these costs under the funder arm.

CCDHB
Total revenue for August was favourable to budget by $204k and $301k YTD. Cost recovery from CRS from personnel costs $100k, price variation to external contracts and high forensic courts assessments was all contributing factors. CCDHB beds continue to be underfunded by 3 beds; $42k per month (actual 21 beds vs. funded 18 beds) and funding for a client is approx. $47k per month short. Personnel costs were adverse to budget by $501K for the month and $580K YTD. This was due to high occupancies in forensics rehab and inpatient units, high forensic courts assessments, vacancies and high sick leave meant backfilling with overtime which reflected on less availability of annual leave to be taken. The above figures include Savings target of $876k YTD. 

Outsourced service favourable to budget $52k for the month & $136k YTD, Savings reflected mainly in Medical, more permanent used than locums.

MHAIDS Service Activity and Comments
We continue to see higher occupancies in Forensic Inpatient, Rangipapa (98%), Forensic Rehab Tane (100.5%), Tawhiri (89%) and Matairangi (99.6%) and Rangatahi (88%). Higher vacancies in nursing and RMO staff have had huge impact on overtime. Total vacancy across MHAID is 98 FTE (excluding casuals) compared to budget and paid FTE.

Paid FTE
The paid FTE converts all paid hours into a Full Time Equivalent. The operational FTE is a measure of the FTE required to run the departments including cover for annual leave etc.
The percentage of people using Mental Health & Addiction services who live in the Central Region DHB districts - Capital & Coast, Hawkes Bay, Mid Central, Hutt Valley, Whanganui and Wairarapa and the proportion of services provided by each DHB for Alcohol and Other Drug (AOD) services, currently do not match the individual DHB population split.

The central region’s AOD residential treatment and community services have been in place for over a decade, with limited service developmental change at a regional level since service agreements were first established. In the Wairarapa there are no DHB Provider Arm AOD services – all AOD services for those 18+ are contracted to an NGO service.

The six DHB’s are at different stages, in terms of local capacity and capability building, and have differing needs for regional addiction services, including local respite options and variable treatment programme types based on identified need. Additionally the regional addiction residential treatment programmes differ greatly in treatment programme type, varying from 9 weeks to 18 months in average length of stay (LOS).

A standardised AOD Service Model was developed 2014 after a review in 2013 that found the regional adult AOD service delivery model contained several significant inconsistencies. The new AOD Service Model for people who enter into and from residential addiction services has improved greatly e.g. A greater focus on respite care (step up step down), Capacity to treat co-existing mental disorders, Development of addiction peer support services.

For the six DHB populations, the NGO’s are funded for different adult AOD services in different ways which can have financial consequences. The differences and inconsistency of investment for adult AOD services need to be rectified, so that the funded community-based AOD services can undertake their responsibilities effectively and efficiently. It is important that locally within the region; DHB’s have flexibility to respond to differences in local AOD needs. To achieve this, DHB’s will require repurposing resources to reflect the needs of the local population.

Services within the scope for implementation include AOD residential and community based services delivered to DHB’s local adult populations who have AOD/Co-existing Problems (CEP) issues. Given the wide scope of change impacting on the region’s AOD service delivery sector, and the potential political and competitive nature of the market, the DHB’s have engaged an independent Probity Assurance Advisor.

The AOD service Model is scheduled for implementation 1st November 2018. A Procurement Plan and RFP document will be submitted to the Central Region CEO forum for endorsement mid November 2017. A Procurement Plan and Business Case will be brought to the Board with recommendations mid December 2017.
16  **SUB-REGIONAL COMMUNITY-BASED ACUTE CRISIS SERVICES (ACUTE ALTERNATIVE TO HOSPITALISATION)**

Every year thousands of New Zealanders use acute mental health services. They come from all communities, age groups and ethnic groups. An increasing proportion of these people are less than 20 years old. Maori are over-represented and Asians are under-represented in acute services. A growing number have drug-related mental illnesses. The percentage of people using mental health and addiction services who live in the three DHB’s districts and the proportion of services provided by each DHB do not match the individual DHB population split.

Each of the three DHBs provide and/or fund acute inpatient beds in some form. In addition to the acute inpatient units, there are a wide array of providers and services that are involved in delivering community-based acute and crisis respite care however community-based acute crisis respite services differ from other mental health services within the acute continuum of care. These services have been contracted by Wairarapa, Hutt Valley and Capital and Coast DHB’s for over 20 years. The use of the respite options and other alternatives to acute admission are intended to be for as short a period as possible during the crisis period.

In 2015/2016, a review of the Community-based Acute and Crisis Respite Services for the Wairarapa, Hutt Valley and Capital & Coast District Health Board’s was completed. The review focused on both short term and medium term changes achievable within the environment provided or procured by the 3DHB’s to improve and maintain sustainability of the acute continuum of care for people who use the service and their families.

The review identified several forms of acute alternative to a hospital inpatient unit service. These were residential facilities in the community offering short-term emergency alternatives to admission, sometimes known as crisis houses, others take the form of beds and programmes (Acute Packages of Care and/or Acute Day Service) some based in a hospital setting, while others are community-based Intensive Home Treatment Service provided by a DHB Provider Arm.

Clinical pathways, also known as acute care pathways, optimise outcomes in the acute care and home care settings. Although an acute pathway of care existed within each of the DHB’s acute crisis service, there was not a standardised Acute Pathway of Care (APC) across the sub-region. The current responses to a persons acute crisis issue in a community-based setting is not always provided in the most appropriate place, by the most appropriate health professional – which may result in a poor outcome, unnecessary cost, or duplication of services.

Implementing the Acute Pathway of Care Model will have an impact on the way the DHB’s interact with their provider base. There is a possibility that up to seven contracted NGO providers delivering community-based acute crisis services across the sub region will be affected by the change. The NGO contracts expire on 30 June 2018 and have three (3) month termination clauses.

The Community-based Acute Crisis Respite Services are scheduled for implementation 1st October 2018. A Procurement Plan and if required an RFP document will be submitted to the sub-regional CEO forum for endorsement mid November 2017. A Procurement Plan will be brought to the Board with recommendations mid December 2017.

17  **REVIEW OF CRISIS RESPONSE SERVICE (WAIRARAPA)**

An urgent review of the Wairarapa Crisis respite service is underway following a serious adverse event and reports from staff regarding the after-hours rostering; The DAO (Duly Authorized Officer) and medical staff have raised issues of sustainably of the 24 hours Crisis response for the Wairarapa DHB population.
The review team includes:

- Dr Michael Doran – Lead Clinician for CRS & CL, Intensive Recovery Sector
- Dr Tom Gibson – Chief Medical Officer, Wairarapa DHB
- Debbie Gell – Quality & Risk Manager MHAID Service 3DHB

The review team are focusing on the serious adverse event, 24 hours crisis response from the Mental Health Adult team, in particular during working hours along with the after-hours clinicians and the DAO Roster.

We expect the final report of this review to be completed by end of October.

## 18 MHAID SERVICE VACANCIES (CCDHB FOR NOTING)

Present number of Full Time Employee Vacancies within CCDHB Mental Health Service

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<th>Category</th>
<th>Employed FTE</th>
<th>Budget FTE</th>
<th>Variance</th>
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<td>192.47</td>
<td>229.98</td>
<td>37.51</td>
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<td>MANAGEMENT/ADMINISTRATION P</td>
<td>110.47</td>
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<tr>
<td>Grand Total</td>
<td>992.74</td>
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</table>

Actual FTE Worked Vs. Establishment

## 19 MH SUPPORT WORKERS IN CRISIS RESOLUTION SERVICE

At the planning day on 4th August jointly planned between management and PSA, the possibility of having Mental Health Support Workers (MHSW) working alongside the team was raised and discussed with an agreement from the staff and PSA to trial this for up to a year.

Mental Health Support Workers have a national qualification NZQA level 3 or 4 in Mental Health Support work.

Prior to the planning day it was signalled to the PSA that this was going to be discussed and they were supportive as long as staff were engaged.

Roles that a support worker can perform in a CRS

- Sit in as ‘second person’ in interviews
- Assist with transporting clients
- Collect medications/deliver
- Drop belongings off
- Help escort people
- Support people whilst they are waiting to be assessed
- Support people in their own homes for short periods of time
- Can assist families with transport to assessments if needed
- Can sit with and/or support families
- Can make telephone arrangements (under the delegation of registered staff)

Recruitment processes are in place to find skilled Support workers so the year-long trial can begin.
INDEX

TWOM – Acute unit Wellington Hospital
TWA – Acute unit Hutt Hospital
Rangatahi – Regional Acute Adolescent unit, Kenepuru Hospital
Ra Uta – Psychogeriatric unit, Kenepuru Hospital
Hikitia – National Intellectual Disability Secure Youth unit
Haumietiketike – National Intellectual Disability Secure Adult unit
Manawanui and Whakaruru – Intellectual Disability Step down Cottages
Purehurehu and Rangipapa – Regional Forensic Secure units
Pukeko and Saunders House – Forensic Service Step down Cottages
Tane Mahuta, Tawhirimatea and 7 Cottages – Regional Inpatient Rehabilitation and Extended Care
EIS – Early Intervention Service
CREDS – Central Region Eating Disorder Service
Primary mental health initiatives and innovations (PMHII)
SACAT – Substance Compulsory Assessment & Treatment Act.
MHSW – Mental Health Support workers.
To: Andrew Blair, CCDHB Board Chairperson  
c.c: Debbie Chin, Rachel Haggerty  
From: Eileen Brown, Roger Blakeley, Sue Driver  
Re: Community Networks Wellington and WCC Meeting  
Date: 6 October 2017

Community Networks Wellington (CNW), who are sponsored by WCC, invited Roger Blakeley, Sue Driver and Eileen Brown to a meeting with them on the 21st September. The invitation was accepted though we had little background to the purpose of the meeting other than expecting to meet with representatives of CNW and local WCC Councilor Brian Dawson.

The meeting was attended by several members of Community Networks Wellington (CNW) and 5 Wellington City Councilors. We were all surprised to arrive to a more formal and a bigger meeting than any of us had expected.

The purpose of the meeting for CNW was to start a conversation between them and CCDHB about health initiatives and services that are working as well as discuss health concerns from the perspective of community organizations. CNW spoke positively about some of the initiatives such as the work by Te Aro Health Clinic and also the positive work of the TACT team responding to mental health needs around the city. Some of the Councilors identified concerns about health needs including mental health services and the need for more public and preventive health approaches.

We, as DHB Board members, reiterated that we did not have mandate to speak for the DHB; that engagement between the DHB and WCC happens on a number of other levels – and cited work going on with the localities plan currently at a senior levels –and that there is engagement at many other levels on operational issues.

One of the Councilors expressed his desire to engage with the DHB at a Board to Board level and with elected members. Other WCC Councilors seemed to support this too.

Sue, Roger and I felt that there is a strong desire for some structured engagement at the Board level to discuss issues that are of common interest and that this could bring mutual benefit.

We are keen to talk about how we can build the relationship and discuss processes of engagement and common interest between the DHB Board and the Council. We fully expect that there may be other Board members interested and we welcome this. We are also mindful that a mechanism for engagement is through the Localities Approach and we understand a paper on the Localities Approach is being prepared by Rachel Haggerty for the 25 October meeting.

We’d ask that this brief note is tabled at the next Board meeting, perhaps following the chairperson’s report, to ensure we report back on something we had previously discussed with you and as a background for a response as to how we engage and with whom.
**RECOMMENDATION**

It is **recommended** that the Board:

a) **Agree** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

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<th>REASON</th>
<th>REFERENCE</th>
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<tr>
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<td>Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations</td>
<td>9(2)(i)(j)</td>
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DISTRICT HEALTH BOARD

BOARD
GOVERNANCE
MANUAL

2017

VERSION 4, July 2017
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Introduction

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

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

This manual is significantly based on a document Resource for Preparation of District Health Board Governance Manuals prepared by the State Services Commission in 2010 in conjunction with the Ministry of Health. The changes and impact of the New Zealand Public Health and Disability Amendment Act 2010, the New Zealand Public Health and Disability (Planning) Regulations 2011, and the Crown Entities Amendment Act 2013 have been reflected in this manual. Schedule 2 in particular (Conflict of Interest Guidelines for District Health Boards) reflects the advice provided by the Ministry of Health, published in July 2010.

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

Material from the Waikato DHB and Hawkes Bay DHB Board governance manuals in drafting this manual is acknowledged.

Further updates and/or new editions of this manual will be produced as necessary. CCDHB Legal Services is responsible for drafting changes to this Board manual.

Relevant Legislation

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

Every District Health Board 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) and its amendments. Other legislation that applies to DHBs includes:

- State Sector Act 1988
- Public Finance Act 1989
- Commerce Act 1986
- Official Information Act 1982
- Privacy Act 1993
- Protected Disclosures Act 2000
- Public Records Act 2005
- Health and Safety at Work Act 2015
Various pieces of employment legislation.

**DHB-specific Legislation: NZPHD Act**

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

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 includes 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. Its objective was to streamline the public health system, to improve coordination of local, regional and national planning, enhance the quality of health care and reduce the duplication of corporate and administrative work.

In addition, the New Zealand Public Health and Disability (Planning) Regulations 2011 which came into effect on 1 June 2011 establish the regulations that govern the annual plans and regional plans for DHBs. These matters are discussed in further detail later in the manual.

**Crown Entities Act 2004**

The Crown Entities Act (CE Act) provides a consistent framework for the establishment, governance and operation of Crown entities, as included in the various chapters of this guidance material. It clarifies the accountability relationships between Crown entities, their Board members, responsible Ministers and the House of Representatives. The application of the CE Act to DHBs includes Board members' individual and collective duties, the role of the responsible Minister, accountability relationships, strategic and performance-related planning and reporting requirements, and must 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 sections of the CE Act as it applies to DHBs**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>Government policy directions</td>
<td>DHBs must give effect to government policy when directed by the responsible Minister (i.e. the Minister of Health) (s.103)</td>
</tr>
<tr>
<td>Whole of government directions</td>
<td>DHBs must give effect to a whole of government direction from the Minister of State Services and the Minister of Finance (s.107, 110)</td>
</tr>
<tr>
<td>Planning and reporting</td>
<td>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)</td>
</tr>
<tr>
<td>Appointed Board members</td>
<td>Appointed by the Minister of Health (s.28)</td>
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</table>
Key sections of the CE Act as it applies to DHBs

<table>
<thead>
<tr>
<th>Section of CE Act</th>
<th>Application to DHBs</th>
</tr>
</thead>
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<tr>
<td>Meetings, disclose of interests, transactions</td>
<td>Rules for meetings. Disclosure of interests and transactions such as sale of land, borrowing and employment (s.3)</td>
</tr>
<tr>
<td>Term of Board members</td>
<td>Appointed members hold office for 3 years or fewer (s.32)</td>
</tr>
<tr>
<td>Removal of appointed Board members</td>
<td>May be removed by the Minister of Health at his or her discretion (s.36)</td>
</tr>
<tr>
<td>Remuneration of Board members</td>
<td>Determined by the Minister of Health in accordance with the Cabinet Fees Framework (s.47)</td>
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According to s.21 of the NZPHD Act, the following sections of the CE Act do not apply to DHBs, or to their Boards, Board members, committee members or employees:

- s.38 (removal of elected members)
- s.60(1) (applications by Board members to restrain action)
- ss.62 to 72 (conflicts of interest); instead, these provisions are found in Schedule 3 of the NZPHDA
- ss.73 to 76 (delegations); ditto
- s.78 (provisions in Schedule 5)
- s.96 (acquisition of subsidiaries)
- s.100 (acquisition of shares or other interests)
- ss.116 and 117 (employment of employees and chief executives)
- ss.120 to 126 (immunities, indemnities, and insurance); instead, immunity and indemnity provisions are found in section 90 of the NZPHDA
- s.161 (in relation to shares and interests covered by s. 28)
- Schedule 5 (Board procedure for statutory entities); instead, these provisions are in Schedule 3 of the NZPHDA.

DHBs also differ from other statutory Crown entities in that the majority (7 of 11) of their Board members are elected by the public, rather than appointed by a Minister.

State Sector Act 1988

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

- to review the State sector system in order to advise on possible improvements to agency, sector, and system-wide performance
- to review governance and structures across all areas of government, to advise on allocation and transfer of functions and powers, cohesive delivery of services, and the establishment, amalgamation, and disestablishment of agencies
- to promote leadership capability and strategies for workforce capacity and capability
to promote and reinforce standards of integrity and conduct in the State services, and promote transparent accountability. The State Services Commissioner has issued a code of conduct that applies to the staff of DHBs (also, see chapter on Boards as Employers).

Public Finance Act 1989

The CE Act specifies most of the provisions relating to a Crown entity's financial powers, accountability and reporting obligations.

However, the following sections of the Public Finance Act apply to Crown entities, including DHBs:

- ss.26Z and 29A provide for the Secretary to the Treasury to request information necessary to report on fiscal responsibility and 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 is to be paid to the Treasury
- s.80A allows for the Minister of Finance to issue instructions on financial reporting matters. Crown entities are required to comply with those instructions, which must be consistent with generally accepted accounting practice.

Commerce Act 1986

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

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

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

Other Legislation with general application to DHBs

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

The Official Information Act 1982 (the OIA) applies to DHBs. Board minutes are among the documents that can be requested under the OIA, though provisions exist for material to be withheld under certain circumstances. The legal obligation 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/internal.asp?cat=100109

The Privacy Act 1993 applies to DHBs and contains principles that govern:

- 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
what personal information can be used for, and when it can be disclosed.


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.

Objectives, Functions and Powers of District Health Boards

Functions of a DHB

Under section 14 of the Crown Entities Act (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
- Any functions that are incidental or related to, or consequential on, the entity’s functions.

Section 23 of the NZPHD Act sets out that for the purpose of pursuing its objectives, each DHB has the following functions:

(a) to ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement

(b) to 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) to 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)

(d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement

(e) to 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) to provide relevant information to Māori for the purposes of paragraphs (d) and (e)
(g) to 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) to promote the reduction of adverse social and environmental effects on the health of people and communities.

(i) to 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) to participate, where appropriate, in the training of health practitioners and other workers in the health and disability sector.

(k) to 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) to 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) to collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes.

(n) to 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 introduction of 22 (ba) and 23 (ba) in October 2010 emphasises the need for DHBs to act more collaboratively at a regional and national level.

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

Section 113 provides that a Minister may not:

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

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

- that specify the persons who are eligible to receive services funded under the NZPHD Act and
- that the Minister considers necessary or expedient in relation to any matter relating to the DHB and
- 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.

The objectives of a DHB

Section 14(2) of the CE Act states that, in performing its functions, an entity must act consistently with its objectives. The "objectives" are set out by s.22 of the NZPHD Act, which are:
(a) to improve, promote, and protect the health of people and communities
(b) to promote the integration of health services, especially primary and secondary health services
(ba) to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
(c) to promote effective care or support for those in need of personal health services or disability support services
(d) to promote the inclusion and participation in society and independence of people with disabilities
(e) to reduce health disparities by improving health outcomes for Māori and other population groups
(f) to 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) to 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) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services
(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations
(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations
(k) to be a good employer [in accordance with section 118 of the CE Act 2004].

CCDHB must pursue its objectives in accordance with any plan prepared under section 38, its statement of intent, and any directions or requirements given to it by the Minister under section 33, 33A, or 33B of the Act, or section 103 of the CE Act 2004 (which concerns entity-specific directions), or under section 107 of the CE Act (which concerns whole of government directions).

CCDHB must consider the specific actions to be taken to meet its objectives, while being mindful of:

- 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
- s.3(4) which promotes the integration of services
- 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, the DHBs must also considers the overall health structure to ensure that individual items of health expenditure fit comfortably with the "big picture" of health funding.

**Powers of a DHB**

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.
Natural person powers: s.17 provides that Boards of entities have all the powers of a natural person of full age and capacity. However, these powers may only be exercised for the purpose of performing the statutory functions of the entity. The CE Act contains some specific constraints on the exercise of natural powers, for example: the requirement to consult the State Services Commissioner before agreeing to the terms and conditions of employment of a DHB's Chief Executive, constraints on bank accounts and limits on powers to indemnify and insure. Ministers' powers of direction, where applicable, can also act as a restraint on a Board's powers.

**Ministerial Directions**

Certain provisions of the CE Act relating to government policy and government directions, apply to the giving of ministerial directions to DHBs. Under s.103(1) of the CE Act, the Minister of Health may direct a DHB to give effect to a government policy. Section 103 is subject to s.113 of the CE Act, which says that the Minister cannot issue a direction requiring anything to be done in respect of a particular person or persons.

Under section 32 of the NZPHD Act, the Minister of Health may give written directions to a DHB that specify the persons who are eligible to receive services funded under the NZPHD Act, and that the Minister considers necessary and expedient in relation to any matter relating to the DHB. The notice must be consistent with the objectives and functions of the DHB. The direction cannot require the supply of identifiable information about an individual.

Under section 33, the Minister may also give directions relating to the provision of services. However, such a direction may not:

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

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

New sections 33A and 33B which came into effect in February 2011 extended the powers of the Minister in giving of directions to individual DHBs to include matters relating to support, administration and procurement, and to all DHBs for purposes of creating greater effectiveness and efficiency.

