HUTT VALLEY DISTRICT HEALTH BOARD

PUBLIC AGENDA

Hutt Valley DHB, High Street, Pilmuir House, Boardroom, Lower Hutt
Friday, 21 March 2014, Commencing at 9.00 am

	Item	Action	Presenter	Min	Time	Pg
1.	**PROCEDURAL**			5	9.00 am	
1.1	Karakia		Peter Douglas			
1.2	Apologies	RECORD	Virginia Hope			
1.3	Continuous Disclosure - Interest Register - Conflict of Interest	CONFIRM	Virginia Hope			**2**
1.4	Minutes of previous meeting	APPROVE	Virginia Hope			**6**
1.5	Matters arising from previous meetings	ACCEPT	Graham Dyer			**11**
2. PRESENTATION						
2.1	Pacific Health	RECEIVE	Tofa Gush	20	9:05 am	**12**
3. DECISION PAPERS						
3.1	Governance Manual	AGREE	Virginia Hope	5	9:25 am	**34**
3.2	Board Representation	AGREE	Virginia Hope	5	9:30 am	**36**
3.3	Fluoridation Position Statement	ADOPT	Ashley Bloomfield	5	9:35 am	**37**
4. DISCUSSION PAPERS						
4.1	Chair Verbal Report	RECEIVE	Virginia Hope	5	9:40 am	-
4.2	Chief Executive Report	NOTE	Graham Dyer	15	9:45 am	**40**
5. INFORMATION PAPER						
5.1	Emergency Management	NOTE	Cate Tyrer	15	10:00 am	**52**
6. COMMITTEE VERBAL REPORT BACKS						
6.1	CPHAC	NOTE	Virginia Hope	5	10:15 am	**54**
6.2	HAC	NOTE	Virginia Hope	5	10:20 am	-
7. OTHER						
7.1	General			5	10:25 am	-
7.2	Resolutions to Exclude the Public	APPROVE	Virginia Hope			**57**
CLOSE					10.30 am	

DATE OF NEXT MEETING

2 May 2014, Hutt Valley DHB, Boardroom, Pilmuir House

HUTT VALLEY DISTRICT HEALTH BOARD

Hutt Valley Board INTEREST REGISTER

9 MARCH 2014

Name	Interest
Dr Virginia Hope *Chair*	• Chair, Hutt Valley District Health Board • Chair, Capital & Coast District Health Board • Chair, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Deputy Chair, Wairarapa, Hutt Valley and CCDHB Community Public Health Advisory Committee and Disability Support Advisory Committees • Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee • Member, Hutt Valley, Finance Risk & Audit Committee • Member, Capital & Coast District Health Board, Finance Risk & Audit Committee • Health Programme Leader, Institute of Environmental Science & Research • Director & Shareholder, Jacaranda Limited • Fellow, Royal Australasian College of Medical Administration • Fellow and New Zealand Committee Member, Australasian Faculty of Public Health Medicine • Fellow, New Zealand College of Public Health Medicine • Member, Territorial Forces Employer Support Council • Member, CRISP Governance Board • Member, Laboratory Round Table • Brother and Sister work in Health Sector in the Wairarapa Disability Support and Laboratories
Wayne Guppy *Deputy Chair*	• Chair, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee • Chair, Hutt Valley District Health Board, Finance Risk & Audit Committee • Deputy Chair, Hutt Valley District Health Board • Member, Capital & Coast, Hutt Valley and Wairarapa DHBs Community Public Health Advisory Committee and Disability Support Advisory Committee • Member, Capital & Coast District Health Board, Finance Risk & Audit Committee • Wife employed by various community pharmacies in the Hutt Valley • Trustee - Orongomai Marae • Upper Hutt City Council Mayor • Director MedicAlert
Katy Austin *Member*	• Member, Hutt Valley District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Fergusson Home (Upper Hutt) – Voluntary input
David Bassett *Member*	• Deputy Chair, Hutt Valley District Health Board, Finance Risk & Audit Committee • Member, Hutt Valley District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee • Deputy Mayor Hutt City Council • Son owns Hutt City Auto Services, which has an automotive contract for the DHB • Director, Capacity Infrastructure Services Ltd
Peter Douglas *Member*	• Chair, Capital & Coast District Health Board, Finance Risk & Audit Committee • Chair, Hato Paora College Board of Trustees • Chair, Hato Paora College Proprietors Trust Board • Deputy Chair, Wairarapa, Hutt Valley & CCDHB Finance Risk & Audit Committee • Member, Hutt Valley District Health Board • Member, Capital & Coast District Health Board

	• Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Member, Capital & Coast District Health Board, Finance Risk & Audit Committee • Member, Hutt Valley, Finance Risk & Audit Committee • Member, Wairarapa, Hutt Valley and CCDHB Community Public Health Advisory Committee and Disability Support Advisory Committees • Director, Te Ohu Kaimoana Custodian Limited • Director, Charisma Developments Limited • Chief Executive, Te Ohu Kaimoana, Māori Fisheries Trust
Jaimes Wood *Member*	• Member, Hutt Valley District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee • Member, Hutt Valley District Health Board, Finance Risk & Audit Committee • Principle Advisor; Melbourne Business School-Mt Eliza • Strategic Advisor; Lightfoot Solutions (UK) Limited • Son-in-Law works for a supplier of HVDHB – and is the son of the principle shareholder WM Bamford & Co Limited • Part time member – Local Government Commission
Ron Mark *Member*	• Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Member, Wairarapa Iwi Kainga Committee • Mayor for Carterton District Council • Patron, Te Awa Ora a Maori Mental Health Service Provider in Christchurch
Ken Laban *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board, Finance Risk & Audit Committee • Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee • Councillor, Hutt City Council • Trustee, Hutt Mana Charitable Trust • Trustee, Te Omanga Hospice • Member, Ulalei Wellington • Member, Hutt City Sports Awards Committee
David Ogden Member	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board, Finance Risk & Audit Committee • Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee • Employee – Simple Accounting Services Limited, and indirectly its subsidiary, Five Plus Accounting Limited. Both companies have various clients involved in the Health Sector. • Presiding Member – Lotteries Commission Wellington and Wairarapa Communities Committee. The Funding Committee shares some applicants with regional health board providers.
John Terris *Member*	• Member, Hutt Valley District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees
Sandra Greig *Member*	• Member, Hutt Valley District Health Board • Seniors with Shayne Nahu • Grey Power President – On Committee with Susan Bowden (Home Care)

Wairarapa and Hutt Valley DHB Executive Leadership Team

Interest register

February 2014

Name	Interest
Graham Dyer *Chief Executive* *Wairarapa and Hutt Valley DHBs*	• Trustee, Bossley Dyer Family Trust • Wife is a Director of i-Management which does consulting and audit work in the Health Sector • Member, Crisp Interim Governance Board • Member, Health Workforce New Zealand
Bridget Allan *Chief Executive,* *Te Awakairaongi Health Network (PHO)*	• Chief Executive, Te Awakairangi Health Network (PHO) • Board member of Vibe
Ashley Bloomfield *Director Service Integration and Development*	• Trustee, AR and EL Bloomfield Trusts • Fellow, NZ College of Public Health Medicine • Board Member, Action on Smoking and Health (ASH) NZ • Member NZ College of Public Health Medicine Finance and Risk Committee • Sister is a nurse at Hutt DHB • Wife was employed at Hutt Family Planning Association clinic during 2009-10
Pete Chandler *Chief Operating Officer*	No interests declared.
Carolyn Cooper *Executive Director, people and Culture*	• Sister in law is an independent member of the Community Labs Group
Judith Parkinson *Finance Manager*	No interests declared.
Helen Pocknall *Executive Director Nursing and Midwifery*	• Board Member, Health Workforce New Zealand
Nadine Mackintosh *Board Secretary*	No interests declared.