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

**The Treaty of Waitangi**

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

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

Specific provisions include:

- minimum Māori membership on Boards of DHBs (s.29(4))
- provision for Māori membership of DHB committees (sections 34, 35, 36)
• familiarity with Treaty issues, for Māori health issues, and for Māori groups or organisations in the DHB (Schedule 3, clause 5)

• a requirement for DHBs to establish and maintain processes to enable Māori to participate in and contribute to strategies for Māori health improvement (s.23(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 (s.23(1)(e))

• provision of relevant information to Māori to enable effective participation (s.23(1)(f)).

Section 3(3) of the NZPHD Act says that nothing in the Act "entitles a person to preferential access to services on the basis of race or limits section 73 of the Human Rights Act 1993" (which relates to measures to ensure equality). This recognises the need for service delivery that positively reduces disparities and is targeted at population related initiatives, rather than any preferential treatment sought by an individual person.

**Exceptions to Board implementing Functions and Powers under Legislation**

Occasionally the Chief Executive or other office holder in a DHB has specific statutory functions or powers under the entity's establishing legislation. For example under s 26(3) of the NZPHD Act, the Board of a DHB is required to delegate to the Chief Executive the power to make decisions on management matters relating to that DHB.

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

**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

• the staff of the entity are responsible to the Chief Executive, who has independent responsibility in respect of individual employees.

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

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

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

Under s.27 of the CE Act, the Minister has powers with regard to all DHBs on matters of strategic direction, targets, funding, performance, reporting and reviews.

The Minister 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

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

The Minister of Health is responsible to the House of Representatives for the performance of DHBs and is often expected to answer to the public for problems or controversies arising in connection with them. However, the DHB itself is also accountable to the House of Representatives (s.3 CE Act) for its own actions (see chapter Planning and reporting).

Parliamentary Select Committees

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

• Examination of the Estimates: The estimates are the government's request for appropriations/authorisation for the allocation of resources, tabled on Budget day. DHBs do not attend the select committee when it examines the estimates, but the Minister and Ministry of Health may be questioned about the intended activities and expenditure of a DHB.

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

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

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

Guidance on appearing before select committees needs to reflect the material contained in Officials and Select Committee Guidelines: www.ssc.govt.nz/officials-and-select-committees-2007. Within that guidance, the term 'official' includes Board members and employees of DHBs.

"No surprises" Approach

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

The enduring letter of expectations from Ministers to Crown entity Boards (www.ssc.govt.nz/expectations-letter-crown-entities-july12), 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

• inform the Minister in advance of any major strategic initiative

• the Minister also expects Boards to provide effective self-monitoring, increased transparency of performance, and to deliver Better Public Services (which is an overarching government programme for better results and improved services by the public sector).

**Relationship with the Monitoring Department**

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

Ministers are usually supported in this engagement with Crown entities by departmental officials who in this role are known as the 'monitoring department'. While the CE Act and the NZPHD Act do not define such a role, the monitoring department (in this case, the National Health Board) 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.


**Cooperative Agreements with Persons in the Health and Disability Sector**

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

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

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

A DHB may not enter into such a co-operative agreement or arrangement, unless it is given consent by the Minister (s.24(2), NZPHD Act) or is authorised to enter into the agreement or arrangement by a plan prepared under section 38 (i.e. Annual plan or Regional plan).

Approval is also needed for DHBs to hold interests in trusts and companies.

**The Role and Authority of the Board of a District Health Board**

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

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

The day-to-day management responsibilities within a DHB are delegated by the Board to the Chief Executive (section 26(3), NZPHD Act). This reflects the application of normal corporate governance principles, and has implications for the manner in which Board members get involved in matters of operational management. Accordingly:

Public comment on current issues will occur as required by the Media Policy.

Complaints received by Board members should be referred to the Chief Executive. Any approach by Board members to staff of the DHB should be through the Chief Executive.

Collective Duties of the Board and Individual Duties of Board Members

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

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

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
- what the sanction is if the duty is breached.

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

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

Collective Duties

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

The collective duties of DHB Boards are to:

- act consistently with their objectives, functions, statements of intent and output agreement (s.49, CE Act)
- perform their functions efficiently and effectively, and consistently with the spirit of service to the public and in collaboration with other public entities (s.50, CE Act)
- operate in a financially responsible manner (s.51, CE Act)
ensure that the DHB complies with sections 96 to 101 of the CE Act (in relation to subsidiaries)\(^1\).

The Board of a DHB must also ensure that the DHB acts in a manner consistent with its annual plan and regional service plan, and any directions the Minister of Health may, by written notice, require the DHB to provide, or arrange for the provision of any services that are specified in the notice (sections 27(1) and 33 of the NZPHD Act). The Board of a DHB also must act in a manner consistent with s.103 or s.107 of the CE Act (Ministerial directions).

**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), if the DHB can establish that the member did not act with good faith or with reasonable care (section 90(2A) of the NZPHD 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
- 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. The power to remove members is also subject to the NZPHD Act, including clause 8(1) of Schedule 3. This requires consultation with the member and the Board before an elected member is removed from office.

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\(^1\) s.28 of the NZPHD Act discusses shares in bodies corporate or interests in associations.

\(^2\) Section 90 of the NZPHD Act. Sections 120 to 126 of the CE Act, on protections from liability, do not apply to a 'publicly-owned health and disability organisation,' members of the Board or a committee of the Board of a DHB.
A Board member is not liable for breach of a collective duty, other than to be removed from office (s.58, CE Act).

**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.

The Chair’s role includes:

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

- providing guidance and support to the Chief Executive to ensure the DHB is managed effectively. This includes establishing and maintaining an effective working relationship, while also taking an independent view to challenge and test management thinking (see chapter Key relationships)

- overseeing the employment of the Chief Executive, including succession planning and organising induction for a new Chief Executive

- representing the Board in formal assessments of the Chief Executive's performance, and in the required discussions with the State Services Commission in respect to Chief Executive terms and conditions at time of appointment and performance reviews (see chapter District Health Boards as employers)

- ensuring that conflict of interest policies, including disclosure provisions, are in place, that members' conflicts of interest (including those of the Chair) are dealt with properly, and that, where appropriate, dispensation is given to act despite being interested

If the Chair of a DHB Board is not present or is unwilling to preside at a meeting of the Board, the Deputy Chair of the Board presides, if he or she is present and willing to do so. If neither of them is present and willing to preside at a meeting of the Board, the members present must elect a member who is present to preside at the meeting.

**General Behaviours of Members**

Board members are expected to act in accordance with the following principles;

- **Responsibility to the entity**: Members need to recognise and always act consistently with their responsibilities to the DHB and to Ministers. Members owe a duty to the organisation as a whole and are not to act purely in the interest of a specific group. They should attend induction training and Board members' professional education to familiarise and update themselves with their governance responsibilities.

- **Strategic perspective**: Members need to be able to think conceptually and see the 'big picture'. They should focus as much as possible on the strategic goals and overall progress in achieving those rather than on operational detail.

- **Integrity**: Members must demonstrate the highest ethical standards and integrity in their personal and professional dealings. They should also challenge and report unethical behaviour by other Board members.

- **Intellectual capacity**: Members require the intellectual capacity to understand the issues put before them and make sound decisions on the entity’s plans, priorities and performance.

- **Independent judgement**: Members need to bring to the Board objectivity and independent judgement based on sound thought and knowledge. They need to make up their own mind rather than follow the consensus.

- **Courage**: Members must be prepared to ask the tough questions and be willing to risk rapport with fellow Board members in order to take a reasoned, independent position.

- **Respect**: Members should engage constructively with fellow Board members, entity management and others, in a way that respects and gives a fair hearing to their opinions. In order to foster teamwork and
engender trust, members should be willing to reconsider or change their positions after hearing the reasoned viewpoints of others.

- **Collective responsibility:** Members must be willing to act on, and remain collectively accountable for, all decisions even if individual members disagree with them. Board members must be committed to speaking with one voice once decisions are taken on a DHB’s strategy and direction.

- **Participation:** Members are expected to be fully prepared, punctual and regularly attend for the full extent of Board meetings. Members are expected to enhance the quality of deliberations by actively asking questions and offering comments that add value to the discussion.

- **Informed views:** Members are expected to be informed and knowledgeable about the DHB’s business and the matters before the Board. They should have read the Board papers before meetings and keep themselves informed about the environment in which the DHB operates.

- **Understanding:** Members are expected to recognise the need for service delivery to positively reduce disparities between various population groups. Members are expected to understand Māori health and Treaty of Waitangi issues (Schedule 3, clause 5 to the New Zealand Public Health and Disability Act 2000). This includes establishing and maintaining processes to enable Māori to participate in and contribute to strategies for Māori health improvement and to foster Māori capability.

- **Financial literacy:** Boards monitor financial performance and thus all members must be financially literate. They should not rely on other members who have financial qualifications, but should undertake training to improve their own financial skills where necessary.

- **Sector knowledge:** Members need to make themselves familiar with the activities of the entity and sector. This is likely to include attending induction sessions and on-going background study.

**Standards of Integrity and Conduct**

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

CCDHB has adopted a Code of Conduct for the Board and Board Committees that aligns with the expectations in the State Sector Act code. The CCDHB Code of Conduct is attached as Appendix 1.

**Members’ Interest and Conflicts; Identification, Disclosure and Management**

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

To address conflicts of interest in the health and disability sector, the Ministry of Health has published "Conflicts of Interest Guidelines for District Health Boards". These guidelines are aimed specifically at District Health Board (DHB) members. They are a resource to help Board members maintain public confidence and integrity in the health sector, in those circumstances where conflicts of interest may exist and need to be managed appropriately. The guidelines discuss members’ interests and conflicts and how to manage these under the provisions set out in the New Zealand Public Health and Disability Act 2000. The resource can be found in the publications section of the Ministry of Health’s website at: [www.health.govt.nz/publication/conflict-interest-guidelines-district-health-Boards](http://www.health.govt.nz/publication/conflict-interest-guidelines-district-health-Boards); Conflict of Interest Guidelines for District Health Boards | Ministry of Health.
Key requirements in respect of conflicts of interest are:

- Board members’ 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 held by stakeholders in the actions of the DHB
- All interests should be listed in the interests register, including the nature and extent of the interests, and where appropriate, their monetary value
- Board members must take a broad and honest approach to identifying their interests and when considering potential conflict of interest situations
- Both perceived and real interests must be identified
- Interests are reviewed at the commencement of every Board or committee meeting and all interests are expected to be submitted in writing
- Conflicts of interest in respect of items on an agenda must be advised at the start of every Board and committee meeting and be recorded in the minutes
- A member must not take part in any deliberations, decisions or quorum of the Board relating to a matter in which they are interested unless permission is granted allowing the member to take part in the deliberation
- Where permission is granted for a member with a conflict to participate, the reason for granting the permission must be recorded in the minutes together with a complete record of what the conflicted member said during deliberation on the matter concerned
- All permissions to participate in deliberations where conflicted must be recorded in the annual report.

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 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 interest
- the member has been authorised by the Board or by the Minister of Health to disclose the information, or
- the disclosure, use or act in question will not prejudice the DHB or will be unlikely to do so.

However, under s.57(2) of the CE Act, a member may disclose, make use of, or act on such information, provided that:
the member is first authorised to do so by the Board

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 only on one or more of the following grounds:

(a) that 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 any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982;

(b) that the public conduct of the whole or the relevant part of the meeting would be likely to result in the 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;

(c) that the purpose of the whole or the relevant part of the meeting is to consider a recommendation of an Ombudsman made under section 30(1) or section 35(2) of the Official Information Act 1982 to the Board

(d) that the purpose of the whole or the relevant part of the meeting is to consider a communication from the Privacy Commissioner arising out of an investigation under Part 8 of the Privacy Act 1993

(e) that the exclusion of the public from the whole or the relevant part of the meeting is necessary to enable the Board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) are established in relation to all or any part of any meeting of the Board.

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/)

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 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 must 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 must 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 policy of the DHBs with respect to accepting and offering gifts, hospitality and other benefits is as follows:

• Board members must not solicit gifts and benefits from, or on behalf of, anyone under any circumstances

• Board members must not accept gifts and benefits from anyone, or on behalf of anyone, who could benefit from influencing them or the DHB

• open and transparent practices in relation to gifts and benefits are in place, to enhance trust in the State Services, and reduce any misplaced speculation

• a principles based approach to each situation rather than the dollar value of gifts or hospitality will determine what is appropriate for Board members to accept, and the practice to be followed regarding the use of benefits in kind (e.g. air points)

• all Boards which are considering offering gifts or hospitality should think very carefully about both the cost and the public and political perception of doing so. Policies need to specify the purposes for which, and occasions on which, it is acceptable to offer gifts, and the nature and value of gifts that are appropriate to particular occasions

• unless they are 'consumable' at the time (e.g. meals, invitation to events), gifts should be regarded as the property of the DHB

• context must be taken into account when considering hospitality offered by stakeholders, to balance the opportunities that may be provided against the potential for criticism. For instance, does the timing coincide with a particular Board decision that affects the donor? How relevant is the event or function to the DHB's role? Will the Board's interests genuinely be advanced by having a member present? Should the DHB itself meet the costs of attendance, to avoid any perceptions of influence?

• close scrutiny must be given to offers such as invitations to attend conferences in New Zealand or overseas that may include travel, accommodation, meals, a speaking fee, and/or inclusion of a member's partner. It is essential to consider whether there would be real value to the DHB from attendance and, if so, who is best placed to represent it
if under any doubt as to whether or not to accept gifts or hospitality members should consult with the Chair.


**Health and Safety**

Board members are officers under the Health and Safety at Work Act 2015. Officers have a legal duty to exercise due diligence to ensure their organisation meets its duties and obligations under the Health and Safety at Work Act. Officers must exercise the care, diligence and skill that a reasonable officer would exercise in the circumstances.

The Health and Safety at Work Act sets out the due diligence requirements and they include reasonable steps in relation to:

- The Board members’ own knowledge of work health and safety matters
- Understanding the operation of the DHB and the hazards and risks associated with its operation
- Ensuring there are appropriate resources and processes available and used to eliminate or minimise health and safety risks from work
- Ensuring information about incidents, hazards and risks is collected and used
- Ensuring the DHB has processes for complying with its health and safety duties and obligations
- Verifying the provision and use of the resources and processes necessary to manage health and safety.

Board members are responsible for their own knowledge about health and safety, and for ensuring health and safety risks are managed by the DBH. These are governance responsibilities.

The Board has approved a Health and Safety Charter that sets out the Board’s expectations of how the health and safety should be managed by the DHB. The Health and Safety Charter provides a framework for Board members to demonstrate that they are fulfilling their duty to exercise due diligence in relation to health and safety. A copy of the Health and Safety Charter is attached as Appendix 2.

**Board Meeting Procedures**

Boards must have 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). A quorum is to be ascertained
following any disclosure of interest by members in relation to particular transactions. This means that the number of members constituting a quorum may fluctuate from time to time reflecting the ineligibility of a conflicted member from being counted amongst the available Board members from whom a quorum will be constituted

- all questions arising at any meeting of a Board must be decided by a majority of the votes cast by the members present\(^3\)
- where a person abstains from voting it is treated as not casting a vote
- 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**

The “Standing Orders” provide more detailed guidance on procedures and processes associated with meetings and are adopted as the supplementary procedures as permitted under clause 30 of Schedule 3 of the NZPHD Act 2000. These Standing Orders apply to the proceedings of all Board and committee meetings, including public excluded sessions, and it is required that all members of the Board and committees shall abide by them. A copy of these Standing Orders is attached as Appendix 3

**Annual Board Workplan**

To ensure that all regular and major strategic issues are addressed in a timely way, the Board will develop and maintain an annual workplan. This workplan will be included in the agenda papers for all Board meetings, and discussed and/or updated at each meeting as appropriate. The Annual Board Workplan will be developed for release by 1 July of each year. The Chair and Deputy Chair in consultation with Board members will be responsible for the submission of the Annual Board Workplan for Board sign off prior to the beginning of each financial year.

**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.

\(^3\) Schedule 3 clause 29(1) NZPHD Act
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.

**Board Workshops**

The Board may hold workshops for the purposes of education, training or for the purposes of gathering views and ideas about a particular matter.

A facilitator may be appointed for such workshops. Attendees at a workshop will be Board members and any other person by invitation by the Chair.

No member of the public will be permitted at these workshops.

Discussions at such workshops will be held in a free and frank manner and therefore must be held in confidence. Attendance at a workshop represents agreement that attendees will not disclose to any other person, other than another of its Board members, matters discussed at the Board meeting, including any oral statements or written material.

No vote will be taken at such workshops.

**Board Committees**

**Legislative Basis**

Every District Health Board (DHB) must establish three Advisory Committees under ss.34-36 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act): these are Community and Public Health, Disability Support, and Hospitals Advisory Committees. In this manual they are referred to as “statutory” 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.

Under clause 38 of Schedule 3 to the NZPHD Act, the Board of a DHB may with the Minister’s approval also establish one or more committees for particular purposes, and appoint to such committees members of the Board and/or other persons. 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. Committees established under Schedule 3 are referred to as “non-statutory” committees.

In making appointments to a committee of a Board, the Board must endeavour, where appropriate, to ensure representation of Māori on the committee.

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 disclose their already known conflicts.

**Non-Statutory Committees**

In addition to the three statutory committees the DHB’s have two non-statutory committees. These are the Finance, Risk and Audit Committee and the Remuneration Committee.

The Finance, Risk and Audit Committee is not simply concerned with the quality of financial processes and systems. Rather, audit in this context includes audit of both financial and non-financial processes and systems.
The Remuneration Committee is concerned with determining in consultation with the State Services Commission the remuneration and performance of the Chief Executive.

**Appointment Process for Board and non-Board Members**

The Chair of the Board in consultation with the Deputy Chair will review the membership of all DHB committees on an annual basis, with the final recommendation on DHB committee membership being made to the first meeting of each Board in the calendar year. The Chair of the Board will consider (along with any other factor considered relevant for Board committee membership) the skills and experience of each DHB Board member when undertaking the review, including any views that Board members may request are considered when DHB Board committee membership is being assessed. The Chairs of the Board will submit the recommendations for the membership of its committees to each of its Boards who will be empowered to make the final decision on Board committee membership.

Proposed appointments of external (i.e. non-Board) members to the three statutory committees by each of the Board will require the Chair of the Board to submit the recommendations to the Board where each Board is empowered to make the final decision on Board committee membership.

**Additional Representation**

External (i.e. non-Board) members are appointed to the three statutory committees by each Board. This supplements the skills available from Board members alone and assists in dealing with conflicts of interests.

A public process is usually used to make such appointments. This allows any person who has an interest to put their name forward for consideration for appointment to a committee.

Māori representation on the Board generally provides the opportunity for the three statutory committees to include members of the Board who are Māori. However, the Board has also, following the receipt of recommendations from the Iwi Māori Council, appointed an additional Māori representative to each of its statutory committees.

**Delegations**

All decisions about the operation of a District Health Board (DHB) must be made by, or under the authority of, its Board in accordance with section 25(2) of the Crown Entities Act 2004 and section 26 of 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 responsible for the exercise of those functions and powers exercised under the delegation.

Each DHB has 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 is 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 is made by letter from the Board to the person concerned.

**Effect of Delegation**

The Board remains responsible for the actions of its delegates in exercising the Board's powers. All requirements applying to a Board in relation to a power will apply equally to the delegate.
To Whom can the Board Delegate?

The Board can (by written notice) delegate any of the functions, duties or powers of the Board or of the DHB concerned to:

- the delegation of a DHB Board’s function, duty or power is revocable at will
- 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.

The day-to-day management responsibilities within a DHB are delegated to the Chief Executive (section 26(3), NZPHD Act).

Conditions Attached to Delegations

There are a number of procedural checks and balances on delegating. These are designed to ensure the Board always remains in control of and responsible for the exercise of functions and powers by delegates. Sections 73 to 76 of the Crown Entities 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)

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.

Delegations to Committees

Under clause 39(4) of schedule 3 of NZPHD Act the DHB Board may, by written notice to a committee of the Board, delegate to that committee any of the functions, duties, or powers, of the Board, or of the DHB concerned.
However, 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.

All matters are recommended to the Board through the minutes of the relevant committee.

**Chief Executives and other Staff**

Boards may give their Chief Executives 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.

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).

**Financial Delegations**

The DHBs delegation policy and the process by which the Board delegates powers and authorities to the Chief Executive of the DHB is included in the Delegations of Authority – Board to CEO policy document. This also outlines the terms and conditions under which the delegations are made. The policy is included in the resource centre.

**District Health Boards as Employers**

District Health Boards (DHBs) have obligations as employers; these are set out in the Crown Entities Act 2004 (CE Act) and the NZPHD Act, together with other employment legislation (for example, the Employment Relations Act 2000), 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. In the absence of any other document to this effect, adoption of this manual shall be deemed to represent the delegation to the Chief Executive or the power to make decisions on management matters relating to the DHB.

Each DHB will follow a robust process 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 it is recommended, at least as a starting point, because they incorporate good legal practice, manage risk, and
are likely to make the consultation process smoother. The model agreements can be tailored to the requirements of the particular DHB. They are available at [www.ssc.govt.nz/model_agreements](http://www.ssc.govt.nz/model_agreements).

**Chief Executive Performance Management**

The following principles guide each Board’s relationship with its Chief Executive;

- the Board defining the performance expectations of the Chief Executive, and the criteria against which performance will be measured
- on-going and constructive discussions between Chair and Chief Executive
- addressing problems early, for instance by the Chair communicating and discussing non-performance concerns
- 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
- 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.