Updated January 2014

Richard Schmidt *Executive Officer*	• Member of the Hutt Foundation
Russell Simpson *Executive Director Allied Health, Scientific and Technical*	• Chair, Central Region Directors of Allied Health • Member, Regional Leadership Committee
Jill Stringer *Communications Manager*	• Trustee, Wairarapa Regional All Weather Track Trust • Husband works for Rigg Zschokke Ltd
Iwona Stolarek *Chief Medical Officer*	• Member, ASMS JCC • Husband Andrew Simpson: - Executive Director for Medicine Cancer & Community CCDHB - Executive Member of the Cancer Society Wellington Division - National Clinical Director Cancer Programme – Ministry of Health
Justine Thorpe	• Tihei Wairarapa Programme Director, employed by Compass Health
Cate Tyrer *General Manager Quality and Risk*	• Shareholder and Director of Framework For Compliance Ltd (FFC) • Husband is an employee of Hutt Valley DHB
Stephanie Turner *Director Maori Health*	• Represent Rangitane Iwi on the Wairarapa Cultural Trust (Aratoi) • Establishing member of Pasifika Wairarapa Trust • Director Waingawa Ltd • Director Aroha Ki Te Whanau Trust • Member Cameron Community House Governance Group
Tofa Suafole Gush *Director Pacific Peoples Health*	• Member of the Te Awakairangi Health Board • Husband is an employee of Hutt Valley DHB
Kuini Puketapu *Manager Maori Health Advisor*	• Chair of Board of Trustees, Pukeatua Te Kohanga Reo • Board Member, Te Runanganui o Taranaki Whanui ki te Upoko o te Ika a Maui who has contracts with Hutt Valley DHB to provide health services in the Hutt Valley area and is an approved Whanau Ora provider • Member, Wainuiomata Community Governance Group • Chair, Waiwhetu Medical Group which is a limited liability company affiliated to Te Awakairangi Health PHO
John Ryan *3DHB Executive Director, Corporate Services*	• Son works for Spotless Services. • Cousin works as Orthopaedic Nurse at Capital and Coast DHB

Updated January 2014

PUBLIC

HUTT VALLEY DISTRICT HEALTH BOARD

PUBLIC MEETING

DRAFT Board Minutes of the meeting held on 10 February 2014
Hutt Hospital, Pilmuir House, Lower Hutt

Commencing at 9.25am

PRESENT

Virginia Hope	Chair
Wayne Guppy	Deputy Chair
Katy Austin	Member
David Bassett	Member
Sandra Greig	Member
Ken Laban	Member
David Ogden	Member
John Terris	Member
Jaimes Wood	Member

APOLOGIES

Peter Douglas	Member
Ron Mark	Member

ATTENDANCE

Graham Dyer	Chief Executive
Ashley Bloomfield	Director SIDU
Helen Pocknall	Executive Director of Midwifery and Nursing
Richard Schmidt	Executive Officer (departed at 9.35am)
Jill Stringer	Communications Manager
Nadine Mackintosh	Board Secretary

PUBLIC GUESTS
Members of the Press

1.0 PROCEDURAL BUSINESS

The Chair provided apologies for the late start.

1.1 APOLOGIES

Apologies were received and recorded above.

MOVED: John Terris **SECONDED**: Wayne Guppy **CARRIED**

1.2 KARAKIA

The meeting was opened with a Karakia.

PUBLIC

1.3 DECLARATION OF INTEREST

Mr D Ogden advised of his daughter's position as intern clinical physiologist at Hutt Hospital.

The Board **RESOLVED** to **ADOPT** the change to the interest register.

MOVED: John Terris **SECONDED**: Wayne Guppy **CARRIED**

1.4 CONFLICT OF INTEREST

CONFIRMED The Board confirmed that it was not aware of any matters (including matters reported to, and decisions made, by the Board at this meeting) which require disclosure but there would be an opportunity at the beginning of each item for members to declare any conflict of interest.

1.5 MINUTES

RESOLVED The Board resolved to move the resolutions as recorded in the minutes of the members' (Public) Hutt Valley DHB meeting held on 1 November 2013 as a true and accurate record of the meeting.