**Pay and Employment Conditions – Government Expectations**

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

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


The Minister of Health requires DHB Boards to have regard to these expectations when establishing pay and employment conditions.
Chief Executives of DHBs may enter into collective agreements on behalf of the Board with any or all of the Board’s employees, provided the Director-General of Health has first been consulted about the terms and conditions of such an agreement. (Schedule 4, clause 44(4), NZPHD Act)

**Employment Code of Good Faith**

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

**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.

**Legislative Basis: Types of Subsidiaries**

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

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

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

**Which Crown Entities may Establish Subsidiaries?**

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

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

(a) hold any shares or interests in a body corporate or in a partnership, joint venture, or other association of persons; or

(b) settle, be or appoint a trustee of, a trust.

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

**Rules that Apply to Subsidiaries**

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

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

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

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

Planning and Reporting

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

Section 42 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) confirms the requirement for all DHBs to prepare planning and reporting documents in accordance with Part 4 of the Crown Entities Act 2004 (CE Act) and any regulations made under s.92(1)(d) of the NZPHD Act.

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

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.nsf.health.govt.nz/.

Regional Service Plans and Annual Plans

Section 38 of the New Zealand Public Health and Disability Act 2000 (as amended in 2010) creates a new regime of plans (DHB Annual Plans and regional plans), that must be produced by DHB’s replacing the old strategic plans and District Annual plans. These plans must follow a certain structure and include specified content which is set out in the New Zealand Public Health and Disability (Planning) Regulations 2011, which came into force on 01 June 2011.

Each DHB must have in place a regional service plan and an annual plan.

A regional service plan means a plan that is prepared under section 38(1)(b) of the NZPHD Act by a group of two or more DHBs that relates to the services to be provided for a region by those DHBs. A regional service plan must identify each DHB involved in each aspect of each element of the plan. It must contain:

(a) a strategic element
(b) an implementation element.

Fully developed, RSPs will have:

• A strategic section (5-10 year focus), covering all services delivered for the region’s population
An implementation section (1-3 year focus) to address prioritised services targeted for action.

It should include actions which should be fully costed, consideration given to models of care and clinical pathways, and it should include requirements of IT, workforce and capital.

The implementation element of the regional service plan must be reviewed annually. Regional service plans must be updated annually.

Regional Service Plans must be signed by all chairs and chief executives of the region on behalf of their DHB before the Minister agrees to it.

The RSP should be reflected in the Annual Plan.

An Annual Plan means a plan for the financial year prepared by a DHB under section 38(1)(a) of the NZPHD Act. It must include:

(a) a statement outlining how the DHB’s performance as a funder and provider of services is to be demonstrated
(b) an outline of the DHB’s stewardship, as owner, of its assets, workforce, information technology and information services, and other infrastructure needed its services
(c) strong intervention logic between funding, key actions, outputs, expected impacts and outcomes
(d) how the DHB will meet Government priorities, health targets and the performance measures within the performance monitoring framework
(e) a statement of service coverage requirements, service change requirements, emerging policy or sector issues and any relevant Māori health or other sub-plan requirements
(f) detailed outputs for which the DHB will be held to account
(g) detailed financial budgets
(h) actions, milestones, budgets, and reporting measures for the DHB to lead, deliver, or support delivery of:
   – the objectives of regional services plans in which the DHB is to participate
   – relevant national service plans, including the Government’s key health priorities.

The Ministry of Health prepares annually a set of templates for DHBs to plan and report against the Government’s health priorities. The range of planning instruments and vehicles make it advisable for each DHB to consider setting up a process to record the actions and time frames for key planning and reporting decisions.

The expectation that Boards are fully engaged in these areas is reflected by the requirement that accountability documents are signed on behalf of the DHB by the Chief Executive and the Chair of the Board.

The Minister of Health's consent must be obtained for all such plans, or amendments to them. All such plans 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 may direct a DHB to contribute to one or more other plans.

The plan may be amended at any time in the same manner as it was made. A DHB that is a party to the plan must ensure that the plan and any amendments to it are publicly available as soon as is reasonably practicable after the plan is finalised. In making the plan (and any amendments to it) publicly available, a DHB
may omit any information that may properly be withheld under the Official Information Act 1982 if a request for that information were made under that Act.

A DHB must consult with the public in relation to either plan if the Minister considers that:

(a) the plan proposes changes to services, including service eligibility, access, or the way services are provided

(b) the proposed changes will have a significant impact on recipients of services, their caregivers, or providers.

**Statements of Intent**

At least once every three years (beginning in the 2014/15 financial year), a DHB must prepare a statement of intent for that financial year and the 3 following financial years. The purpose of a Statement of Intent (SOI) is to promote the public accountability of a Crown entity (s.138, CE Act) by:

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

The Minister may participate in determining the DHB’s strategic priorities and other 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). The Minister may also require a DHB to prepare a new SOI at any time within the three year period of its currency (s. 139A, CE Act).

An SOI flows out of a DHB’s strategic planning process, and through it the Board expresses its strategic thinking and future intentions. The SOI must explain, among other matters (s.141, CE Act):

- the nature and scope of the DHB’s functions and intended operations;
- how the DHB intends to manage its functions and operations to meet its strategic intentions;
- how the DHB proposes to manage its organisational health and capability;
- how the DHB proposes to assess its performance.

The SOI is prepared under the leadership of the Board, signed off by two members of the Board, and presented by the Minister to the House of Representatives.

The SOI will reflect engagement with the Minister and Ministry of Health through the planning process.

**Statements of Performance Expectations**

Each DHB must prepare an annual Statement of Performance Expectations (SPE) under sections 149C of the CE Act. The purpose of a SPE (s. 149B, CE Act) is to:

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

The SPE must contain information about each reportable class of outputs, and the performance expectations in relation to that class, along with forecast financial statements (ss 149E, 149G, CE Act).
As with the SOI, the Minister may participate in determining the contents of the SPE. A draft must be presented to the Minister at least 2 months before the start of each financial year. The Minister may provide directions as to the form in which any information in the SPE must be disclosed. On completion, the SPE must be published and sent to the Minister, who must present it to the House of Representatives. The Minister may direct the DHB to amend any provision contained in the SPE, and the DHB may itself amend the SPE at any time. (These provisions are all set out in ss 149H to 149M, CE Act).

**Advice and Guidance**

Advice on developing robust performance measures and preparing an SOI and SPE can be found at:


**Crown Funding Agreements**

The Crown Funding Agreement (CFA) is the agreement between the Minister of Health and District Health Boards. Through the CFA the Crown agrees to provide funding in return for service provision as specified in the CFA. The CFA incorporates by reference the requirements in the Operational Policy Framework and the Service Coverage Schedule. A DHB is required to have a CFA in place in accordance with section 10 of the NZPHD in order to receive Crown funding. The CFA is 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 outputs, including the standards, terms and conditions under which the DHB will deliver and be paid for the outputs.

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

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

**Annual Report**

DHBs report on their performance to the Minister and Parliament through their annual reports (ss.150 - 157, CE Act). The annual report must provide information that enables an informed assessment to be made of the DHB’s operations and performance for that financial year, including a report on the DHB’s progress in relation to its strategic intentions (as set out in the most recent SOI) and an assessment against the standards of delivery performance set out in 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 CE Act sets out specific
information that must be included, for instance the annual financial statements for the DHB, a statement of performance, any direction given to the DHB by a Minister in writing, and the total value of the remuneration paid to each Board member during the financial year (sections 151 and 152, CE Act).

Every annual report of a DHB also must contain:

- a report on the extent to which it has met its other objectives under s.22, NZPHD Act
- a report on the performance of the hospital and related services the DHB owns
- the names of any bodies corporate, partnerships, joint ventures or other associations, or trusts with which the DHB is involved, and a list of all shares and interests the DHB holds in such bodies
- 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 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.

**Enduring Letter of Expectations**

An enduring letter of expectations to Crown entities is issued periodically with the most recent in July 2012 see [www.ssc.govt.nz/expectations-letter-crown-entities-july12](http://www.ssc.govt.nz/expectations-letter-crown-entities-july12). It sets out the on-going expectations that the Minister of Finance and the Minister of State Services have of all statutory Crown entities, including DHBs. These expectations include value for money, demonstrating performance, and engagement with Ministers and monitoring departments. An enduring letter remains 'in force' until it is replaced.

**Annual Letter of Expectations**

Ministers "participate in the process of setting and monitoring the entity's strategic direction and targets" (s.27(1)(f), CE Act). Ministerial expectations for DHBs' strategic direction and their specific priorities for the planning period may be reflected in a letter of expectation from the Minister to the DHB. It may also cover expectations of a DHB's governance and performance and of the monitoring information to be provided. The letter will usually be sent to the Chair of the Board during the planning process.
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 will 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 obligation
- monitoring entity performance
- monitoring and reviewing the performance of the Chief Executive
- 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
- assisting the Minister of Health with succession planning, appointment and reappointment processes.

Evaluating performance will be undertaken each financial year.

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

Board Appointments and Reappointments

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)
- 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
- in any event, there are at least 2 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
- 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 the Chair in Appointment Processes**

The Minister or Ministry of Health will generally engage with the throughout the process of appointing a DHB Board member. The Chair must 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
- suggest nominees for consideration.

**Desirable Attributes in Appointment of 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 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 sections 53-57 and 59 of the CE Act).

Generic skills for a Board member will usually include:

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

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

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

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

**Conflicts of Interest**

Before a chair, deputy chair or member is appointed or elected, they must declare their conflicts of interest. Members to be appointed declare their interests to the Minister of Health before their appointment (s.31(1)(c), CE Act). Candidates for elected member positions give a statement to the electoral officer, who then discloses any conflicts of interest to the public (Schedule 2, clause 6, NZPHD Act). Further information on conflicts of interest can be found at [http://www.health.govt.nz/publication/conflict-interest-guidelines-district-health-boards](http://www.health.govt.nz/publication/conflict-interest-guidelines-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). 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.
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
- s.31: Requirements before appointment, which includes disclosure of interests.

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

Board Member Induction and Training

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

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

- the name of each member of the Board and the date on which they most recently came into office as a member of the Board
- any familiarity each member of the Board has at that date with the obligations and duties of a member of a Board, Māori health issues, Treaty of Waitangi issues, and Māori groups or organisations in the district of the DHB concerned
- the nature of the training (if any) the Board is required to fund and, to the extent practicable, have any of its members undertake and complete
- 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.

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

The State Services Commission has developed induction modules, to assist those giving induction sessions for Crown entity Board members (www.ssc.govt.nz/crown-entity-induction-material). The primary audience for the induction material is new members of Boards but it may also be helpful for existing Board members. The material needs to be shaped to the Board’s situation.

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
- 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.

**Further Information on Appointments**

If Board members wish to further understand Government processes in this area, they should refer to the State Services Commission *Board Appointment and Induction Guidelines* [www.ssc.govt.nz/board-appointment-guidelines](http://www.ssc.govt.nz/board-appointment-guidelines).
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. Boards using it need to be sure they are working from the latest version, as it is reviewed periodically. The current version is located at: www.dpmc.govt.nz/cabinet/circulars/co12/6.html.

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

In general:

- Board chairs are paid more than other members due to their larger role
- Deputy Chairs are paid an additional amount on top of their member fee
- members who receive an annual fee for Board membership do not generally receive additional payment under the CE Act 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 one of the DHB’s three statutory committees
  - As the Disability Support Advisory Committee and the Community & Public Health Advisory Committee sit at the same time the Minister has approved that members be paid $3,500 per annum and the Chair, $4,375 per annum as a total fee. (Reference letter from Hon Tony Ryall dated 9 August 2013).
  - For the Hospital Advisory Committee the fee will be $2,500 per annum for each member and $3,125 for the Chair up to a maximum of 10 meetings.
  - For the Finance Risk and Audit Committee the fee will be $2,500 per annum for each member and $3,125 for the Chair up to a maximum of 10 meetings
  - In all instances of committee attendance, the fee is pro-rated if a member or Chair attends less than 10 meetings per year and members and chairs do not receive any additional payment if they attend more than 10 meetings of their subcommittee in a year
- 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.
Administrative Matters

Board members who travel to meetings or on other Board business that requires them to be away from their normal places of residence are entitled to reimbursement of actual and reasonable travelling, meal and accommodation expenses. The CCDHB Policy “Board fees and expense reimbursement is attached as Appendix 5.

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).

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:

(i) for any liability, act or omission of the organisation

(ii) 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 collective duties could result in removal from office by the Minister, and that failing to comply with a member’s individual duties could lead to personal liability, civil proceedings or criminal prosecution.

Although Crown entities are legally separate from the Crown, in some cases a court may decide that the Crown is liable for the actions of 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. However, the Crown is not liable for the debts of Crown entities (Public Finance Act 1989, section 49). Board members are collectively responsible for ensuring that the entity operates in a financially responsible manner.

Every Board should spend time discussing these matters as they relate to themselves and their employees, preferably with the assistance of a trained specialist, perhaps the entity's legal advisor.

Indemnities

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

**Health and Safety**

Board members cannot contract out of their personal liabilities as officers of the DHB under the Health and Safety at Work Act 2015. Any liability would be for a fine by virtue of a prosecution, and it would not be covered by s.90 of the NZPHD Act.

The only indemnity under s.90 that would be available for Board members prosecuted under the Health and Safety at Work Act would be for costs arising from a successful defence. No insurance is available against fines Board members might incur under the health and safety legislation (or any other legislation).

The Board has approved a Health and Safety Charter that sets out the Board’s expectations of how the health and safety should be managed by the DHB. The Health and Safety Charter provides a framework for Board members to demonstrate that they are fulfilling their duty to exercise due diligence in relation to health and safety. A copy of the Health and Safety Charter is attached as Appendix 2.

**Memorandum of Understanding with Iwi**

CCDHB has a governance level relationship and agreement with the Māori Partnership Board (MPB). The MPB provide advice and guidance to CCDHB on strategic Māori and related issues. MPB members fulfil this important role as mandated representatives of local Wellington tribes and Tauahere 1 living in the Wellington DHB district.

The 2004 Memorandum of Understanding and Protocol between CCDHB and MPB are attached in Appendix 6.
Appendix 1 Code of Conduct for Board Members

CODE OF CONDUCT

FOR THE BOARD AND BOARD COMMITTEES

OF CAPITAL & COAST DHB
1. CODE OF CONDUCT

This Code of Conduct has been agreed to by all Board members of the Capital & Coast 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 recognised the unique nature of the District Health Board. As a Crown Entity that is also an agent of the Minister ref: New Zealand Public Health & Disability Act 2000, C&C DHB 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. However, the Board as a corporate governance body 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.

Some sections of the Code are and will be further supported in time by organisation policies - (e.g. Communications and Consultation Policies)

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:

- act in good faith;
- act with honesty and integrity;
- exercise reasonable care, diligence and skill at all times in carrying out their duties; and
- lay aside all private and personal interests in their collective decision-making.

b) Accountability

Members are accountable to the Minister of Health for the performance of the DHB. The Minister, in turn, holds DHB Boards to account for engaging with their local communities.

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 recognise 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 Capital & Coast district and are expected to avail themselves of opportunities for training in these areas.

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

e) Collective Responsibility  
Members recognise that there may at times be tension between the concepts of collective accountability of a Board of directors and individual accountability to the public of elected members. 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  
In summary, all statements on behalf of the Board and/or relating to Board or Government policy should be made by the Chair. Either the Board Chair or the Chief Executive (or other senior staff under her delegation) speak on operational matters. On occasions members may be asked their opinions and when talking to the media members should:

- Make clear the capacity in which they are speaking.

- Make it clear that they are expressing their own personal views and not speaking for the Board.

- Remember that they are representing the Government and Minister.

- Not make any promises in relation to funding or service provision.

- Not criticise any service provided by the DHB until such time as it has been formally raised with the Board

- Be aware of the governance role, and that management is responsible for policy implementation and operational issues.

- Whenever appropriate, let the Board Chair know in advance if they are contacted by or intend to speak to the media.
g) Clarity about Roles

The Board is responsible for the governance of the DHB, and delegates to the Chief Executive responsibility for implementing the decisions of the Board, and the day to day management of the organisation. 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 shall not become involved in management’s activities.

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 beyond authorised delegations.

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 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

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.

l) Conflict of Interest

The NZ Public Health and Disability Act sets out the definition and procedure for disclosure of members’ interests. The Act states that:
1. A Board member who is ‘interested in a transaction’ of the District Health Board must, as soon as practicable, disclose the nature of the interest to the Board.

2. The Board member must not take part in any deliberation or decision of the Board relating to the transaction.

3. The disclosure must be recorded in the minutes and entered in a separate interests register.

“interested in a transaction” is defined within the NZH&DA (Interpretation Section) as: “if the Board member:

(a) is a party to, or will derive a material financial benefit from, the transaction;

(b) has a material financial interest in another party to the transaction; or

(c) is a director, member, officer, or trustee of another party to, or person who will or may derive a material financial benefit from, the transaction; or

(d) is the parent, child, or spouse (or de facto partner) of another party to, or person who will or may derive a material financial benefit from the transaction; or

(e) is otherwise directly or indirectly materially interested in the transaction.”

Board members:

- Recognise that at times there may arise a ‘perception of interest’ which is a wider interpretation than that defined in the legislation. A “perception of interest” is where any member is “perceived to have an interest greater than the general public”. 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.

- Recognise that where an 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. The Board can, however, exercise its discretion in allowing the member to remain. In such circumstances the member would not participate in any decision.

- Will not use 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.

- Will exercise care and judgement in accepting any gifts, and advise the Chair and/or Board of any offer received.

CONFLICTS OF INTEREST POLICY

1. Board Members

- Board members should readily and promptly disclose all actual or potential conflicts to the Board or Committee, describing in detail the
nature of the conflict

- The disclosure should be recorded in the minutes of next Board or Committee meeting

- The disclosure (if not already disclosed) should be entered into the separate Board or Committee Interests Register

- The Board needs to ensure that the Board/Committee Member interested in the transaction does not take part in a decision/vote of the Board/Committee on a transaction nor form a quorum. The Board/Committee member interested in the transaction should also not take part in deliberations, unless the Board majority, after hearing the circumstances of the particular case, votes against this general policy pursuant to clause 36(4) of Schedule 3 of the New Zealand Public Health and Disability Act 2000

- The Board needs to consider the extent of the Board/Committee member’s abstention to ensure procedurally fair process/probity of decision making process

- The Board needs to ensure that the Board/Committee member interested in the transaction does not take part in policy/strategy formation and the lead up process to the transaction, including receiving confidential/insider information regarding the transaction, unless the Board majority, hearing the circumstances of the particular case, votes, contrary to this general policy

2. Management and Employees

An early warning system ensures at an early stage that a Board Member is not privy to information surrounding the strategy/policy of a transaction for which he or she declared interest (if considered appropriate by the Board in the circumstances of case)

- Management brings potential conflicts of interest to the attention of the Board

- Employees working under delegation in areas where conflict likely to arise, for example, Planning and Funding, should:
  - regularly check Register of Conflicts of Interest
  - identify potential conflicts of interest, e.g., contracts with private providers where Board Members have disclosed an interest or directorships
  - identify, as part of their day to day work practice, policies/proposed strategies and proposed contracts which raise potential conflict
  - bring potential conflict to the attention of their manager who raises this with CEO

- The CEO informs the Chair who ensures Board members are aware of the potential conflict and will take appropriate action (disclosure of the conflict of interest)
• The collective Board makes a decision regarding the conflict of interest.

ADVERSE STATEMENTS

A Board member should not make statements adverse to C&C DHB’s interests in any legal proceedings or discuss claims against C&C DHB with a claimant or interested person unless it is required by law or in the interests of justice to do so.

A Board member should advise the Chair before making any adverse statement or entering into discussions regarding proceedings with a claimant or interested person. The matter can be discussed to the extent discussion is appropriate in the circumstances”.

m) Members undertaking work for the DHB

Board members should be aware that undertaking work for the DHB for additional remuneration needs to be handled very carefully and with complete transparency. Such situations should be guided by the following principles/processes:

• The Chair should be given early notification of any situations where members might engage in work for the DHB.

• Members should not receive additional remuneration for undertaking work which is already covered by the role/duties and responsibilities of Board members.

• Board members should only be engaged to undertake other work or assignments for the DHB on the basis of their particular qualifications, skills and suitability for the work and any such engagement should follow the normal employment/contracting processes for such work within the DHB.

• Members should not in any way use their position as Board members to influence their selection/engagement for work with the DHB.

• Any such engagements should be declared to the Board and recorded in the Conflict of Interest Register.

n) Consultation and Participation

C&C DHB has previously approved a separate Consultation Policy.

In summary, 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). 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:

• Will endeavour to keep an open mind during formal consultation with the
public and be 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:

  “Consultation does not mean negotiation or agreement. It means setting out a proposal not finally decided upon, adequately informing a party of relevant information upon which the proposal is based, listening to what others have to say with an open mind (in that there is room to be persuaded against the proposal), undertaking that task in a genuine and not cosmetic manner, reaching a decision that may or may not alter the original proposal.”

o) Requests for Items to be placed on Board or Committee Agendas

The Agenda will be structured to ensure that decision papers have priority with information papers included under separate cover.

In addition to the formal Board papers and Board Agenda, all relevant information papers will be passed to the Board under separate cover. In the first instance if any Board member has any questions in regard to information papers, they will bring them up with Director Strategic Community Relations or the CEO or the Chair (whoever they think is appropriate). If having bought the item up and it is considered that the item should be discussed by the full Board, this will be put on the Agenda for the next meeting.