MOVED: Wayne Guppy **SECONDED**: David Bassett **CARRIED**

RESOLVED The Board resolved to move the resolutions as recorded in the minutes of the members' (Public) Hutt Valley DHB meeting held on 6 December 2013 as a true and accurate record of the meeting.

MOVED: Wayne Guppy **SECONDED**: David Bassett **CARRIED**

RESOLVED The Board resolved to move the resolutions as recorded in the minutes of the members' (Public) 3DHB meeting held on 6 December 2013 as a true and accurate record of the meeting.

MOVED: Wayne Guppy **SECONDED**: David Bassett **CARRIED**

1.6 MATTERS ARISING

The Chief Executive reported that all matters arising are provided in papers or scheduled for a future date.

2.0 DELEGATIONS POLICY

Management reported the paper is provided due to the requirement to addresses amendments to the titles of existing roles.

The Board **RESOLVED** to **AGREE** to the proposed change to the Hutt Valley DHB Delegations of Authority Policy.

MOVED Ken Laban **SECONDED** Jaimes Wood **CARRIED**

3.0 CHAIR UPDATE

The Chair had no public engagements to update the Board on for the month of January.

PUBLIC

4.0 CHIEF EXECUTIVE REPORT

The paper was taken as read noting that Te Awakairangi Health Network has achieved the largest increase in performance on the Cardio Vascular Disease target in the country.

The Chief Executive reported on the health targets noting management will be reviewing the current access criteria as reporting indicates the DHB are meeting the elective target but struggling with the wait times. The Christmas period was a little strained although no busier than usual on a patient/resource ratio level.

The introduction of technology for delivery of voice therapy across the Wairarapa and Hutt Valley has commenced providing an opportunity for virtual rounds to be trialled in the critical care unit in the near future.

The financial result for both November and December were challenging. The management team have investigated the pressures which highlights an increase in low volume high cost patient IDFs, noting a $250,000 burn case and $250,000 neonatal case. The result for January will be discussed in detail at the Finance Risk and Audit Committee noting the preliminary results for January indicates a $250,000 saving. The Board discussed future budgeting opportunities for IDFs. Management are reporting a $1.5mil adverse to budget position with risk to the end of the financial year. The deficit position has been reported to the Ministry and they support management seeking opportunities to reduce the deficit position.

Health Pathways was highlighted as a good example of 3DHB co-operation with a report being provided to CPHAC and then onto the Boards.

The health passport launch and icon launch across the sub-region provides the DHBs to recognise a patient with a disability. There was a brief discussion on the privacy policy with the Chief Executive reporting the random audit process at the DHB.

The Board **NOTED** the contents of the report.

5.0 OVERVIEW OF HEART DISESE AND DIABETES

The presentation provided an overview of the range of services across the three DHBs. It was noted the death rates from Cardio Vascular Disease has been reducing with improvements in interventions.

It was reported that people with diabetes commonly die of cardio vascular disease. There remains interest in prevention, reduction in smoking with a number of interventions provided through public practices.

The Hutt Valley has a smaller workforce in primary care across the 3 DHBs and are in the bottom third nationally noting the DHB is working with primary care to retain and attract staff. Hutt Valley DHB also has the highest deprivation level across the 3 DHBs.

The presentation covered:

- Patient dashboard and benefits of the opportunistic tools that have been developed.
- Long term patient outcomes is an end point
- Changes to diabetic checks and pathway initiatives
- Reporting for higher quintile areas and the priorities
- Controls on good nutrition and lifestyles

PUBLIC

Patients in the Hutt Valley have a lower opportunity for interventions by the time they reach secondary specialist services and this maybe impacted by the lower primary care numbers. The private practice care in the Hutt Valley is modest.

- Smoking remains a factor
- Behaviour change is complex
- Gastro surgery of which the DHB performs 10 per annum has a positive impact on diabetes and if patients can self fund then this is a good opportunity.

Opportunities for improvement remain.

ACTION

B01 The Board to be provided with number of annual CVD checks – PHO to provide this information into the next Chief Executive report.