If any Board member wishes to bring up any item at the Board meeting which is not covered in a Board paper or on the Board Agenda, they must notify in writing the Chair or the Governance Support Team 48 hours prior to the Board meeting.

p) Behaviour at Board and Committee Meetings

As a general practice members have agreed that meetings of the Board and committees should be conducted in as informal manner as possible. In order to achieve this and to make meetings as productive and efficient as possible, members undertake to observe the following protocols:

- Members will behave in a polite and respectful manner with colleagues and the executive.
- 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 interrupt each other or talk while another member is speaking.
- 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 CEO will endeavour to clarify questions, issues, requests, before taking actions or responding.

• Discussions will be terminated by the Chair if information is not available to pursue the discussion.

• No cell-phones will be on during Board meetings.

• All members will assist the Chair to uphold the behaviour protocols agreed to by the Board.
HEALTH AND SAFETY CHARTER

September 2016
This Charter is approved by the Board to assist Capital & Coast District Health Board. This Charter will be reviewed after 12 months.

1.0 Policy Statement

This policy meets the requirements of the proposed legislation and the ACC Partnership Programme standard AS/NZS 4801:2001 Section 4.2, 4.4 and 4.6).

The Board is committed to ensuring a safe environment for its people (employees and Contractors), patients, families and other people for whom we are responsible in the vicinity of the organisation's place of work.

The Board recognises that it is has a critical role to play in the implementation of health and safety and the health and safety culture of the organisation.

The Board will fulfill its role by ensuring that appropriate policies and procedures are adopted and implemented and by reviewing and monitoring the identification, reporting, culture and management of health and safety hazards and risks.

All board members will familiarise themselves with their obligations under the relevant legislation (including any amendments) and their obligations as officers and ensure the appropriate policies and processes are in place to meet those obligations.

The Board will ensure the above by:

1.1 Policy and Planning

Ensuring the DHB:

- Has effective health and safety policies
- Has an annual Health and Safety plan
- Holds the Chief Executive Officer (CEO) accountable for the implementation and management of the plan and polices by specifying expectations and feedback requirements
- Tracks the DHBs health and safety performance via timely reports.

1.2 Delivery

- Laying down clear expectations that the DHB will have a fit for purpose health and safety management system
- Exercising due diligence by ensuring that this system is effectively implemented, regularly reviewed and continuously improved
- Being sufficiently familiar with best practice health and safety systems to know whether the DHB systems are fit for purpose
- Monitor the implementation of the health and safety program
- Seeking independent expert advice if needed

1.3 Monitoring and Review

- Ensuring internal and external health and safety system audit reports are submitted to the Board in a timely manner and that any recommendations from these reports are acted on and the Board is notified when they are remedied
• Ensure progress reports on the DHBs Annual Health and Safety Plan are included in the Quarterly Health and Safety report to the Board.

2.0 Responsibilities of the Board

The health and safety responsibilities of the Board will include:

• Considering, approving and making changes to all major health and safety strategy, policy and procedures including the organisation wide Safety Management System Framework
• Setting health and safety indicators together with the Chief Executive and assessing performance in accordance with available resources against those indicators
• Ensuring the Board and its members are properly and regularly informed and updated on matters relating to health and safety governance, performance, and compliance
• Reviewing the adequacy of the organisation’s systems for monitoring compliance with both relevant applicable law and the organisation’s policies
• An annual assessment/audit of the organisation’s health and safety risk profile and compliance and control processes
• Obtaining regular reports from management on the operation of the organisation’s risk management, compliance and internal control processes as they relate to health and safety
• Evaluating the adequacy of the organisation’s relevant systems for the reporting of actual or potential incidents and breaches, subsequent investigations and remedial actions. This shall include reviewing all health and safety incidents that meet the definition of notifiable events under the Health and Safety at Work Act 2015 occurring across the organisation’s operations and considering the appropriateness and efficacy of any identified corrective actions to minimise the risk of recurrence.

3.0 Responsibilities of Managers

• All managers have a responsibility to ensure that a safe and healthy work environment is achieved and maintained
• Managers are accountable for integrating CCDHBs health, safety and wellbeing system and policies into their work areas, for themselves, their employees, students, volunteers, contractors and visitors.

4.0 Responsibilities of Staff

All employees have a duty and responsibility, to maintain their own health, safety and wellbeing and to ensure that no action or inaction on their part causes themselves or another person harm.

5.0 Health and Safety Training

Training starts at orientation, with employees understanding their responsibilities and how they can contribute to a healthy and safe environment and ensure compliance with CCDHBs vision and statutory requirements. All relevant health, safety and wellbeing training will be made available to all CCDHB employees.

6.0 Employee Participation and Consultation

CCDHB will ensure that all employees have on-going opportunities to be involved and to have their interests represented in the development, implementation and evaluation of safe workplace practices. This includes management and proactive engagement of employees, their H&S representatives and the Union, through their organisers and members.
7.0 Meetings

At all Finance Risk and Audit Committee and Board meetings, the Committee and Board will receive a report on CCDHBs health and safety systems. The report will contain a comprehensive summary of health and safety activity across the organisation. The Committee and Board will review the report and respond to recommendations as appropriate and/or provide any feedback and direction as required.

Board workshops or meetings dedicated to health and safety will be scheduled at least six times a year and minuted. These meetings will comprehensively review the organisation's health and safety strategy and its health and safety performance against the relevant indicators and targets and make any adjustments to the strategy, indicators or targets as necessary. The Board may arrange to visit any site managed by or for CCDHB and such visits should be recorded in the minutes. These visits will be arranged and co-ordinated via the Chief Executive.
Appendix 3 Standing Orders for the Board and Board Committees

STANDING ORDERS

FOR THE BOARD AND BOARD COMMITTEES

OF CAPITAL & COAST DHB
1 General

1.1 Interpretation

For the purpose of these Standing Orders

**Act** means the New Zealand Public Health and Disability Services Act 2000.

*DHB will comply with the requirements of the Act. If there is any inconsistency between the Act and these Standing Orders then the Act shall prevail.*

**Board Administrator** means the principal administrative officer of the Board and its committees, and includes for the purpose of these Standing Orders any other officer so authorised by the Board.

**Chair** means the chairperson of the DHB and, where appropriate, also includes any person acting as the chairperson of any committee or sub-committee of the DHB *(refer Schedule 3, clause 27 of the Act).*

**CEO** means Chief Executive Officer of the DHB.

**Committee** means a committee of the Board, including:

a) A Community and Public Health Advisory Committee;

b) A Disability Support Advisory Committee;

c) A Hospital Advisory Committee

d) any committee established under clause 38 of Schedule 3 of the Act; and

e) any subcommittee of a committee described in a) – d) above.


**Commissioner** means a person appointed by the Minister of Health under section 31 of the Act and who, by virtue of that section, has all the functions, duties and powers and protections of the Board and of a member of the Board including the Chair, while he/she holds office as Commissioner.

**Deputation** means a request from any interest group in the community to make a presentation to the Board or a committee.

**DHB** means Capital & Coast District Health Board (CCDHB), Hutt Valley District Health Board (HVDHB) and Wairarapa District health Board (WDHB)

**Meeting** means any first, ordinary, special or emergency meeting of the DHB; and any meeting of any committee or subcommittee of the DHB. At any meeting of the Board, any committee or subcommittee of a DHB at which no resolutions or decisions are made, the provisions of section 4 of these Standing Orders in relation to public access need not apply.

**Member** means any person elected or appointed to the Board of a DHB or to any committee or subcommittee of the DHB.

**Minister** means Minister of Health.
**Minutes** means any minutes or other record of the proceedings of any meeting of the Board and its committees.

**Ordinary meeting** means any meeting publicly notified by the DHB in accordance with Schedule 3, clause 16 of the Act.


**Public excluded information** includes:

Information which is:

i) currently before a public excluded session; or

ii) proposed to be considered at a public excluded session; or

iii) had previously been considered at a public excluded session (other than information subsequently released by the DHB as publicly available information); and

Any minutes (or portions of minutes) of public excluded sessions (other than those subsequently released by the DHB as publicly available information); and

Any other information which has not been released by the DHB as publicly available information.

**Publicly excluded session** refers to those meetings or parts of meetings from which the public is excluded by the DHB pursuant to clauses 32 and 33 of Schedule 3 of the Act.

**Publicly notified** means notified to the resident population of the DHB by advertisements in one or more newspapers circulating in the district, or by advertisements of that kind and any or more of the following means: printed placards affixed to public places in the district; radio or television broadcasts; and/or notices available on the internet, e-mail or other electronic means.

**Statutory Committee** means: the Community and Public Health Advisory Committee (CPHAC); the Disability Support Advisory Committee (DSAC); and the Hospital Advisory Committee (HAC).

**Working day** means any day of the week other than:

Saturday, Sunday, Good Friday, Easter Monday, Anzac Day, Labour Day, Queen’s Birthday, and Waitangi Day; Anniversary Day; and

A day in the period from 25 December through to 15 January of the following year.

### 1.2 Application of Standing Orders

1.2.1 These Standing Orders shall, so far as applicable, extend to the proceedings of all the Board and committee meetings of the DHB, including public excluded sessions.

1.2.2 All members of the Board and its committees shall abide by the Standing Orders adopted by the Board.
1.3 **Chair’s ruling is final**

1.3.1 The Chair shall decide all questions where these Standing Orders make no provision or insufficient provision.

1.3.2 In regard to order 1.3.1 the Chair’s ruling shall be final and not open to debate.

1.3.3 **Disorderly persons may be excluded**

At any meeting of the Board or a committee, the Chair may require a member of the public attending the meeting to leave if the Chair believes on reasonable grounds that, if the person is permitted to remain, the behaviour of that person is likely to prejudice, or continue to prejudice, the orderly conduct of the meeting.

If any person who is required, pursuant to a ruling under Standing Orders, to leave a meeting:

a) refuses or fails to leave the meeting; or

b) having left the meeting, attempts to re-enter the meeting without the permission of the Chair; then

any officer or employee of the DHB or member of the Police, may, at the request of the Chair, remove or, as the case requires, exclude that member from the meeting.

(Refer clause 35, Schedule 3 and clause 37, Schedule 4 of the Act)

1.4 **Suspension of Standing Orders**

1.4.1 The Board or a committee may temporarily suspend Standing Orders during a meeting by a vote of three-quarters of the members present and voting, and the reason for the suspension shall be stated in the resolution of suspension.

1.4.2 Any motion to suspend one or more Standing Orders shall state the specific order or orders which it is proposed to be suspended.

1.5 **Alteration of Standing Orders**

1.5.1 After the adoption of the first Standing Orders of the DHB, the adoption of amended Standing Orders shall require, in every case, a vote of three-quarters of the members present.

1.6 **First meeting of the Board following election**

1.6.1 a) The first meeting of the Board following an election shall be called by the Chief Executive as soon as practicable after the elected members have taken office on the 58th day after polling day.

b) The Chief Executive shall give the persons elected or appointed to the Board not less than ten (10) working days’ notice of the meeting.

c) The meeting shall be chaired by the Chair of the Board appointed by the Minister under clause 10 of Schedule 3 of the Act.
1.7 Members

1.7.1 Members to give notice of addresses

Every member of the Board and a committee shall give to the 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 DHB business may be sent or delivered.

1.7.2 Member receiving information

If notice is sent to the address notified by the member, then the member is deemed to have received the notice of meeting two (2) working days after posting and the next working day if emailed or faxed.

1.8 Committees

1.8.1 Standing or Special Committees

The Board may:

a) appoint standing or special committees and the presiding members and other members of such committees;

b) determine the duties of, and the matters which shall normally be referred to, such committees;

c) determine whether the Standing Orders shall apply in full or part of the meetings of such committees.

1.8.2 Committees subject to the direction of the Board

Every committee is subject, in all things, to the control of the Board and is required to carry out all directions given in relation to the committee or its affairs by the Board.

1.8.3 Appointment or removal of committee members

The Board may at any time appoint or remove any member of a committee.

1.8.4 Members of committees

The Board may appoint to any committee any person who is not a member of the Board if, in the opinion of the Board, that person has knowledge which will assist the work of the committee. At least two members of every committee shall be members of the Board.

The Board must endeavour, where appropriate, to ensure representation of Māori on the committee.

1.8.5 Minimum number on committees

The minimum number of members of a committee is three (3).

1.8.6 Tenure of committees

Every non-statutory committee shall, unless sooner discharged, be deemed to be discharged on the coming into office of the members of the Board elected or appointed, as the case may be, at or after the next general election following the appointment of the committee.
1.9 Chair ex officio member

1.9.1 Chair ex-officio

The Chair shall be an ex-officio member of every committee of the Board.

1.9.2 Chair not obliged to apologise for absence

Despite being ex-officio a member of every committee of the Board the Chair shall not be obliged to apologise for absence from any committee.

1.10 Powers of Delegation

1.10.1 Delegation to Committees

The Board may, by written notice, delegate to any committee any of the functions, duties, or powers, of the Board or of the DHB. Such a delegation does not prevent the Board or DHB from performing the function or duty or exercising the power.

(refer to clause 39, Schedule 3 of the Act)

1.10.2 Committee use of delegated powers

Every committee to which any functions, duties or powers are delegated by the Board may, without confirmation by the Board, perform the function or duty, or exercise the power, in the same manner, subject to the same restrictions, and with the same effect, as if the delegate were the Board or the DHB.

The committee must not delegate the delegated function, duty or power except in accordance with the provisions of the delegation or with the written consent of the Board.

(refer to clause 40, Schedule 3 of the Act)

1.11 General Provisions as to meetings

1.11.1 The Board and committees shall hold such meetings as are necessary in order to carry out its functions and responsibilities under the Act and, where applicable, its terms of reference.

1.11.2 Every member of the Board or committee shall, unless lawfully excluded, have the right to attend any meeting of the Board or committee.

1.11.3 Every meeting of the Board and any committee shall be called, publicly notified, and conducted in accordance with:

a) the NZPHD Act 2000; and
b) the Board’s Standing Orders.

1.12 Special and emergency meetings

1.12.1 The Board may hold special or emergency meetings.

1.12.2 A “special meeting” means a meeting called pursuant to –

a) a resolution of the Board; or

b) a requisition in writing delivered to the Chief Executive and signed by:

i) the Chair of the Board, or
ii) a majority of the total membership of the Board (including vacancies).
which resolution or requisition shall specify the time and place at which the meeting is to be held and the general nature of the business to be brought before the meeting.

1.12.3 The Chair shall give notice in writing of the time and place of a Board meeting and of the general nature of the business, to every member of the Board:

a) at least three (3) working days before the day appointed for the meeting; or

b) where the meeting is called pursuant to a resolution or requisition of the Board, within such lesser period of notice, being not less than 24 hours, as is specified in the resolution.

1.12.4 Notification of emergency meetings to members

In the event of an emergency meeting being required, the Chair shall convene such meetings on the written authority of the Chair or of any five (5) Board members, and for such meetings notice by letter, facsimile, telephone, or email shall be deemed to be sufficient.

1.13 Notice to members of meetings

1.13.1 The Chair shall give notice in writing (by delivery or electronic transmission) to members of the time and place appointed from time to time for holding each ordinary meeting already scheduled and any special meetings, and the members shall attend such meetings without further notice.

1.13.2 Agenda and agenda papers to be sent to members

In the case of each meeting to which order 1.13.1 applies, an agenda detailing the business to be brought before that meeting, together with relevant agenda papers and associated reports, shall be sent to every member no less than two (2) working days before the day appointed for the meeting.

(refer clause 18, Schedule 3 of the Act)

1.14 Meetings not invalid because notice not received

1.14.1 No ordinary meeting, special meeting, or emergency meeting of the Board shall be invalid because notice of the meeting was not received or was not received in due time by any member, if the Chair made all reasonable efforts to ensure each member was given notice.

(refer clause 16, Schedule 3 of the Act)

2 Procedure at meetings

2.1 Chair to preside at meetings

2.1.1 a) The Chair of the Board shall preside at every meeting of the DHB at which he or she is present.

b) The Chair of any committee shall preside at every meeting of the committee at which he or she is present.

c) The Board may appoint a member of any committee to be the Chair of that committee, and that power may be exercised by the committee where the Board, on the appointment of the committee, does not appoint a Chair. Any committee may from time to time appoint a Deputy Chair to act in the absence of the Chair.

d) If the Chair of the Board or of any committee, as the case may be, is absent from any meeting, the Deputy Chair (if any) of the Board or committee, as the case may be, shall preside, but, if the Chair and Deputy Chair are both absent, the members of the Board or committee present, as the case may be, shall elect one of their number to preside at that
meeting, and that person shall have and may at that meeting perform all the functions and duties and exercise the powers of the Chair.

(refer clauses 27, Schedule 3 and 29, Schedule 4 of the Act)

2.2 Order of Business

2.2.1 The Board shall adopt an order of business which shall normally apply at ordinary meetings and may vary it from time to time.

2.3 Quorum

2.3.1 The Board or a committee cannot exercise any authority, power, or discretion, and no business of the Board or committee, can be transacted, at any meeting of the Board or committee, as the case may be, unless the quorum of members of the Board or committee, is present at the meeting.

(refer clauses 25, Schedule 3 and 27, Schedule 4 of the Act)

2.3.2 Subject to any exceptions in the Act, the quorum of members of the Board is:

a) if the total number of members of the Board is an even number, half that number; but

b) if the total number of members of the Board is an odd number, a majority of the members.

2.4 Agenda

2.4.1 The Chief Executive shall prepare an agenda for each meeting in consultation with the Chair.

2.4.2 The agenda paper will include any matters which the Chief Executive considers the Board or committee is likely to wish to exclude the public, provided that an indication of the subject matter likely to be considered in exclusion of the public shall be placed on the Agenda available to the public.

(refer to clauses 19(2), Schedule 3 and 21(2), Schedule 4 of the Act)

2.5 Extraordinary or urgent business at ordinary meeting

2.5.1 Only business on the agenda may be dealt with at any meeting of the Board or a committee. Where an item is not on the agenda for a meeting, that item may be dealt with at the meeting if:

a) The Board by resolution so decides; and

b) The presiding member explains at the meeting, at a time when it is open to the public,

i) the reason why the item is not on the agenda; and

ii) the reason why the discussion of the item cannot be delayed until a later meeting.

Despite the above, where an item is not on the agenda for a meeting:

c) The item may be discussed at that meeting if:

i) The item is minor matter relating to the general business of the Board; and

ii) The Chair explains at the beginning of the meeting, at a time when it is open to the public, that the item will be discussed at the meeting; but

iii) No resolution, decision, or recommendation may be made in respect of that item except to refer the item to a later meeting of the Board for further discussion.

(refer clauses 28, Schedule 3 and 30, Schedule 4 of the Act)
d) 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 Decision to be decided by majority votes

2.6.1 All acts of the Board are to be done and all questions before the Board are to be decided at a meeting by the majority of such members as are present and voted thereon. The Chair does not have a second casting vote.

2.6.2 Any member may abstain from voting and have their abstention recorded in the minutes when requested.

2.7 Motions and resolutions

2.7.1 Every endeavour shall be made to achieve consensus in decision-making.

2.7.2 Discussions on any proposal shall be broad and informal and constrained as to time by the guidance of the Chair rather than through procedural motions.

2.7.3 Where there is a resolution, it shall require a mover and a seconder, to be identified and named.
   a) A motion is a proposal put before a meeting for consideration and discussion. Once a motion is before the meeting members shall confine discussion to the motion.
   
   b) Once passed, a motion is called a resolution, as its status changes from having been ‘moved’ to having been ‘resolved’. Once the Chair puts a motion to the vote, no further discussion should occur.

2.7.4 Silence when a motion is put shall be deemed to be a vote in support of the motion.

2.7.5 Votes for and against particular motions shall not be recorded, unless requested by a Board or committee member or the Chair.

2.7.6 When a motion has been seconded, and opened by the Chair for discussion, an amendment may be moved and seconded by any member.

2.7.7 Board members shall attempt to contribute once only to discussion with a maximum speaking time of five minutes (except with the consent of the meeting) on a particular item, although the Chair shall be entitled to summarise and guide debate.

2.7.8 No member shall speak on any question after it has been put by the Chair, or during a vote.

2.7.9 In the case of a tied vote, the Chair has no second or casting vote, and the question or motion is decided in the negative.
   (refer clauses 29, Schedule 3 and clause 31, Schedule 4 of the Act)

2.7.10 A resolution reflects the will of the majority, and members should not criticise the resolution unless the member is taking steps to revoke the resolution.

2.7.11 Any resolution may be rescinded by a subsequent resolution at a subsequent meeting without recourse to procedural motions.
2.7.12 All questions arising at any meeting of a Board must be decided by a majority of the votes cast by
the members present. Where a Board Member abstains from voting it is treated as not casting a
vote. The majority will be of those present and voting.

2.8 Requirement for a Seconder

2.8.1 All motions or amendments moved at Board or committee meetings must be seconded.

2.9 Speeches in English or Māori

2.9.1 A member may address the Chair or Board in English or Māori. The Chair may order that a speech
be translated and printed in another language, and/or that an interpreter be present. Any member
intending to make an address in Māori shall give the Chair reasonable prior notice to enable an
interpreter to be present.

2.10 Use of public excluded information

2.10.1 No member, officer or other person is permitted to disclose to any person, other than a member or
officer who was or is to be present, any information which has been or is to be presented to any
meeting from which the public is properly excluded. No discussion, deliberations or decisions are
to be disclosed following any such meeting except by way of release of information by the Board.

2.11 Conflict of interest and interests

2.11.1 The DHB Board manual sets out the requirements of members in relation to conflicts of interest
and members’ interests.