B02 Circulate to the Board a map of deprivation by mesh block

B03 Management to request that the PHO report back on the cardio-vascular disease and risk programme as part of their bi-annual reports to the Board.

6.0 FINANCIAL REPORT

The paper was taken as read.

The Board **NOTED** the contents of the report**.**

7.0 REGIONAL SERVICE PLAN QUARTER TWO

The paper was taken as read.

The Board **RESOLVED** to **NOTE** the contents of the report**.**

8.0 GENERAL

Hospital service tours to be included on the Board's planned schedule of meetings and management to investigate opportunities to tie this into Board decision papers where appropriate.

The 14 April 2014 workshop will be an opportunity to address the District Annual Plan and requirements of the Board during this triennium. An approach for the session could include the outcomes that the Board would like to reach which will provide an indication of what information the management should provide to the Board.

9.0 RESOLUTIONS TO EXCLUDE THE PUBLIC

RESOLVED: The Board resolved to 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:

Agenda Item	Reason	Reference
Chief Executive Report	Project the privacy of the naturals persons and to enable a Minister of the Crown or any department or	Section 9(2)(a) (i)

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Sustainability Plan	organisation holding the information to carry out, without prejudice or disadvantage, commercial activities	
Board Representation	Opportunity to discuss availability including personal commitments	Section 9(2)(a)
DRAFT Governance Manual	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
CTAS Constitution	To allow for commercial negotiations between the regional DHBs or TAS	Section 9(2)(j)
Common Operating Environment Business Case	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
CRISP	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Fire Contract	Paper contains information and advice that is likely to prejudice or disadvantage commercial activities	Sections 9(2)(i)
Gas Contract	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Health Benefits Limited	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)

MOVED: Ken Laban **SECONDED**: David Bassett

THE MEETING CLOSED AT 10.45am

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

DATED this day of 2014

VIRGINIA HOPE
CHAIR

PUBLIC

SCHEDULE OF ACTION POINTS FOR PUBLIC BOARD

Original Meeting Date	Ref	Topic	Action	Resp	How Dealt with	Delivery date	Completed Date
10 February 2014	**B01**	Overview of Heart Disease and Diabetes	The number of annual CVD checks to be provided by the PHO.	Ashley Bloomfield	TeAHN Presentation	May	
	B02		Circulate to the Board a map of deprivation by mesh block	Ashley Bloomfield	Email	March	Completed
	B03		Report back on the PHO cardio vascular disease and risk programme as part of their bi-annual reports to the Board.	Bridget Allan	TeAHN Presentation	May	
1 November 2012	**AP74**	Annual Workplan	Management to review the annual work plan and integrate service visits when an agenda is light.	Board Secretary	CE's Report	Ongoing	
	AP75	Chief Executive Report	A plan on opportunities for smoking cessation identifying what we will do differently will be provided to CPHAC.	Ashley Bloomfield	CPHAC	April CPHAC	
4 October 2013	**AP69**	Maori Health Targets	TeAHN to provide an update at their next presentation on the strategy for addressing Maori health targets. Maori Health Service could be requested to assist with this strategy.	CE TeAHN	Presentation	May	

Pacific Peoples Health -an overview

Hutt Valley District Health Board

21 March 2014

Presentation Outline

- Pacific Health Journey
- Pacific Population Demography
- Our Health issues
- What we are doing well
- What's not going so well
- What could be done differently to improve our health

Pacific Health Journey

- 2000 — DHB Reform
- 2001-2003 — Race-based policy introduced *Pacific by Pacific for Pacific*

  Pacific Health Sector established and developed

  Pacific community engaged and participated (Pacific Advisory Group)

  HVDHB Pacific Health unit set up

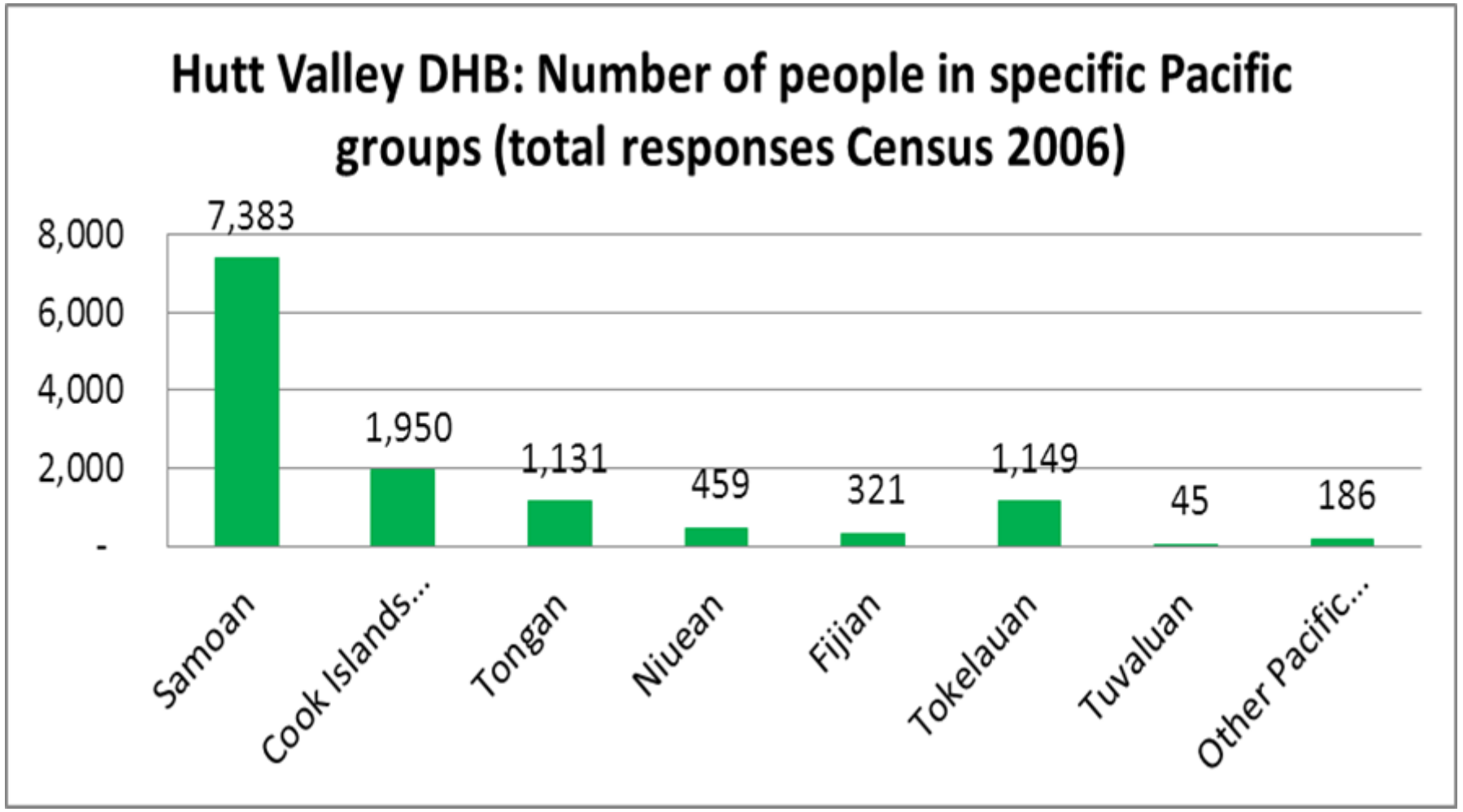
  Pacific Provider Capacity & Capability Funding