2.11.2 A member of the Board or committee who has an interest in a transaction of the DHB must, as
soon as practicable after the relevant facts have come to the member’s knowledge, disclose the
nature of the interest to the Board or committee, as the case may be.

2.11.3 A member of the Board who makes a disclosure under Standing Order 2.11.2 must not (unless
Standing Order 2.11.5. applies; or the Minister, by a waiver or modification of the application of
this Standing Order under clause 37, Schedule 3 of the Act, permits the Board; or the Board under
clause 39 of Schedule 4 permits a committee):

a) take part, after the disclosure in any deliberation or decision of the Board or committee, as
the case may be, relating to the transaction; or

b) be included in the quorum required by the Act for any such deliberation or decision; or

c) sign any document relating to the entry into a transaction or the initiation of the
transaction.

2.11.4 A disclosure under this Standing Order must be recorded in the minutes of the next meeting of the
Board or committee, as the case may be, and entered in the Interests Register maintained for the
purpose.

2.11.5 However, a member of the Board or committee who makes a disclosure under this Standing Order
may take part in any deliberation (but not any decision) of the Board or committee, as the case may
be, relating to the transaction concerned if a majority of the other members of the Board or
committee, as the case may be, permits the member to do so.

2.11.6 If Standing Order 2.11.5 applies, the Board or committee, as the case may be, must record in the
minutes of its next meeting:

a) the permission and the majority’s reasons for giving it; and
b) what the member says in any deliberation of the Board or committee relating to the transaction concerned.

2.11.7 Every member of the Board must ensure that:

a) the statement completed by the member under sections 29(6) of the Act and 31(1)(c) of the CE Act (interests disclosure statement made before appointment, or clause 6 of Schedule 2 of the Act interests disclosure statement made before election), is incorporated in the Interests Register maintained under Standing Order 2.11.4; and

b) any relevant change in the member’s circumstances affecting a matter disclosed in that statement is entered in that register as soon as practicable after the change occurs.

(refer clauses 36, Schedule 3 and 38, Schedule 4 of the Act)

3 Minutes of proceedings

3.1 Minutes to be evidence of proceedings

3.1.1 The Board shall keep minutes of all its proceedings. Minutes of proceedings approved by the Board and confirmed by the Chair shall be prima facie evidence of those proceedings. Minutes shall be prepared on the basis that the minutes are not a verbatim record of proceeding.

3.1.2 No discussion shall arise on the substance of the minutes at the succeeding meeting, except as to their correctness.

3.1.3 The Chief Executive shall ensure the minutes of meetings are kept. The minutes shall record:

a) the date, time and venue of the meeting;

b) the names of those members and officers present;

c) identification of the Chair

d) apologies tendered, including arrival and departure times;

e) any failures of a quorum

f) any declarations of interests and/or conflicts of interest

g) any decision of the Board in relation to a declared interest or conflict of interest, including any waiver given by the majority of the Board in accordance with Standing Orders 2.11.5 and 2.11.6.

h) if a waiver is given to a member under Standing Orders 2.11.5 and 2.11.6, what the member says in any deliberation of the Board or committee in relation to the transaction concerned

i) a list of speakers under public comment and topics they cover

j) a list of items considered

k) resolutions pertaining to those items

l) objections to words used

m) all divisions taken

n) contempt, censure and removal of any members

o) resolutions to exclude members of the public
p) the time the meeting concludes or adjourns.
q) the names of persons who move and second a resolution.

3.2 Approval of minutes

3.2.1 The minutes and proceedings of every meeting shall be circulated to members and considered at the next meeting succeeding, and, if approved by that meeting, or when amended as directed by that meeting, shall be signed by the Chair of such succeeding meeting.

3.2.2 Standing Order 3.2.1 applies only to meetings of the Board and statutory committees. For other committees, a report of the proceedings shall be submitted to the next ordinary meeting of the Board at which meeting the report shall be adopted, amended or otherwise dealt with.

3.3 Minutes of last meeting before election

3.3.1 The Chair and the Chief Executive shall be responsible for election confirming the correctness of the minutes of the last Board or committee meeting, as the case may be, prior to the next election or appointment of members.

4 Admission of Public

4.1 Meetings normally to be open

4.1.1 All meetings of the Board and committees shall be open to the public and news media in accordance with the Act.

(refer to clauses 31-35, Schedule 3 and 33-37, Schedule 4 of the Act.)

4.1.2 The Chair of the Board or committee, as the case may be, shall make provision for public comment on agenda items at the beginning of each Board and committee meeting.

4.1.3 Public comment during a meeting from any member(s) of the public present will be on the invitation of the Board or committee Chair.

4.2 Lawful reasons to exclude the public

4.2.1 The Board or committee may, by resolution, exclude the public from whole or part of the proceedings of any meeting only on one or more of the grounds specified in clause 32 of the Act in respect of the Board, or clause 34 of Schedule 4 of the Act in respect of a committee.

4.3 Resolutions and motions to exclude public

4.3.1 Any resolution to exclude the public shall state the general subject of each matter to be considered whilst the public is excluded, with the reason for passing that resolution in relation to that matter, and the grounds on which the resolution is based. The motion shall be put whilst the meeting is open to the public.

4.3.2 A resolution to exclude the public may provide for a person with, in the Board’s or committee’s opinion, relevant knowledge to remain at the meeting. This resolution will briefly state the relevance of this knowledge to the matter being discussed.

(Refer to clauses 33, Schedule 3 and 35, Schedule 4 of the Act.)

4.4 Information to be available to public

4.4.1 All information, except public excluded information provided to members at Board and committee meetings shall be available to the public and news media unless a specific provision of the Act (including its Schedules) applies.
4.5 Availability of agendas and reports

4.5.1 Any member of the public may, without payment of a fee, inspect at the Board office during normal office hours, within a period of at least two (2) working days before every meeting, all agendas and associated reports (except public excluded information) circulated to members of the Board and relating to that meeting. Any member of the public may take notes from any agenda or report inspected and, on payment of any prescribed amount, is to be given a copy of any part of an agenda or report requested as soon as practicable. Where a meeting is an emergency or special meeting, the agenda and reports are to be made available as soon as is reasonable in the circumstances.

4.6 Exclusion of reports to be discussed with public excluded

4.6.1 The Chief Executive may exclude from the reports made available, items from the reports that are reasonably expected to be discussed with the public excluded. These items are to be indicated on each agenda.

4.7 Public entitled to inspect confirmed minutes

4.7.1 The public are entitled, without charge, to inspect, take notes from, or receive copies of, confirmed minutes of any meetings or part of any meeting from which the public was not excluded.

4.8 Request for minutes of meetings in closed session

4.8.1 The Board shall consider any request for the minutes of a meeting or part thereof from which the public was excluded in accordance with clauses 21(5) Schedule 3 and 23(4) of the Act.

4.9 Privilege

4.9.1 Oral statements at meetings and written statements contained in agenda, minutes shall enjoy privilege in accordance with clauses 24, Schedule 3 and 26, Schedule 4 of the Act.

5. Other Provisions

5.1 Code of conduct/Code of ethics

5.1.1 Any Code of Conduct and/or Code of Ethics adopted by or applied to the Board shall apply to all members of the Board and committees.

5.2 Confidentiality

a) No member of the Board or committee shall discuss business conducted in the public excluded section of a meeting or the business of the Board or DHB, with any person who is not a member of the Board or its management staff, unless authorised to do so by the Chair.

b) No member of the Board shall release any information to any person not a member of the Board or the DHB’s management staff, or make any statement to the media, unless approved by the Chair.

5.3 Teleconferences

5.3.1 Members may participate in Board or committee meetings by teleconference or video link as if they were present at the meeting in person.

5.3.2 Each member taking part must acknowledge their participation and be able to hear each of the other members taking part. Members may not leave a teleconference or video link unless they first obtain permission to do so from the presiding member.

5.3.3 A written record of a teleconference or video link must be made by the member who presided in it.
5.4 Application of model standing orders

5.4.1 Where it is necessary to seek further guidance in respect of the Standing Orders, reference may be made to the “Model Standing orders for Meetings of Public Bodies” MP 9204:1993, issued by Standards New Zealand, which shall apply.

5.5 Statutory Advisory Committees

5.5.1 Removal of Members

A member can be removed by the Board if that member has, without permission from the Board and without reasonable excuse, been absent from four (4) consecutive meetings of the committee.

6.0 Public Comment

6.1.1 No comment shall be permitted during a meeting from any member(s) of the public present, unless an invitation to this effect is extended by the Chair.

6.1.2 In the event that unauthorised comment is made, by any member of the public present during a meeting, no response shall be made by members, other than through the Chair.

6.1.3 Deputations shall only be permitted to address the Board with the prior consent of the Chair. With the consent of the Chair, Board members may ask questions of speakers during the period reserved for public comment provided that such questions are to be confined to obtaining information or clarification on matters raised by the speaker.

6.1.4 No discussion shall occur during a meeting as to whether any member(s) of the public may constitute a deputation for the purposes of these guidelines.

6.1.5 In the event that the behaviour of the public is deemed likely to prejudice, or to continue to prejudice, the orderly conduct of the meeting, the person(s) concerned shall be asked to leave. In the event that this request is refused, or the person(s) concerned attempt to re-enter the meeting, the meeting will be adjourned whilst management takes the appropriate actions as per clause 35, Schedule 3 of the Act.

6.1.6 With the permission of the Chair, Board members may ask questions of speakers, provided that such questions are to be confined to obtaining information or clarification on matters raised by the speakers.

6.1.7 In the event that any question is asked by a member of the public in relation to a matter that is known or in respect of which a decision has been previously made by the Board the Chair may ask the Chief Executive to provide an answer to that question.

7.0 Attendance at Committee Meetings

7.1.1 Board members may attend, as an observer, meetings of committees of which they are not a member, including both part I and part II discussions. Such Board members shall, at the request of the Chair, with the committee’s consent, be entitled to make comments in respect of matters under discussion by the relevant committee.

7.1.2 Other than Board members, external appointed committee members’ attendance at meetings of committees of which they are not a member shall be as a member of the public.

8.0 Teleconferences

8.1.1 The Board may hold teleconferences in accordance with clause 14, Schedule 3 of the Act.
9.0 Minutes

9.1.1 The Board or Committee Secretary shall prepare minutes in conjunction with the Chair on the basis that the minutes are not a verbatim record of proceedings.

9.1.2 Minutes shall have no status, and be able to be amended at any time, up until they are confirmed.

9.1.3 The minutes shall note those decisions that require adoption by the Board.

9.1.4 Minutes shall be kept in two sections reflecting the public and ‘in-camera’ sessions of a meeting.

10.0 Agendas

10.1 Agendas shall be prepared based on the Work Programme. Any variation to the Work Programme shall be advised to the Board/Committee.

10.2 In the event that a member wishes to add an item to the agenda but is unable to do this through the Work Programme process, they shall raise with the Board/Committee Chair as appropriate, who will progress the item in conjunction with management.

10.3 The Chief Executive shall have the authority to make formal recommendations on all matters appearing on an agenda except those pertaining to the Chief Executive’s own employment and performance management.

10.4 In accordance with clause 28, Schedule 3 of the Act, if an item is not on the agenda, it may be dealt with at the meeting as a ‘late item’ if the Board by resolution so decides, and it is explained at the meeting, at the time when it is open to the public, the reason why the item is not included on the agenda, and why discussion of the item cannot be delayed until a later meeting. Such late items can only be discussed if they are a minor matter relating to general business of the Board/Committee, and no resolution, decision or recommendation can be taken other than to refer the item to a later meeting for further discussion.

11.0 Meeting Start Times

11.1 All meetings which are open to the public shall start no earlier than the advertised time. They must commence within 10 minutes of the advertised start time.

11.2 The start time for other meetings can be amended in consultation with the Chair.

12.0 Conduct at Meetings

12.1 All persons present at the meeting shall act with courtesy, and shall not be disrespectful. They shall address each other by name or designation.

13.0 Confidentiality

13.1 No member of the Board shall discuss confidential business of the district health Board, with any person, unless authorised in writing to do so by the Chair.

13.2 No member of the Board or a Committee shall release any confidential information to any person or make any statement to the media unless approved in writing by the Chair.

14.0 Collective Responsibility

14.1 Board members shall ensure that they will abide by the general principle of Collective Responsibility in respect of all decisions made by the Board and once a decision is made Board members shall all abide by that decision, notwithstanding that they may have voted against it, and will not publicly criticise any decision.
15.0 Definition

15.1 For the purpose of these Standing Orders, the term ‘Chair’ shall include ‘Deputy Chair’ when this person is acting in the role of Chair.

15.2 The Board means the members of the Board of the Capital & Coast District Health Board acting together as a Board in relation to a publicly owned health and disability organisation in accordance with Section 6(1) of the New Zealand Public Health and Disability Act 2000 (the Act).

15.3 For the purpose of these Standing Orders the term ‘organisation’ refers to Capital & Coast District Health Board.

15.4 For the purpose of these Standing Orders the term ‘Board Members’ shall, in respect of meetings of Committees of the Board, be deemed to include Committee Members who are not Board Members.

15.5 Within the context of this document the term ‘information’ means any information about or relating to Capital & Coast District Health Board or any of its employees or patients.

16.0 Application

16.1 These Standing Orders shall apply to the Board and all Committees of the Board.
Appendix 4 Statutory Committees

Capital & Coast DHB Community & Public Health Advisory Committees (CPHAC): Terms of Reference

Terms of Reference

1. Compliance

In accordance with section 34 of the New Zealand Public Health and Disability Act, the Board shall establish a Community and Public Health Advisory Committee whose members and chairperson shall be as determined by the Board from time to time.

The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference for the Community and Public Health Advisory Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy.

These Terms of Reference:

(a) are supplementary to the provisions of the Act and Schedule 4 to the Act;
(b) supersede the previous Terms of Reference dated [date]; and
(c) are effective from [date].

2. Functions of the Committee

(1) The functions of the community and public health advisory committee of the Board of a DHB are to give the Board advice on —

(a) the needs, and any factors that the committee believes may adversely affect the health status, of the resident population of the DHB; and

(b) priorities for use of the health funding provided.

(2) The aim of a community and public health advisory committee's advice must be to ensure that the following maximise the overall health gain for the population the committee serves:

(a) all service interventions the DHB has provided or funded or could provide or fund for that population;

(b) all policies the DHB has adopted or could adopt for that population.

(3) A community and public health advisory committee's advice may not be inconsistent with the New Zealand health strategy.

The Committee shall present its findings and recommendations to the Board for its consideration.

3. Objectives and Accountability

a. To provide advice on the local and sub-regional implications of nation-wide and sector-wide health goals and planning and funding performance expectations.

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4 Clause 2 of Schedule 4 to the NZ Public Health and Disability Act.
b. To provide advice to each Board on the needs of the DHB resident population within the context of the Lower North Island (LNI) sub-region (being the geographical areas of Wairarapa DHB, Capital & Coast DHB and Hutt Valley DHB).

c. To provide advice to each Board on priorities for use of the health funding available.

d. To provide advice on how to ensure that all service interventions funded or contributed to by Capital & Coast DHB have the objective of contributing to the maximisation of health gain.

e. To provide advice to the Board on strategies to reduce disparities in health status for population groups, including but not limited to Māori, Pacific, people living in high deprivation, and people with disabilities.

f. To provide advice on robust and fair frameworks for prioritisation, evaluation and decision making for provider selection, that address issues of principles, Māori involvement and clear documentation of process.

g. To provide advice on provider development strategies consistent with service planning and provision priorities, including for Māori and Pacific providers.

h. To monitor the DHB’s planning and funding performance through the Strategy, Innovation and Performance Unit (SIP) against expectations set in annual plans, accountability documents, and accepted industry/sector standards.

i. To assist SIDU with providing sub-regional advice, but with clear understanding of impacts on and for resident populations.

j. To provide advice to each Board and SIP on strategies and policies (including for the planning and funding of services) that can deliver improved health outcomes to resident populations and the population of the LNI sub-region.

k. To recommend an annual work-plan to the Board.

l. To report regularly to the Board on the Committee’s findings (generally the minutes of each meeting will be placed on the agenda of the next Board meeting).

m. To collaborate as required with Committees of other District Health Boards.

n. To perform any other functions as directed by the Board.

4. **Authorities**

The following authorities are delegated to the Community and Public Health Advisory Committee:

a. To require the Chief Executive Officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.

b. To interface with any other Committee(s) that may be formed from time to time.

5. **Meetings**

The Community and Public Health Advisory Committee shall hold no less than six meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon the instruction of the Board. A quorum is a majority of Committee Members.
6. **Membership**

Membership of the Committee shall be as directed by the Board. The Committee has the ability to co-opt expert advisors as required.

7. **Procedure**

*Schedule 4 of the NZ Public Health & Disability Act will apply to the business and procedure of the Committee.*
Wairarapa DHB, Hutt Valley DHB and Capital & Coast DHB
Disability Support Advisory Committees: Terms of Reference

All three DHBs have the same Terms of Reference

1. Compliance

In accordance with section 35 of the New Zealand Public Health and Disability Act, the Board shall establish a Disability Support Advisory Committee whose members and chairperson shall be as determined by the Board from time to time.

The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference for the Community and Public Health Advisory Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy, the New Zealand Disability Strategy and the Positive Ageing Strategy.

These Terms of Reference:

a) are supplementary to the provisions of the Act and Schedule 4 to the Act;

b) supersede the previous Terms of Reference dated [date]; and

c) are effective from [date].

2. Functions of the Committee

(1) The functions of the disability support advisory committee of the Board of a DHB are to give the Board advice on—

(a) the disability support needs of the resident population of the DHB; and

(b) priorities for use of the disability support funding provided.

(2) The aim of a disability support advisory committee's advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB’s resident population:

(a) the kinds of disability support services the DHB has provided or funded or could provide or fund for those people:

(b) all policies the DHB has adopted or could adopt for those people.

(3) A disability support advisory committee's advice may not be inconsistent with the New Zealand disability strategy.

The Committee shall present its findings and recommendations to the Board for its consideration.

3. Objectives and Accountability

a. To recommend advice to each Board on the disability support needs of the DHB resident population, including the disability support needs of Older People, within the context of the Lower North Island (LNI) sub-region (being the geographical areas of Wairarapa DHB, Capital & Coast DHB and Hutt Valley DHB).

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5 Clause 3 of Schedule 4 to the NZ Public Health & Disability Act.
b. To develop an annual workplan for the Board’s consideration and approval.

c. To monitor the effectiveness of disability support services being provided for the resident population.

d. To advise on the range of disability support services provided and/or funded (or contributed to) by the Wairarapa DHB, Capital & Coast DHB and Hutt Valley DHB which maximise the independence of people with disabilities within the DHB’s resident population, within the context of the LNI sub-region.

e. To advocate to external parties and organisations on the means by which their practices may be modified so as to assist those experiencing disability.

f. To support Primary Health Organisations (PHOs) in the development of policies and practices for people with disabilities.

g. To consider and recommend the disability support component of annual plans and annual provider business plan.

h. To provide advice to each Board and the Strategy, Innovation and Performance (SIP) on strategies and policies (including for the planning and funding of services) that can deliver improved health outcomes to resident populations and the population of the LNI sub-region relating to the planning, purchasing and provision of disability services.

i. To assist the SIP with providing sub-regional advice, but with clear understanding of impacts on and for resident populations.

j. To recommend what ‘expert’ assistance will be required in order for the Committee to fulfil its obligations, and achieve its annual work-plan by co-opting experience when required.

k. To report regularly to each Board on the Committee’s findings (generally the minutes of each meeting will be placed on the agenda of the next Board meeting).

l. To collaborate as required with Committees of other District Health Boards in the interests of providing optimum, economical and efficient services.

m. To monitor the effectiveness of disability support services being provided for the DHB resident population, within the context of the LNI sub-region.

n. To perform any other functions as directed by the Board.

4. Authorities

The following authorities are delegated to the Disability Support Advisory Committee:

a. To require the Chief Executive Officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.

b. To interface with any other Committee(s) that may be formed from time to time.

5. Meetings

Meetings of the Disability Support Advisory Committee shall be held at least six times per annum, but may determine to meet more often if considered necessary. A quorum is a majority of Committee Members, and must include at least one member from the Board and at least one co-opted member from each of the other two LNI sub-regional Boards.
6. **Membership**

Membership of the Committee shall be as approved by the Board. The Committee has the ability to co-opt expert advisors as required.

7. **Procedure**

*Schedule 4 of the NZ Public Health & Disability Act will apply to the business and procedure of the Committee.*
**Capital & Coast DHB**  
**Hospital Advisory Committee: Terms of Reference**

1. **Compliance**

In accordance with section 36 of the New Zealand Public Health and Disability Act, the Board shall establish a Hospital Advisory Committee (hereinafter called “The Committee”) whose members and chairperson shall be as determined by the Board from time to time.

The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference for the Hospital Advisory Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy.

The Committee shall comply with the Board’s Standing Orders for Statutory Committees.

These Terms of Reference:

a. Are supplementary to the provisions of the Act and Schedule 4 to the Act

b. Supersede the previous Terms of Reference 2 October 2012

c. Are effective from February 2014

2. **Objectives and Accountability**

i. To monitor the financial and operational performance of the DHB-provided services.

   a. To assess the performance of the DHB as a provider against expectations set in the annual plan, accountability documents, and accepted industry/sector standards.

   b. To ensure provider systems are developed to manage operational and clinical risk.

   c. To provide oversight of DHB property maintenance issues.

   d. To collaborate as required with committees of other District Health Boards.

ii. To assess strategic issues relating to the provision of DHB services by the DHB including the way in which funding models might be reconfigured to support more appropriate service delivery.

iii. To give the Board advice and recommendations on that monitoring and that assessment as noted in 2(i) and (ii) above.

iv. To recommend an annual workplan for the Committee’s consideration and approval.

v. To perform any other functions as directed by the Board

vi. To recommend approval of policies relative to the good governance of DHB-provided services.