  Cadetship programme started

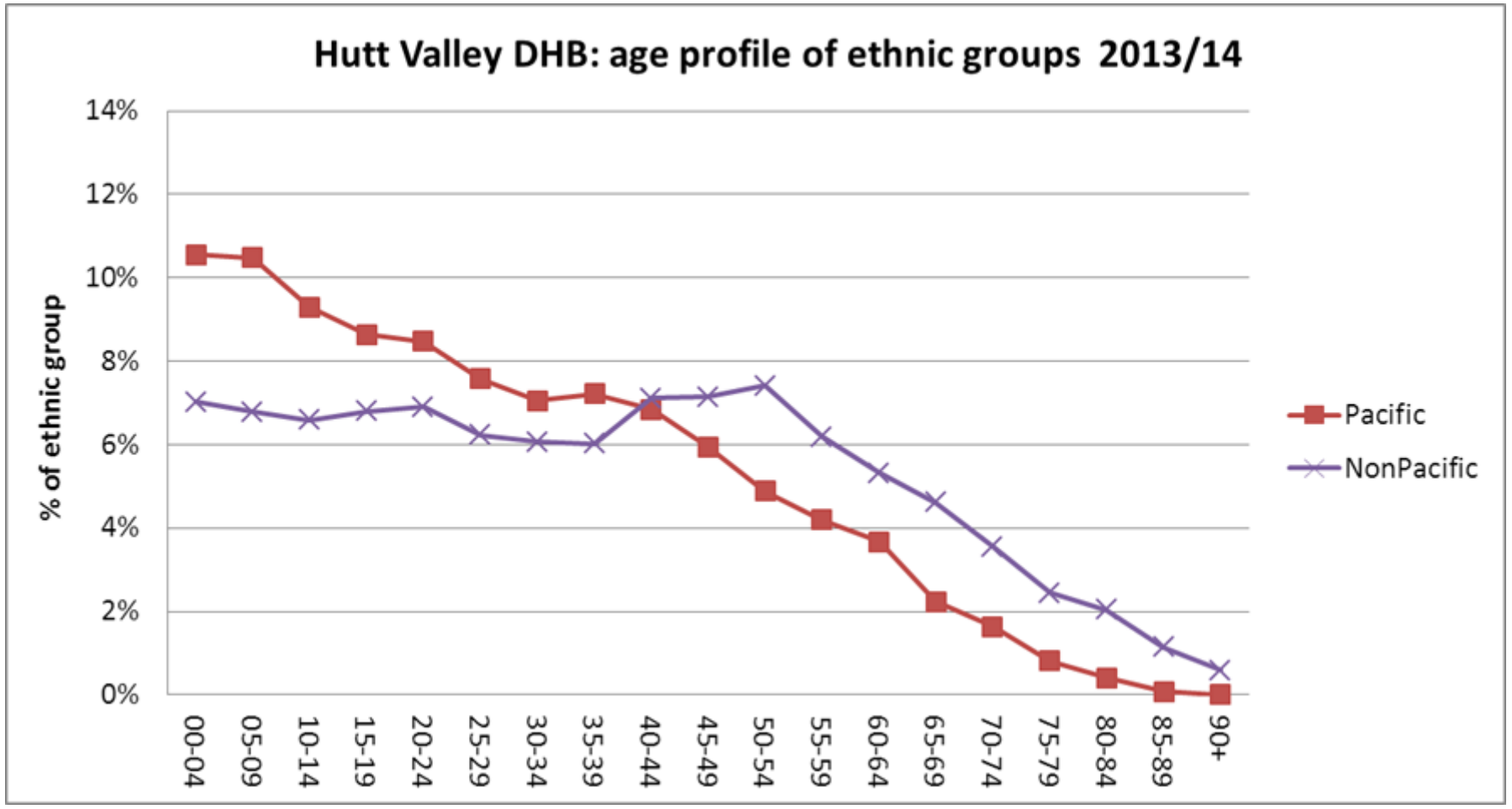
Journey con't

- 2004 HVDHB Pacific Action Plan '***Ili ole Ola'*** launched
- 2010 Action Plan reviewed –changed direction
- 2011 Joint sub-regional Pacific Advisory Health Group set up
- 2013 Appointment Director of Pacific Health Wairarapa & Hutt Valley
- 2014 Start of Pacific Health conversation in the WPDHB