3. **Authorities & Access**

The following authorities are delegated to the Hospital Advisory Committee:

a. To require the Chief Executive Officer and/or delegated staff to attend its meetings, provide regular advice and information and prepare reports upon request, including as required summarising strategic issues for consideration.

b. To interface with any other Committee(s) that may be formed from time to time.
The following access processes are available to the Hospital Advisory Committee:

a. The Committee has access through the Chief Executive Officer and the Chief Operating Officer to the management and records of the DHB. The Committee is empowered to meet with other relevant health sector groups and entities, to call for reports from management and to take independent advice.

b. Committee members shall disclose any conflicts of interest and potential conflicts of interests to the Chair of the Committee, as soon as they become aware of them. The Chair of the Committee shall determine in conjunction with the Board the appropriate action that should be taken in accordance with the requirements set out in the Board Standing Orders and Board and Committee members Governance Handbook.

4. Delegated Powers

The committee shall not have any powers except as specifically delegated by the Board from time to time.

5. Meetings

The Hospital Advisory Committee shall hold no less than six meeting per annum, but may determine to meet more often if considered necessary by the Committee or upon the instruction of the Board.

6. Membership

Membership of the Committee and all matters of procedure are provided for in Schedule 4 of the Act together with the Board and Committee Standing Orders. The Board shall appoint members and the Committee Chair for a term not exceeding three years. The committee has the ability to co-opt expert advisors as required.

7. Quorum

The quorum of members of the Hospital Advisory Committee is a majority of Committee members.

8. Standing Orders

Adopted Standing Orders for Statutory Committees will apply.

Reporting by the Committee

Minutes of committee meetings shall be available to DHB members and shall be presented at the Board meeting following confirmation from the committee. Where required, a report by management shall be given to the following Board meeting with any recommendations arising from the Hospital Advisory Committee presented for consideration.

9. Procedure

*Schedule 4 of the NZ Public Health & Disability Act will apply to the business and procedure of the Committee.*
Capital & Coast DHB Finance, Risk and Audit Committee: Terms of Reference

The Board hereby confirms the terms of reference of its Finance, Risk and Audit Committee hereafter referred to as the Committee.

The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference for the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy.

1.0 Committee of the Board

1.1 The Finance, Risk and Audit Committee is a committee of the DHB established in terms of clause 38, schedule 3 of the New Zealand Public Health and Disability Act 2000 (the Act).

1.2 These Terms of Reference are supplementary to the provisions of the Act and schedule 3 to the Act and are effective from 4th February 2009.

1.3 All previous Terms of Reference are hereby revoked.

2.0 Role of the Committee

2.1 The primary role of the Committee is to assist members of the Board in fulfilling their governance and oversight duties and responsibilities as determined by the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004. The Committee will undertake, on behalf of the Board, responsibility for monitoring and oversight of the management of the DHB’s strategic, operational, clinical and financial risks, the control environment, financial reporting, audit processes and compliance with regulatory matters and standards. The Committee will have responsibility for overseeing health and safety matters together with the Board.

2.2 The Committee’s responsibilities relate to two primary business areas:

- Risk, Safety and Quality Management, Health and Safety
- Audit.

3.0 Authority

3.1 The Committee is a committee of the Board and shall have no authority independent of the functions delegated to it by the Board.

3.2 The Committee is authorised by the Board to investigate any activity it deems appropriate. It is authorised to seek any information from any officer or employee of the organisation all of whom are directed to co-operate with any request made by the Committee.

3.3 The Committee will meet the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 in the appointment of external auditors.

3.4 The Committee is authorised to engage any firm of accountants, lawyers or other professionals as the Committee sees fit to provide independent counsel and advice and to assist in any review or investigation on such matters as the Committee deems appropriate.

4.0 Membership and Procedure

4.1 Membership of the committee shall be determined by the Board as required and from time to time.
4.2 The Committee shall consist of a minimum of seven Board members including the Chair, ex officio. The committee shall consist of:

- No more than five Governance Board members; and
- Up to three independent non-Board members (external advisers) where the required skills are not available from existing Board members.

4.3 Committee members shall be approved annually by the full Board. The Chair and Deputy Chair of the committee shall be appointed by the Chair of the Board. The committee Chair shall not be the Chair of the Board.

4.4 DHB Board members who are not committee members can attend this committee as observers and have the right to speak. The committee Chair can ask for specific comment from observers on agenda items.

4.5 Matters of procedure shall be provided for by the Act and the Board and Committee Standing Orders adopted by the Board. A quorum is a majority of committee members.

4.6 The committee shall meet at a frequency determined by the Board except when circumstances require more frequent meetings. The Board shall pre-determine the business (Risk or Audit) to be considered by the committee at each meeting and will determine the attendance of the external advisor appropriate to the business being considered. The Chair of the Committee shall chair the meeting when Risk Business is being considered. The Deputy Chair of the Committee shall chair the meeting when Audit Business is being considered.

4.7 Changes in role and/or responsibilities, if any, shall be recommended to the full Board for approval.

4.8 The committee will be serviced and fully supported by a person engaged as secretary for this purpose by the Chief Executive. The secretary will be competent to provide normal secretarial duties as well as liaison and related activities to ensure the committee is able to fulfil its functions.

5.0 Access

5.1 The committee members are able to request access to DHB information to assist them to execute their duties, obligations and accountabilities. All information received remains the property of the DHB and will be used for lawful purpose for the benefit of the DHB only.

5.2 Information governed by privacy legislation, including information relating to personal health record will not be available to committee members except where necessary for the function of the committee and with the approval of the Board Chair.

5.3 Committee members shall disclose any conflicts of interest and potential conflicts of interests to the Chair of the Committee, as soon as they become aware of them. The Chair of the Committee shall determine in conjunction with the Chair of the Board the appropriate action that should be taken in accordance with the requirements set out in the Board Standing orders and Board and committee Members Governance Handbook.

5.4 The Chief Executive will ensure all information requests are handled in a timely manner (in consultation with the Committee Chair). The committee is empowered to call for reports from management and, with the prior consent of the Board, to take independent advice.

6.0 Reporting by the Committee

6.1 Minutes of committee meetings shall be available to the DHB Board with any recommendations presented for consideration.
6.2 The Chair of the respective meetings shall report on Committee business to the Board with such recommendations as the Committee may deem appropriate.

6.3 The Committee shall recommend approval of the interim and annual financial statements and other audit obligations along with any other certificates requiring approval to the Board.

6.4 The Secretary shall distribute copies of the minutes of meetings of the Committee to all members of the Board, for noting at the next Board meeting.

7.0 Duties of the Committee

7.1 Risk, Safety and Quality Management

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

7.1.1 Regular review of technology system risks with a focus on:
- Adequacy of systems
- Business continuity/disaster recovery.

7.1.2 Review of THE DHB’S’s risk management programme to ensure:
- Adequate monitoring of critical risks and responsibilities for risk management.
- A robust identification and assessment process and an early warning system is in place.
- Risk management policies and strategies reflect the Board’s views and priorities.
- Risks and risk management are regularly reported to the Board in meaningful format.

7.1.3 Regular review of clinical risks and quality control including:
- Risk practices and policies and the adequacy and effectiveness of systems controls
- Quality Control.
- Sentinel reports.
- Infection risks management.
- Safety and quality provisions for Community Service delivery contracts.

7.1.4 Project Risks focusing on:
- Overall project register.
- NRH completion risk around the completion of projects, establishment risk and change management risk.

7.1.5 Operating Risks:
- Includes review of annual insurance placement including ensuring adequate cover is provided.

7.1.6 Other Risks:
- Includes safety policies relating to staff/employee health, safety and wellbeing.
- Policies and procedures to minimise and manage conflicts of interests among Board members, management and staff.
- Policies and procedures to minimise and manage risks in contracting of health services.
- Reputation and communication.
- Other monitoring responsibilities as determined by the Board.

7.2 **Health and Safety**

The duties of the Committee in respect to Health and Safety include the following:

- Review, monitor and make recommendations to the CCDHB on the organisation's health and safety risk management framework and policies to ensure that the organisation has clearly set out its commitments to manage health and safety matters effectively;
- Review and make recommendations for CCDHB approval on strategies for achieving health and safety objectives;
- Review and recommend for CCDHB approval targets for health and safety performance and assess performance against those targets;
- Monitor the organisation's compliance with health and safety policies and relevant applicable law;
- Ensure that the systems used to identify and manage health and safety risks are fit-for-purpose, being effectively implemented, regularly reviewed and continuously improved. This includes ensuring that the CCDHB is properly and regularly informed and updated on matters relating to health and safety risks;
- Seek assurance that the organisation is effectively structured to manage health and safety risks, including having competent workers, adequate communication procedures and proper documentation;
- Review health and safety related incidents and consider appropriate actions to minimise the risk of recurrence;
- Make recommendations to the CCDHB regarding the appropriateness of resources available for operating the health and safety management systems and programmes; and
- Any other duties and responsibilities which have been assigned to it from time to time by the CCDHB.

7.3 **Audit**

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

- Provide assurance to the Board that all audit processes required by the Board or by statute are completed
- Ensure that there is an open avenue of communication between the Internal Auditor, the external auditors and the Board. The Internal Auditor and external auditors have direct access at any time to each other and the Committee.
• Consider, in consultation with the external auditors and the Internal Auditor, the audit plans and scope of the external auditors and internal auditors, ensuring that coordination of audit effort is maximised.

• Work with other statutory committees of the Board to ensure an integrated approach to all audit processes.

• Review annually and, if necessary propose for formal Board adoption, amendments to the Committee’s Terms of Reference.

7.3.2 In addition the Committee shall review:

• the external audit strategy plans and all audit outcomes

• the interim results and financial statements

• the annual results and financial statements

• any internal audit plans and a summary of outcomes of specific audits.

• Clinical audits and Audits of funding contracts, including those currently undertaken within the arrangement with Central TAS.

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

• The Chief Executive, Chief Financial Officer, Internal Auditor and representatives of the external auditors shall normally attend. All other Board members shall have the right to attend.

• The Committee may instruct any officer or employee of the DHB to attend any meeting and provide pertinent information as necessary.

• The Internal Auditor reports functionally to the Deputy Chair (and administratively to the Chief Executive).

• The acceptance of findings of the Committee by the Board shall not relieve the Board from any of its responsibilities.

• At least once a year, the Committee shall meet with the external auditors without the presence of executive management to discuss any matters that either the Committee or the external auditors believe should be discussed privately.

7.3.4 Specific Responsibilities of the Committee shall be:

7.3.4.1 Financial

• Review with management and the external auditors:
  • The DHB’s interim and annual financial statements.
  • The external auditors' audit of the financial statements and report thereon (where applicable).
  • Any significant changes which have been required in the external auditors' audit plan.
• Any significant difficulties or disputes with management encountered during the course of the audit.

• Other matters related to the conduct of the audit which are to be communicated to the Committee under generally accepted auditing standards.

• The DHB’s accounting and financial reporting practices and policies with regard to the application of current accounting standards, legislation and other appropriate standards.

• Significant transactions which are not a normal part of the DHB’s business.

7.3.4.2 Financial and Other Risks and Internal Control

• Consider and review with management and the Internal Auditor the DHB’s Financial Risk Analysis report.

• Enquire of management, the Internal Auditor, and the external auditors about significant Financial and other Risks or exposures and evaluate the steps taken to minimise such Financial Risk to the organisation.

• Consider and review with management and the Internal Auditor significant findings and management’s responses thereto.

• Consider and review with the external auditors and the Internal Auditor:

  • The adequacy of the organisation’s systems of internal control including computerised systems controls and security.
  
  • All audit processes including audit of risk management
  
  • Any related significant findings and recommendations of the external auditor including the management letter and of the internal auditor, together with management’s responses there to.

  • The six monthly management statutory compliance reports.

• Consider and review with management and the Internal Auditor the DHB’s Policies and Procedures in relation to:

  • Delegated Signing Authorities for financial transactions and contract authority.
  
  • Capital Expenditure approvals.
  
  • Consider and review with management and the Internal Auditor the DHB’s Business Continuance planning.

  • Health and Safety Policies.

7.3.4.3 External Audit

The appointment of the Audit Office as the Board’s external Auditor is mandatory as outlined in Section 43 of the NZPH&D Act 2000 and Section 156 of the Crown Entities Act 2004.

According to the Acts audits are not limited to financial audit.

7.3.4.4 Internal Audit

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Owner: CCDHB Chief Legal Counsel
Consider and review with management and the Internal Auditor:

- significant internal audit reports and summary of internal audit activity.
- any difficulties encountered in the course of internal audit, and any restrictions placed on internal audit scope of work or access to required information or personnel.
- the internal audit plan of future audits to be conducted.
- any changes which have been required in the previously approved internal or external audit plan.
- the internal audit department’s Charter.

Consider the appropriateness of the internal audit function from time to time.

7.3.4.5 Statutory

- Review whether statutory and regulatory financial and other obligations have been met by the DHB, including any certifications required from directors under legislation.
- Review whether any disclosure documents reflect a true and fair view and comply with relevant legislation.
Capital & Coast DHB Remuneration Committee: Terms of Reference

1.0 Committee of the Board

1.1 The Remuneration Committee is a committee of the Board of Capital and Coast DHB established in terms of clause 38, schedule 3 of the New Zealand Public Health and Disability Act (the Act). These Terms of Reference are supplementary to the provisions of the Act and schedule 3 to the Act and are effective from 1 July 2003.

2.0 Purpose

2.1 The Committee has been established to advise and assist the Board in the appointment, review, and remuneration of the Chief Executive and on senior management salaries and payments related to industrial processes.

3.0 Functions of the Committee

3.1 The Committee will review management proposals and make recommendations to the Board in relation to the following:

- review of the Chief Executive’s performance twice annually;
- priorities and KPIs in the Chief Executive’s Performance Agreement;
- Chief Executive’s annual remuneration review, performance payments provided for under the Employment Agreement, and any changes that may be proposed from time to time in the Chief Executive’s terms and conditions of appointment; and
- Senior management and senior clinical salaries and extraordinary payments to staff.

3.2 The Chief Executive may also seek the advice of this committee on remuneration changes or changes in the terms and conditions for staff reporting directly to the Chief Executive.

4.0 Committee Membership and Procedure

4.1 Membership of the committee will be the Chair, Deputy Chair and the Chair of FRAC. The Committee will be chaired by the Chair of the Board.

4.2 Matters of procedure shall be provided for by the Act and the Board and Committee Standing Orders adopted by the Board. A quorum is a majority of committee members.

5.0 Delegation

5.1 The Committee has the authority to give advice, and make recommendations to the Board.

6.0 Meetings

6.1 The Committee shall meet at least twice annually. Additional meetings shall be scheduled as considered necessary by the Chair or the Committee. Meetings shall be scheduled to set the Chief Executive’s KPIs and Performance Review and to make recommendations to the Board in line with the timing of the Board’s annual plan of activities. The Committee may have in attendance such members of management, including the Chief Executive and such persons as external remuneration experts, as it considers necessary to provide appropriate information and explanations. Minutes of the meeting will be kept.

7.0 Access
7.1 The Committee members will have access to all DHB information to assist them to execute their duties, obligations and accountabilities. All information remains the property of the DHB and will be used for lawful purpose. Information governed by privacy legislation, including information relating to personal records will not be available to committee members except with the express authorisation of the Chair of the Board and the Chief Executive. Committee members shall disclose and resolve any conflicts of interest as soon as they become aware of them. The Chief Executive will ensure all information requests are handled in a timely manner (in consultation with the person making the request). The committee is empowered to call for reports from management and, with the prior consent of the Board, to take independent advice. The Committee should be advised of the Chief Executive’s direct report’s annual remuneration reviews after the Chief Executive has completed them and of any extraordinary payments including redundancy and personal grievance payments in excess of $50,000.

8.0 Reporting by the Committee

8.1 Minutes of committee meetings shall be available to DHB Board with any recommendations presented for consideration.
Appendix 5 Board fees and expense reimbursement policy

Type: Policy

Name: Board fees and expense reimbursement

Purpose of policy
The purpose of this policy is to ensure fees and expenses payable to Board and committee members are in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004. The purpose of this policy is also to ensure Board members are aware of the associated procedures.

Scope
This policy applies to:

- CCDHB Board members
- External members of Statutory Advisory Committees

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<td>6</td>
</tr>
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Policy statement
Board Members are entitled to be paid Board fees and in addition, paid for attendance at Statutory Committee and Discretionary Committee meetings as outlined below. Adhering to this policy ensures the process is transparent and robust for audit purposes.

Members of the Board travelling to meetings, or on Board business (where the members are required to be away from their normal places of residence) are entitled to reimbursement of out of pocket expenses for travelling, meal and accommodation reasonably incurred. The expectation is that the standard of travel, accommodation, meals and other expenses are modest and appropriate to reflect public service norms.
Where travel or other costs are incurred for the purposes of both CCDHB and another organisation (e.g. HVDHB), then a fair and pragmatic apportionment shall be made between organisations, and only that part attributable to CCDHB shall be claimed. Members should not claim more than once for the same costs.

Board members are advised to consult with the Board Chair prior to incurring any other form of significant expense for which reimbursement will be sought.

The Board Chair’s expense claims shall be approved by the FRAC Chair.

Definitions

**Board business** is defined as:

1. Attendance of Board or committee meetings.
2. Attendance of formal Board events or activities.
3. Situations where individual Board or committee members are requested, by the Board Chair, to represent the Board.
4. Any other specific tasks or business, requested by the Board Chair that may arise from time to time.

Procedure

**Board fees**
The board fees payable are determined by the Minister of Health under the *Crown Entities Act* and are subject to change in accordance with the *Cabinet Fees Framework*. Fees are payable regardless of meeting attendance. Currently for Board fees this is expressed as below:

<table>
<thead>
<tr>
<th>Position</th>
<th>Annual fee</th>
<th>Monthly fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>$61,000</td>
<td>$5,083.33</td>
</tr>
<tr>
<td>Deputy Chair</td>
<td>$31,875</td>
<td>$2,656.25</td>
</tr>
<tr>
<td>Board Members</td>
<td>$25,500</td>
<td>$2,125</td>
</tr>
</tbody>
</table>

The annual fees for Board meetings are paid monthly, by direct credit, into the individual Board members’ bank accounts net of withholding tax. Remittances supporting the payments will be provided to Board members upon payment.

**Statutory Advisory Committee fees**
The Statutory Advisory Committees for which fees and expenses are payable are determined by the Minister of Health under the *Crown Entities Act* and are subject to change in accordance with the *Cabinet Fees Framework*. Statutory Advisory Committees are listed below:

- Community and Public Health Committee
- Disability Support Advisory Committee
- Hospital Advisory Committee

Fees relating to attendance at the Hospital Advisory Committee meetings are currently:
### Positional Fees

<table>
<thead>
<tr>
<th>Position</th>
<th>Annual fee</th>
<th>Attendance fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>$3,125</td>
<td>$312.50</td>
</tr>
<tr>
<td>Board Members</td>
<td>$2,500</td>
<td>$250</td>
</tr>
<tr>
<td>External Members</td>
<td>$2,500</td>
<td>$250</td>
</tr>
</tbody>
</table>

In July 2013, the Minister of Health approved a change in the fee payment for the Community and Public Health and the Disability Support committees, allowing them to meet contemporaneously with a subsequent amendment to the fee structure.

<table>
<thead>
<tr>
<th>Position</th>
<th>Annual fee</th>
<th>Attendance fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>$4,375</td>
<td>437.50</td>
</tr>
<tr>
<td>Board Members</td>
<td>$3,500</td>
<td>$350</td>
</tr>
<tr>
<td>External Members</td>
<td>$3,500</td>
<td>$350</td>
</tr>
</tbody>
</table>

- The fees are paid monthly in arrears, on a pro rata basis, based on attendance of 10 meetings per annum.
- The annual fee is a maximum. Additional meetings above 10 are not eligible for payment.
- The fee for CPHAC/DSAC attendance is split 50:50 between the two meetings.
- For members on both Capital & Coast and Hutt Valley DHB Boards, the fee reimbursement for joint committees will be paid at 50% from each DHB.
- For members on both Capital & Coast and Wairarapa DHB Boards, the fee reimbursement for joint committees will be paid at 50% from each DHB.
- For members deputising, in the absence of the Chair, they will receive the corresponding Chair rate for that particular meeting.

### Fees for Statutory Advisory Committee meetings

Fees for Statutory Advisory Committee meetings are based on attendance:

- Following a meeting, the designated person from the Board support team, or meeting secretary, completes a register of attendance. Attendance is taken from the minutes of the meeting.
- Following approval, by the Board Chair, Board members are paid, net of withholding tax, directly into their bank accounts.

### Discretionary Committee fees

The *Cabinet Fees Framework* establishes that Board members serving on Discretionary Committees are not paid. An exception has been made (by Ministerial Directive) for Board members serving on the equivalent of the Finance Risk and Audit Committee of DHBs. However, where the DHB has more than one committee dealing with Finance, Risk or Audit Matters then Board members of only one committee can be paid.

Board members serving on other Discretionary Committees will not be entitled to fees remuneration.

Members attending meetings of Discretionary Committees will continue to be paid expenses and mileage for reasonable actual costs incurred (refer next section).

Where Board members can be remunerated for attendance at Discretionary Committee meetings, the procedure for payment is the same as Statutory Committee fees (refer above).

### Expenses

Reasonable travel costs associated with travel from a member’s normal place of residence to a scheduled meeting of the Board or a committee may be incurred without prior consultation. Provided, these costs are
in line with any detailed guidance approved by the Board Chair and advantage is taken of any CCDHB bulk discount arrangements.

Expenses must be incurred in accordance with the *Sensitive Expenditure Policy*.

**Taxis**
Where appropriate or more economical, taxis may be used. CCDHB may provide vouchers or taxi chits for this purpose. This includes out of Wellington travel.

**Other public transport**
Where appropriate, other means of public transportation may be used (e.g. train / bus / ferry). CCDHB may also provide vouchers for this purpose.

**Air travel**
Air travel requires specific advance approval by the Board Chair. Bookings should be made through CCDHB’s preferred travel agent to obtain discounted rates. Travel should be economy class.

**Conferences and overseas travel**
These require specific advance approval by the Board Chair. Bookings should be made through CCDHB’s preferred travel agent to obtain discounted rates. Travel should be economy class.

**Meals and accommodation**
Costs must be incurred in accordance with the *Sensitive Expenditure Policy*.

**Office expenses**
As a general rule, CCDHB does not reimburse for use of home office, telephone and fax rental or connection charges, or similar costs. Where extraordinary costs are incurred these may be approved at the discretion of the Board Chair.

**Car mileage**
Car/vehicle travel from a member’s residence may be reimbursed at rates, in accordance with the *Cabinet Fees Framework*. The motor vehicle reimbursing rates reflect the public mileage rates currently used by the Inland Revenue Department.

Public mileage rates should be used where:
- it is not possible to estimate annual average total running;
- the vehicle is not used almost exclusively for work purposes; and
- the total work related travel is relatively small.

Motor vehicles annual work-related kms (current as at date of issue of this Policy):

<table>
<thead>
<tr>
<th>Distance</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5,000 km</td>
<td>72 cents per km</td>
</tr>
<tr>
<td>5,001 km and over</td>
<td>actual expenses</td>
</tr>
</tbody>
</table>

**Reimbursements versus allowances**

**Reimbursements**
The following requirements must be satisfied before the expenditure is able to be reimbursed and tax free in the hands of the recipient:

- The expenditure must have been incurred by the member in the course of duties performed on Board business.
- The payment must be a direct reimbursement of expenditure, incurred by the member, substantiated by a receipt or invoice given to the DHB by the member.
- Invoices or receipts are not required for reimbursements using IRD public mileage rates, which are accepted by the IRD as a reasonable proxy for actual costs incurred.

**Fees and allowances**

All fees and allowances must have withholding tax deducted, as prescribed by the Inland Revenue Department (IRD). Fees and allowances are in the nature of reward for personal effort and treated as remuneration. They are not directly related to reimbursement of ‘actual’ costs by their very nature.

Exception: ‘reimbursement allowances’ for specifically identified items of expenditure, related to actual costs incurred, can be paid without withholding tax deduction. The only exception recognised in this regard by the IRD, and therefore by this policy, are ‘reimbursement allowances’ utilising IRD public mileage rates which are acknowledged by the IRD as a reasonable proxy for actual costs incurred. Should any other mileage rate be used, other than actual costs evidenced by invoice, then withholding tax must be deducted.

The withholding tax rate is 33 cents in the dollar, unless IRD has issued an exemption certificate or a special tax rate certificate to the individual. This rate does not apply to other contractual arrangements that may exist for the member.

The deduction of withholding tax is an interim tax deduction only, which may be refunded in the member’s tax return, depending upon their individual tax position.

**Claims procedure**

Board expense reimbursements should be submitted using the *Expense claim form*.

Mileage claim reimbursements should be submitted using the *Mileage claim form*.

Expense claims should be lodged with the Board support team on a monthly or quarterly basis. The delegated member of the Board support team shall arrange payment of claims within the above guidelines and seek approval of the Board Chair for any other items. Upon payment remittances will be emailed to members.

Invoices/receipts for all expenses are required to be attached to expense claims.

**Related documents**

**Legislation**

- New Zealand Public Health and Disability Act 2000
- Crown Entities Act 2004 and Cabinet Fees Framework (regulations)
- Income Tax Act 2007

**CCDHB documents**

- Delegation of authority policy
- Sensitive expenditure policy
Appendix 6: Memorandum of understanding and other related documents agreed with Iwi

ATTACHMENT ONE:

PARTNERSHIP AGREEMENT BETWEEN:-

*TE ATIAWA*, REPRESENTED BY THE WELLINGTON TENTHS TRUST AND TE RUNANGA O ATIAWA KI WHAKARONGOTAI INC.

AND

*NGATI TOA RANGATIRA*, REPRESENTED BY TE RUNANGA O TOA RANGATIRA INC, known as NGA IWI TANGATA WHENUA

AND

*CAPITAL AND COAST DISTRICT HEALTH BOARD* – (CCDHB)

AND

*OTHER MĀORI*, WHO MAY BE SUBSEQUENTLY INCLUDED AS PARTIES TO THIS AGREEMENT FROM TIME TO TIME WHO ARE DESCRIBED IN THE ATTACHED SCHEDULE.

HEREIN REFERRED TO AS THE PARTIES TO THIS AGREEMENT WHO SHALL PROVIDE THE KOROWAI FOR MĀORI HEALTH IN THIS DISTRICT HEALTH BOARD AREA.
PURPOSE:

The purpose of this agreement is to facilitate:

- The parties mutual understandings of and responsibilities in connection with the Treaty of Waitangi;

- the establishment of a formal partnership between Nga Iwi Tangata Whenua and CCDHB; and

- to work to achieve the best policies and health outcomes for Māori people in the CCDHB area.

PRINCIPLES:

Nga Iwi Tangata Whenua and CCDHB share the fundamental principles of the Treaty of Waitangi and the Health and Disability Act 2000. These principles will be applied to:

- building on the understandings and gains already made in Māori health;
- decisions to achieve the best and sustainable health outcomes for Māori.

In doing so the parties are committed to:

- partnership
- consultation
- good faith;
- mutual benefit;
- honesty;
- integrity and friendship
- respecting each other’s Mana and Tikaanga.

The parties recognise and accept that these principles are intended to facilitate an excellent working relationship and will evolve and mature over time on the basis of mutual knowledge and experience.

ROLE & RESPONSIBILITIES:

To give effect to the purpose and principles above the parties accept the following responsibilities:

Nga Iwi Tangata Whenua will:

- Provide strategic advice and overview on Māori health issues in general and in the context of the strategic plan and development;

- Provide feedback and reports on performance and service delivery effectiveness.

AS WELL AS:-

- Share and disseminate relevant information to and from Māori in the region;

- Provide co-ordinated leadership on Māori health issues;

- Recommend suitable candidates for the statutory advisory committees of the CCDHB;

- Provide other comments and information relevant to the advancement of Māori Health outcomes;

- Report bi-monthly on significant issues discussed at meetings.
Capital and Coast District Health Board will:-

- Accept Māori health as a priority in accordance with Government’s strategic policy guidelines;
- Complete the regions needs assessment and discuss with Nga Iwi Tangata Whenua the results and implications for Māori health programmes and funding priorities;
- Design and implement with Nga Iwi Tangata Whenua a joint engagement/consultation process for Māori;
- Discuss and agree with Nga Iwi Tangata Whenua on strategic priorities for Māori;
- Provide and discuss with Nga Tangata Whenua monitoring reports on Māori services and delivery;
- Provide leadership to work creatively within Tīkanga Māori;
- Provide joint leadership with Nga Iwi Tangata Whenua in developing Māori health capacity;
- Report on achievements;
- Fund administrative and secretarial services as defined for Nga Iwi Tangata Whenua.

TERM:

This Agreement has no fixed term.

TERMINATION:

This agreement may be terminated:-

- by either party giving the other at least six months’ notice in writing; or
- by both parties mutually agreeing to a termination date and time.

OPERATIONAL REQUIREMENTS:

The operational requirements of Nga Iwi Tangata Whenua are set out in Schedule 1.

REMUNERATION:

- The fees specified by regulations for CCDHB members will apply to the representatives of Nga Iwi Tangata Whenua for attendance and participation at meetings.
- Remuneration for other services provided including the use of independent expert advice will be determined and agreed to on a case by case basis.

MEETINGS:

- Nga Iwi Tangata Whenua and CCDHB representatives will meet bi-monthly and up to eight times and in any financial year.

CONFIDENTIALITY:

Unless otherwise required by law or mutually agreed to, the parties will keep all information acquired as a result of this partnership in confidence.
DISPUTE RESOLUTION:

In the event of any dispute or difference arising out of this agreement the parties shall in the first instance make every endeavour to settle the dispute between themselves.
If the dispute or difference is not settled by mutual agreement the parties will refer the matter for mediation by an independent Mediator of the Arbitrators and Mediators Institute of New Zealand.

If mediation is unsuccessful the matter will be resolved in accordance with the Health Sector Mediation and Arbitration Rules 1993.

AMENDMENTS:

This agreement shall be amended by mutual consent of the parties.

Signed on Behalf of
Nga Iwi Tangata Whenua
Name……………………..
Te Atiawa Tangata Whenua
Represented by the Wellington Tenths Trust
Witness………………….

Signed on behalf of
Capital & Coast District Health Board
Name…………………….
Chairman

Nga Iwi Tangata Whenua

Witness……………………….

Te Atiawa ki Whakarongotai
Represented by Te Runanga o Atiawa
Ki Whakarongotai Inc
Witness………………….

Te Atiawa ki Whakarongotai
Represented by Te Runanga o Atiawa
Ki Whakarongotai Inc
Witness………………….

Ngati Toa Rangatira
Represented by Te Runanga o Toa
Rangatira Inc
Witness………………….

Ngati Toa Rangatira
Represented by Te Runanga o Toa
Rangatira Inc
Witness………………….

Date…………………… Date…………………….

Date…………………… Date…………………….

Date…………………… Date…………………….
SCHEDULE 1: OPERATIONAL REQUIREMENTS OF THE NGA IWİ TANGATA WHENUA

1. Nga Iwi Tangoa Whenua shall initially comprise of six representatives, two from Wellington Tenths Trust and, two from Te Runanga o Atiawa ki Whakarongoatū Inc representing Te Atiawa, and two from Te Runanga o Toa Rangatira Inc representing Nga Toa Rangatira plus two representatives from CCDHB, who for the time being shall be the Chairman and Deputy Chairman.

2. Nga Iwi Tangoa Whenua will advise the CCDHB of their representatives appointed for the time being and of any subsequent change to their representatives.

3. Nga Iwi Tangoa Whenua shall appoint a Chair within its membership through an agreed process among Nga Iwi Tangoa Whenua members.

4. Nga Iwi Tangoa Whenua shall meet at a location determined by Nga Iwi Tangoa Whenua within the district of the Board.

5. Nga Iwi Tangoa Whenua may send replacements(s) should their representatives be unable to attend a meeting so long as the total numbers does not exceed two.

6. Nga Iwi Tangoa Whenua shall meet once every two months but shall not meet more than eight times per annum except with the consent of the parties. This shall not, however, preclude the Nga Iwi Whenua holding informal (that is unpaid and unreimbursed) meetings as often as it requires.

7. Nga Iwi Tangoa Whenua shall compile its own agenda. However, the CCDHB may, through the chair of the Nga Iwi Tangoa Whenua, request that specific items be considered by Nga Iwi Tangoa Whenua.

8. The secretary will compile a meeting agenda from items submitted by the parties at the nominated time and ensure relevant material are received by representatives by no less than three full working days prior to the date of the meeting.

9. The proceedings of the meetings will be recorded and circulated to the parties accordingly.

10. Representatives of Nga Iwi Tangoa Whenua may attend meetings of the CCDHB for a specific agenda item to expand or clarify any matters raised in the Nga Iwi Tangoa Whenua’s minutes or reports.

11. Where the Nga Iwi Tangoa Whenua considers that issues may best be resolved through direct contact with the CCDHB it may request the Chair of the CCDHB for such a meeting.

12. For the time being and until rates change, Nga Iwi Tangoa Whenua members shall receive a fee of $250 per meeting per person. A fee of $312 - 50 for the Chair and $280 for the Deputy Chair. In addition, payment of actual and reasonable travelling expenses incurred by Nga Iwi Tangoa Whenua representatives for attending meetings will be met.
ATTACHMENT TWO:

PROTOCOLS BETWEEN THE CAPITAL AND COAST DISTRICT HEALTH BOARD AND NGĀ IWI TANGATA WHENUA SEPTEMBER 2002

(To be read in conjunction with the Partnership Agreement of September 2002.)

PREFACE TO THESE PROTOCOLS

1.1 The parties agree that the partnership agreement does not encroach on the Board’s statutory functions and accountabilities, but acts as a catalyst in discharging its responsibilities and commitment to the improvement of Māori health in this district.

1.2 The parties agree that these protocols will not vary or undermine the spirit of the Partnership Agreement. Instead they are intended to facilitate the understandings and operations of that Agreement.

2.0 Principle

2.1 The parties will have a no surprises principle and that key issues affecting the parties and Māori will be communicated promptly via the respective chairs.

3.0 Relationship

3.1 Ngā Iwi Tangata Whenua is recognised by CCDHB as its key strategic adviser on Māori health issues as they affect local Iwi and all Māori within CCDHB.

3.2 Engagement will be between the Chair/Deputy Chair of the parties.

4.0 Information & Advice

4.1 Where there are requests for information by Ngā Iwi Tangata Whenua or by CCDHB, such request will be directed through the Chair, Ngā Iwi Tangata Whenua and the Chair, CCDHB.

4.2 Where the information requested is directed to CCDHB, the Chair will arrange with the CEO to undertake the work.

4.3 Where the information requested is directed to Nga Iwi Tangata Whenua, the Chair will arrange for its support staff to respond as required.

4.4 Māori Groups may wish to offer advice direct to Ngā Iwi Tangata Whenua. In that case the Chair/Deputy Chair of Ngā Iwi Tangata Whenua will liaise with the Chair of CCDHB to seek their views and together decide appropriate course of action on the advice given.

4.5 All other advice on Māori health to CCDHB will be referred to the Chair Nga Iwi Tangata Whenua first. The Chair Nga Iwi Tangata Whenua will then act according to 4.4 above.

5.0 Strategic Advice

5.1 Ngā Iwi Tangata Whenua is the principal strategic adviser to the CCDHB on matters that concern Māori health or Tikanga within the CCDHB and will be the first point of contact.

5.2 Where there is strategic as well as operational advice to be offered to CCDHB, the CEO or her designate should be informed.

5.3 Where the advice tendered to CCDHB requires clarification and discussion, the Chair will communicate with the Chair/ Deputy Chair for Ngā Iwi Tangata Whenua for this purpose.
5.4 Nga Iwi Tangata Whenua minutes will be tabled at future CCDHB meetings. These minutes will identify any advice Ngā Iwi Tangata Whenua will submit to CCDHB. The CCDHB will consider the advice and will in its minutes indicate to Nga Iwi Tangata Whenua its decision on the advice given.

6.0 Communication
6.1 To improve understanding on issues there will be regular meetings between the two Chairs of the parties. This forum will cover wide-ranging issues relevant to the smooth operations between the parties, but will not make decisions.

6.2 The Deputy Chairs of the parties may participate in these meetings. As required through circumstances the respective chairs by mutual consent will invite the CEO or her designate, or the Māori Board representative or other members of Nga Iwi Tangata Whenua to participate in these meetings.

7.0 Joint Work Program
7.1 The parties will develop a joint work program. This work program will include issues related to – Regional Hospital Development, District Strategic Plan, Draft Annual Plan and Māori Health Plan.

7.2 Ngā Iwi Tangata Whenua will develop its own work program to examine issues around Māori health/ Tikanga. The programme will prioritise advice to the Board and build on district priority areas and the Māori Health Plan.

8.0 Support for Nga Iwi Tangata Whenua
8.1 A budget will be jointly agreed between the parties so that Nga Iwi Tangata Whenua can meet and give advice to the agreed work plan set out in 7 above.

9.0 Review of Protocol
9.1 Both Parties agree to undertake periodic (Six month) reviews of these protocols.
## DHB GLOSSARY

<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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<tbody>
<tr>
<td>3D HSD</td>
<td>3D Health Services Development</td>
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<tr>
<td>A&amp;D</td>
<td>Alcohol &amp; Drug</td>
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<td>A&amp;E</td>
<td>Accident and Emergency Department</td>
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<td>A&amp;R</td>
<td>Audit and Risk</td>
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<td>AAU</td>
<td>Acute Assessment Unit</td>
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<td>ACA</td>
<td>Access Criteria for First Assessment</td>
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<td>ACEM</td>
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<td>Australian Council on Healthcare Standards</td>
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<td>Advanced Cardiac Life Support</td>
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<td>DHB Shared Services (supersedes District Health Boards New Zealand)</td>
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<td>Fellow of Accident &amp; Emergency Medicine - (A Dr at Consultant level)</td>
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<td>PACU</td>
<td>Post Anaesthetic Care Unit</td>
</tr>
<tr>
<td>PAFT</td>
<td>Parents As First Teachers</td>
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<tr>
<td>PAM</td>
<td>Performance &amp; Accountability Monitoring</td>
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<tr>
<td>PAS</td>
<td>Patient Administration Services</td>
</tr>
<tr>
<td>PATHS</td>
<td>Providing Access to Health Solutions Programme</td>
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<tr>
<td>PBFF</td>
<td>Population Based Funding Formula</td>
</tr>
<tr>
<td>PC</td>
<td>Personal Care</td>
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<td>PCO</td>
<td>Primary Care Organisation</td>
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<td>Professional Development and Recognition Programme</td>
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<tr>
<td>PET</td>
<td>Pre-eclampsia Toxemia</td>
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<td>PFA</td>
<td>Public Finance Act 1989</td>
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<tr>
<td>PHOAG</td>
<td>Primary Health Organisation Advisory Group</td>
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<tr>
<td>Acronyms</td>
<td>Description</td>
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<tr>
<td>-----------</td>
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</tr>
<tr>
<td>PIB</td>
<td>Proposal for Inclusion in Budget</td>
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<td>PICU</td>
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<td>PIP</td>
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<td>Pacific Island Unit</td>
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<td>PLs</td>
<td>Professional Leaders</td>
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<td>Point of Care Testing Proposal</td>
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<td>PPE</td>
<td>Personal, protective equipment.</td>
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<tr>
<td>PPPR Act</td>
<td>Protection of Personal and Property Rights Act</td>
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<tr>
<td>PQ</td>
<td>Parliamentary Question(s)</td>
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<td>PSA</td>
<td>Public Service Association</td>
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<tr>
<td>PSLG</td>
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<td>PUC</td>
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<td>Pacific Women Data Advisory Group</td>
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<td>Quality Health New Zealand</td>
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<td>Quality Innovation &amp; Patient Safety Directorate</td>
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<td>Quantity Surveyor</td>
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<td>Rangatiratanga</td>
<td>Self-determining and taking responsibility</td>
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<td>Responsible Clinician</td>
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<td>RCSQP</td>
<td>Regional Clinical Services Plan</td>
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<tr>
<td>RDA</td>
<td>Resident Doctors Association</td>
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<td>Regional Funding Forum</td>
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<td>Acronyms</td>
<td>Description</td>
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<td>----------</td>
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<tr>
<td>RMA</td>
<td>Resource Management Act</td>
</tr>
<tr>
<td>RMO</td>
<td>Resident Medical Officer</td>
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<tr>
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<tr>
<td>ROI</td>
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<td>Regional Public Health</td>
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<tr>
<td>RSM</td>
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<td>Sexual Assault Assessment and Treatment Service</td>
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<td>Self-Assessment Tool</td>
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<td>Surgical Booking List</td>
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<td>SBVS</td>
<td>School Based Vaccination Service</td>
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<tr>
<td>SC</td>
<td>Service Continuums or Service Co-ordination</td>
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<td>SCBU</td>
<td>Special Care Baby Unit</td>
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<tr>
<td>SDS</td>
<td>School Dental Service</td>
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<tr>
<td>Sentinel event</td>
<td>Physical or psychological injury</td>
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<tr>
<td>SF</td>
<td>Schizophrenia Fellowship</td>
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<td>SFG</td>
<td>Service Framework Group</td>
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<td>Service and Food Worker Union</td>
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<td>Society of Hospital Pharmacists Australia</td>
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<td>Services to Improve Access</td>
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<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
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<td>SIP</td>
<td>Strategy, Innovation and Performance</td>
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<td>SLA</td>
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<td>SMM</td>
<td>Safe Medication Management</td>
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<td>SMO</td>
<td>Senior Medical Officer</td>
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<td>SNA</td>
<td>Special Needs Assessment</td>
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<td>Description</td>
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<td>----------</td>
<td>-------------</td>
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<td>SOI</td>
<td>Statement of Intent</td>
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<td>Strategic Plan</td>
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<td>Service Planning and New Health Intervention Assessment (Framework)</td>
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<td>SRCLG</td>
<td>Sub-Regional Clinical Leadership Group</td>
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<td>Specialist Rehabilitation Service</td>
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<td>SSC</td>
<td>State Services Commission</td>
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<td>SSH</td>
<td>Selina Sutherland Hospital</td>
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<td>SSRI</td>
<td>Selective Serotonin reuptake inhibitors (a group of antidepressants)</td>
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<td>Shared Support Services Group</td>
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<td>Short Stay Unit</td>
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<td>SSU</td>
<td>Sterilizing Services Unit</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Groups and individuals who have a direct or indirect interest in the District Health Board and its activities</td>
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<tr>
<td>STR</td>
<td>Standard Discharge Ratio</td>
</tr>
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<td>STV</td>
<td>Single Transferable Vote</td>
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<td>SW</td>
<td>Social Work</td>
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<td>Surgery, Women &amp; Children’s Directorate</td>
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<td>TAC</td>
<td>Travel and Accommodation</td>
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<td>TAG</td>
<td>Technical Advisory Group</td>
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<tr>
<td>Tangata Whaiora</td>
<td>Consumers</td>
</tr>
<tr>
<td>TAP</td>
<td>Technical Advice Programme - for drinking water</td>
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<tr>
<td>TAS</td>
<td>Technical Advisory Service</td>
</tr>
<tr>
<td>TAT</td>
<td>Turnaround Times</td>
</tr>
<tr>
<td>Taumatatanga</td>
<td>Excellence</td>
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<tr>
<td>TBA</td>
<td>To be advised</td>
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<tr>
<td>TBC</td>
<td>To Be Confirmed</td>
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<tr>
<td>Tikanga</td>
<td>The essence of Māori values and traditions</td>
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<td>TLA</td>
<td>Territorial Local Authorities</td>
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<td>TMP</td>
<td>Top Management Programme (run through DHBNZ)</td>
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<td>TOP</td>
<td>Termination of Pregnancy</td>
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<td>TOR</td>
<td>Terms of Reference</td>
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<td>TOW</td>
<td>Treaty of Waitangi</td>
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<td>TWA</td>
<td>Te Whare Ahuru (Acute In-Patient Service – Mental Health)</td>
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<td>UHHC</td>
<td>Upper Hutt Health Centre</td>
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<td>Acronyms</td>
<td>Description</td>
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<tr>
<td>----------</td>
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<tr>
<td>UPC</td>
<td>User Park Charge</td>
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<tr>
<td>VfM</td>
<td>Value for Money</td>
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<td>VHT</td>
<td>Vision Health Technician</td>
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<td>VNT</td>
<td>Visiting Neurodevelopment Therapist</td>
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<td>WAICAP</td>
<td>Wairarapa Care of Aged Persons</td>
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<tr>
<td>WaiDHB</td>
<td>Wairarapa District Health Board</td>
</tr>
<tr>
<td>Wairuatanga</td>
<td>Holism with spirituality as the underlying essence</td>
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<tr>
<td>WAS</td>
<td>Wairarapa Ambulance Service</td>
</tr>
<tr>
<td>Wash-up Process</td>
<td>Where delivery is compared to contract and any over or under delivery results in a change of revenue. I.e. volumes not delivered are not paid for.</td>
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<tr>
<td>WAVE</td>
<td>Working to add value through E information (Information Technology term)</td>
</tr>
<tr>
<td>WBS</td>
<td>Wairarapa Building Society</td>
</tr>
<tr>
<td>WCPHO</td>
<td>Wairarapa Community Primary Health Organisation</td>
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<tr>
<td>WCSAP</td>
<td>Wairarapa Clinical Services Action Plan</td>
</tr>
<tr>
<td>WCTAG</td>
<td>Well Child Technical Advisory Group</td>
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<td>WDHB</td>
<td>Wairarapa District Health Board</td>
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<tr>
<td>Whakamiharo</td>
<td>Acknowledging our achievements</td>
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<tr>
<td>Whanaungatanga</td>
<td>Creating relationships and partnership</td>
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<tr>
<td>WHF</td>
<td>Wellington Heart Foundation</td>
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<tr>
<td>WHF</td>
<td>Wellington Hospital Foundation</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WHT</td>
<td>Well Health Trust, PHO</td>
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<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separation</td>
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<td>WIPA</td>
<td>Wellington independent Practitioners Association</td>
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<td>WOOPS</td>
<td>Wairarapa Organisation for Older Persons</td>
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<td>WPH</td>
<td>Wairarapa Public Health</td>
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<tr>
<td>YAG</td>
<td>Youth Action Group</td>
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<tr>
<td>YLD</td>
<td>Years Lost to Disability</td>
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<tr>
<td>YLL</td>
<td>Years of Life Lost</td>
</tr>
<tr>
<td>YOT</td>
<td>Youth Offending Teams</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
Te Haika
1st September – 30 September 2017

• Te Haika operates 24/7, 365 days
• Triaging crisis and acute calls
• Managing referrals to MHAID services for Wairarapa, Hutt Valley and Capital and Coast DHBs
Te Haika Data

- Total Number of Referrals entered = 1391
Te Haika: Referrals by Domicile

2016-10: Other DHBs 41, Wairarapa DHB 17, Hutt Valley DHB 33, Capital and Coast DHB 207; 2016-11: Other DHBs 17, Wairarapa DHB 33, Hutt Valley DHB 204, Capital and Coast DHB 157; 2016-12: Other DHBs 29, Wairarapa DHB 47, Hutt Valley DHB 44, Capital and Coast DHB 165; 2017-01: Other DHBs 39, Wairarapa DHB 29, Hutt Valley DHB 26, Capital and Coast DHB 177; 2017-02: Other DHBs 45, Wairarapa DHB 26, Hutt Valley DHB 32, Capital and Coast DHB 179; 2017-03: Other DHBs 39, Wairarapa DHB 28, Hutt Valley DHB 30, Capital and Coast DHB 169; 2017-04: Other DHBs 44, Wairarapa DHB 45, Hutt Valley DHB 24, Capital and Coast DHB 147; 2017-05: Other DHBs 44, Wairarapa DHB 45, Hutt Valley DHB 24, Capital and Coast DHB 169; 2017-06: Other DHBs 44, Wairarapa DHB 45, Hutt Valley DHB 24, Capital and Coast DHB 179; 2017-07: Other DHBs 44, Wairarapa DHB 45, Hutt Valley DHB 24, Capital and Coast DHB 247; 2017-08: Other DHBs 44, Wairarapa DHB 45, Hutt Valley DHB 24, Capital and Coast DHB 1149; 2017-09: Other DHBs 28, Wairarapa DHB 43, Hutt Valley DHB 276, Capital and Coast DHB 1044.
Total number of referrals by DHB

Referrals by DHB

CCDHB: 1044
HVDHB: 276
Other DHB: 28
WDHB: 43
Percent of referrals by DHB

75% for CCDHB
20% for HVDHB
2% for Other DHB
3% for WDHB
Ethnicity percentage for total referrals

- **Maori**: 15%
- **Other**: 78%
- **Pacific**: 7%

CCDHB Public 25 October 2017 - APPENDICIES
# Ethnicity totals by DHB

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>CCDHB</th>
<th>HVDHB</th>
<th>Other DHB</th>
<th>WDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>143</td>
<td>19</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>824</td>
<td>207</td>
<td>19</td>
<td>39</td>
</tr>
<tr>
<td>Pacific</td>
<td>77</td>
<td>50</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

CCDHB Public 25 October 2017 - APPENDICIES
Referral Source
Top referrers are GPs and Self referrals
# Chad Buckle Fellowship 2017

**Professor Peter Haddad BSc, MD, FRCPsych**

Peter Haddad is a consultant in community psychiatry at The Greater Manchester Mental Health NHS Foundation Trust. He is also an Honorary Clinical Professor of Psychiatry at the University of Manchester. His main research interests are the management of affective disorders, schizophrenia and psychosis, with an emphasis on widening treatment choice and improving outcomes for people with these disorders.

## Wednesday 25 October

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30 - 10.30am</td>
<td>Acute treatment of mania and bipolar depression</td>
<td>Porirua Ngā Wāhi Ākonga, Moa</td>
</tr>
<tr>
<td>11am – 12.30pm</td>
<td>Long term management of bipolar affective disorder</td>
<td>Porirua Ngā Wāhi Ākonga, Moa</td>
</tr>
<tr>
<td>1.30 – 3pm</td>
<td>Antipsychotic side-effects: Challenges and management strategies</td>
<td>Porirua Ngā Wāhi Ākonga, Moa</td>
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</tbody>
</table>

## Thursday 26 October

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30am - 11am</td>
<td>Managing bipolar affective disorder through different phases (acute and long-term)</td>
<td>Hutt Hospital Antenatal Education Room, Community Health</td>
</tr>
<tr>
<td>1.30pm - 3pm</td>
<td>Non-adherence with antipsychotic medication: Challenges and management strategies</td>
<td>Wellington Horne Lecture Theatre</td>
</tr>
<tr>
<td>6pm – 7pm</td>
<td>PUBLIC LECTURE : Schizophrenia – Changes in management over the last 70 years</td>
<td>Wellington – Bunny St. Rutherford House Victoria University RHLT1</td>
</tr>
</tbody>
</table>

## Friday 27 October

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>10am-12.30pm</td>
<td>Antipsychotic medication - side-effects, and non-adherence: Challenges and management strategies</td>
<td>Masterton Hospital CSSB Lecture theatre</td>
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</tbody>
</table>

Book on Connect Me [MHAID Chad Buckle Fellowship](#)
Capital Coast District Health Board presents

Buckle Fellowship 2017

Professor Peter Haddad

Public lecture

Schizophrenia – changes in the management over the last 70 years.

Professor Peter Haddad is a consultant in community psychiatry at The Greater Manchester Mental Health NHS Foundation Trust.

He is also an Honorary Clinical Professor of Psychiatry at the University of Manchester. His main research interests are the management of affective disorders, schizophrenia and psychosis, with an emphasis on widening treatment choice and improving outcomes for people with these disorders.

6pm, Thursday 26th October 2017

RHLT1, Rutherford house, Bunny Street, Victoria University

For more information and RSVP – email carla.nahr@ccdhb.org.nz

www.mhaids.org.nz
### Patient Experience

<table>
<thead>
<tr>
<th>Target</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
<th>Forensic &amp; Rehab</th>
<th>ID Services</th>
<th>MHAID</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Day acute readmissions rate – adult acute units (%)</td>
<td>10%</td>
<td>NA</td>
<td>22%</td>
<td>5%</td>
<td>NA</td>
<td>11%</td>
<td>11%</td>
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<tr>
<td>Long-term consumers with a current wellness plan (%)</td>
<td>95%</td>
<td>NR</td>
<td>67%</td>
<td>41%</td>
<td>36%</td>
<td>22%</td>
<td>NA</td>
</tr>
<tr>
<td>Better help for inpatient smokers to quit (%)</td>
<td>95%</td>
<td>NA</td>
<td>43%</td>
<td>91%</td>
<td>NA</td>
<td>100%</td>
<td>77%</td>
</tr>
<tr>
<td>HFKOS compliant inpatient discharges – matched pairs (%)</td>
<td>80–100%</td>
<td>81%</td>
<td>45%</td>
<td>50%</td>
<td>0%</td>
<td>57%</td>
<td>46%</td>
</tr>
<tr>
<td>HFKOS compliance – Community (%)</td>
<td>80–100%</td>
<td>80%</td>
<td>51%</td>
<td>59%</td>
<td>18%</td>
<td>45%</td>
<td>55%</td>
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<tr>
<td>Consumer death by suspected suicide (n)</td>
<td>NA</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>SAC 1 &amp; 2 (n)</td>
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<td>1</td>
<td>0</td>
<td>0</td>
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<tr>
<td>All reportable events (n)</td>
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<td>0</td>
<td>40</td>
<td>92</td>
<td>108</td>
<td>90</td>
<td>330</td>
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<td>Medication errors (n)</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>22</td>
<td>35</td>
</tr>
<tr>
<td>Complaints (n)</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Complaints resolved within 30 days (%)</td>
<td>100%</td>
<td>0%</td>
<td>83%</td>
<td>73%</td>
<td>100%</td>
<td>100%</td>
<td>82%</td>
</tr>
<tr>
<td>Health &amp; DisabilityCommission Complaints (n)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Complaints count (n)</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Personal restraints count (n)</td>
<td>0</td>
<td>4</td>
<td>13</td>
<td>7</td>
<td>4</td>
<td>28</td>
<td>50</td>
</tr>
<tr>
<td>All consumers under Section 11 to Section 15 (n)</td>
<td>0</td>
<td>33</td>
<td>164</td>
<td>16</td>
<td>NR</td>
<td>216</td>
<td>364</td>
</tr>
<tr>
<td>All consumers under Compulsory Treatment Order (n)</td>
<td>0</td>
<td>40</td>
<td>94</td>
<td>416</td>
<td>87</td>
<td>8</td>
<td>645</td>
</tr>
<tr>
<td>Maori under Community Treatment Order (n)</td>
<td>19</td>
<td>28</td>
<td>111</td>
<td>38</td>
<td>4</td>
<td>200</td>
<td>241</td>
</tr>
<tr>
<td>Seclusion hours</td>
<td>1</td>
<td>28</td>
<td>266</td>
<td>398</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seclusion hours – Maori</td>
<td>NA</td>
<td>0</td>
<td>0</td>
<td>247</td>
<td>5</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Seclusion hours – Pacific</td>
<td>NA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>

### Healthy Workforce

<table>
<thead>
<tr>
<th>Target</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
<th>Forensic &amp; Rehab</th>
<th>ID Services</th>
<th>MHAID</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff turnover/headcount-YTD average annualised (n)</td>
<td>8–10%</td>
<td>4%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>NA</td>
</tr>
<tr>
<td>Sick leave (n)</td>
<td>2–4%</td>
<td>3.0%</td>
<td>4.8%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>4.5%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Staff with annual leave &gt; 200 hours (n)</td>
<td>7</td>
<td>49</td>
<td>98</td>
<td>98</td>
<td>66</td>
<td>318</td>
<td>NA</td>
</tr>
<tr>
<td>Physical assaults on staff (n)</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Performance appraisals completed (%)</td>
<td>100%</td>
<td>16%</td>
<td>12%</td>
<td>19%</td>
<td>34%</td>
<td>53%</td>
<td>25%</td>
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</tbody>
</table>

### Financial

<table>
<thead>
<tr>
<th>Target</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
<th>Forensic &amp; Rehab</th>
<th>ID Services</th>
<th>MHAID</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating (actual) costs ($'000)</td>
<td>314</td>
<td>2,165</td>
<td>4,725</td>
<td>2,144</td>
<td>1,009</td>
<td>10,517</td>
<td>20,184</td>
</tr>
<tr>
<td>Personnel including outsourced ($'000)</td>
<td>306</td>
<td>1,622</td>
<td>4,422</td>
<td>2,227</td>
<td>1,061</td>
<td>9,638</td>
<td>18,114</td>
</tr>
<tr>
<td>Overtime hours (%)</td>
<td>NA</td>
<td>1.3%</td>
<td>2.8%</td>
<td>3.4%</td>
<td>2.8%</td>
<td>4.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td>FTEs – actual</td>
<td>36</td>
<td>155</td>
<td>97</td>
<td>306</td>
<td>135</td>
<td>718</td>
<td>NA</td>
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<tr>
<td>FTEs – vacancy</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td>NA</td>
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### Productivity

<table>
<thead>
<tr>
<th>Target</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
<th>Forensic &amp; Rehab</th>
<th>ID Services</th>
<th>MHAID</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access rate (%)</td>
<td>3%</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>NA</td>
<td>NA</td>
<td>4%</td>
</tr>
<tr>
<td>Acute Adult Inpatients ALOS (days)</td>
<td>14-21</td>
<td>11</td>
<td>15</td>
<td>12</td>
<td>15</td>
<td>12</td>
<td></td>
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<tr>
<td>ALOS Adolescent Unit (days)</td>
<td>27</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>ALOS Psychiatric Unit (days)</td>
<td>35</td>
<td>NA</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALOS Eating Disorders Inpatient Unit (days)</td>
<td>NA</td>
<td>44</td>
<td>NA</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALOS Regional Rehabilitation Units (days)</td>
<td>NA</td>
<td>NA</td>
<td>277</td>
<td>NA</td>
<td>675</td>
<td></td>
<td></td>
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<tr>
<td>ALOS Adult Forensic Inpatient Units (days)</td>
<td>71</td>
<td>135</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALOS Adult Intellectual Disability Unit (days)</td>
<td>314</td>
<td>156</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALOS Youth Intellectual Disability Unit (days)</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Inpatient Units Occupancy (%)</td>
<td>85%</td>
<td>91%</td>
<td>98%</td>
<td>95%</td>
<td>95%</td>
<td></td>
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<tr>
<td>Adolescent Unit Occupancy (%)</td>
<td>87%</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Psychiatric Unit Occupancy (%)</td>
<td>71%</td>
<td>NA</td>
<td>74%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Eating Disorders Occupancy (%)</td>
<td>NA</td>
<td>64%</td>
<td>72%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Regional Rehabilitation Units Occupancy (%)</td>
<td>NA</td>
<td>NA</td>
<td>93%</td>
<td>NA</td>
<td>93%</td>
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<td></td>
</tr>
<tr>
<td>Adult Forensic Inpatient Units Occupancy (%)</td>
<td>96%</td>
<td>96%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Adult Intellectual Disability Unit Occupancy (%)</td>
<td>NA</td>
<td>72%</td>
<td>74%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Youth Intellectual Disability Unit Occupancy (%)</td>
<td>NA</td>
<td>67%</td>
<td>68%</td>
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<td></td>
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</tr>
<tr>
<td>Pre-admission community care (%)</td>
<td>75–100%</td>
<td>13/16</td>
<td>16/35</td>
<td>29/53</td>
<td>29/53</td>
<td></td>
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</tr>
<tr>
<td>Post-discharge community care (%)</td>
<td>90–100%</td>
<td>21/32</td>
<td>32/72</td>
<td>NA</td>
<td>$3/104</td>
<td>$3/104</td>
<td></td>
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<tr>
<td>Consumer related time – child and youth (%)</td>
<td>38–40%</td>
<td>NR</td>
<td>NR</td>
<td>25%</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer related time – adults (%)</td>
<td>35–40%</td>
<td>NR</td>
<td>NR</td>
<td>16%</td>
<td>5%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>Community treatment days per quarter (days)</td>
<td>10–20</td>
<td>NR</td>
<td>NR</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Wait-time &lt; 3 weeks – child and youth (%)</td>
<td>80%</td>
<td>78%</td>
<td>42%</td>
<td>53%</td>
<td>95%</td>
<td>NA</td>
<td>56%</td>
</tr>
<tr>
<td>Wait-time &lt; 3 weeks – adult (%)</td>
<td>95%</td>
<td>92%</td>
<td>75%</td>
<td>86%</td>
<td>98%</td>
<td>84%</td>
<td>NA</td>
</tr>
<tr>
<td>Wait-time &lt; 3 weeks – adult (%)</td>
<td>80%</td>
<td>88%</td>
<td>83%</td>
<td>59%</td>
<td>93%</td>
<td>47%</td>
<td>74%</td>
</tr>
<tr>
<td>Wait-time &lt; 8 weeks – adult (%)</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
<td>90%</td>
<td>97%</td>
<td>87%</td>
<td>94%</td>
</tr>
<tr>
<td>Community DNA rate (%)</td>
<td>3%</td>
<td>12%</td>
<td>6%</td>
<td>2%</td>
<td>2%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Community DNA rate – Maori (%)</td>
<td>NA</td>
<td>12%</td>
<td>20%</td>
<td>8%</td>
<td>2%</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Community DNA rate – Pacific (%)</td>
<td>NA</td>
<td>0%</td>
<td>14%</td>
<td>5%</td>
<td>0%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Case load consumer participation in last 90 days (%)</td>
<td>NA</td>
<td>95%</td>
<td>97%</td>
<td>83%</td>
<td>87%</td>
<td>91%</td>
<td>86%</td>
</tr>
</tbody>
</table>

### Mental Health & Addictions Services Benchmarking Programme KPI

- National health target
- Health Quality and Safety Commission KPI
- Staff performance measure or Maori Health Measure

### Key Issue

- Alert
- Good News
July 2017 Pre Admission and Post Discharge Contact - Wairarapa site*

MHAIDS 3DHB (Wairapapa site)
% Admissions with clinical contact seven days prior to admission

MHAIDS 3DHB (Wairapapa site)
% Discharges with clinical contact within seven days of discharge

Pre-admission contact
Numerator: Number of acute adult IP admissions occurring during the reference period for which service user participation contact is recorded in the seven days preceding the admission but not on the day of admission.

Denominator: Admissions to Te Whare Ahuru and Te Whare o Matairangi when the client is a current client on the Wairarapa DHB community mental health service case load with a referral open for at least 7 days prior to the admission.

Exclusions: Planned admissions as a result of non-acute treatment requirements are excluded, for example overnight admission for electroconvulsive therapy.

Post - discharge contact
Numerator: Number of in-scope, overnight, acute adult IP discharges occurring during the reference period for which service user participation contact is recorded within seven days of discharge but not on the day of discharge.

Denominator: Discharges from Te Whare Ahuru or Te Whare o Matairangi where there is an open Wairarapa community mental health team referral.

Exclusions: Planned admissions as a result of non-acute treatment requirements are excluded, for example overnight admission for electroconvulsive therapy.

* As the National Mental Health and Addiction Service KPI Program specifications for pre admission and post discharge do not apply to district health boards without an inpatient unit, these indicators are not reported for Wairarapa DHB in the MHAIDS 3DHB Balanced Score Card (BSC). As defined above, local indicators have been developed and are reported with a one month lag which allows time for the post discharge contact to occur and be recorded. This is consistent with the Hutt Valley and Capital and Coast DHB indicators reported in the BSC.