Pacific population

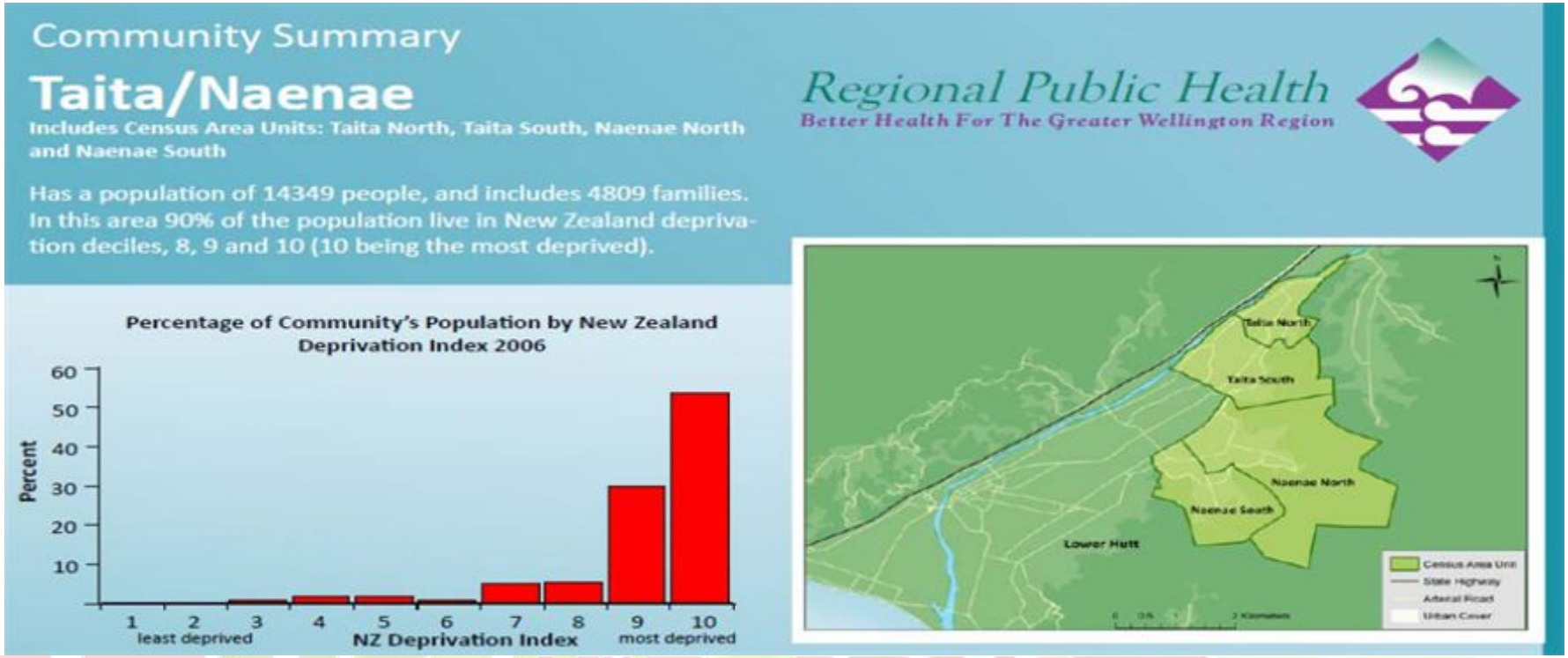


Pacific population : age profile



Where do we live?

- Lower Hutt, rather than Upper Hutt – some in our most deprived communities.
- Taita/Naenae: 3675 Pacific people



Health of Pacific People

Risk and Protective factors

Pacific people in the Hutt Valley have

- Higher prevalence of obesity
- Lower rates of breastfeeding
- Lower number of pre-school dental enrolment
- Lower consumption of vegetables and fruit
- Lower number of uptake for cervical and breast screening
- Higher DNA rates

Health service utilisation

- Pacific people have more avoidable hospitalisations for conditions including :

  Skin infections, dental conditions, rheumatic fever, asthma, gastroenteritis, pneumonia

- Poorer access to

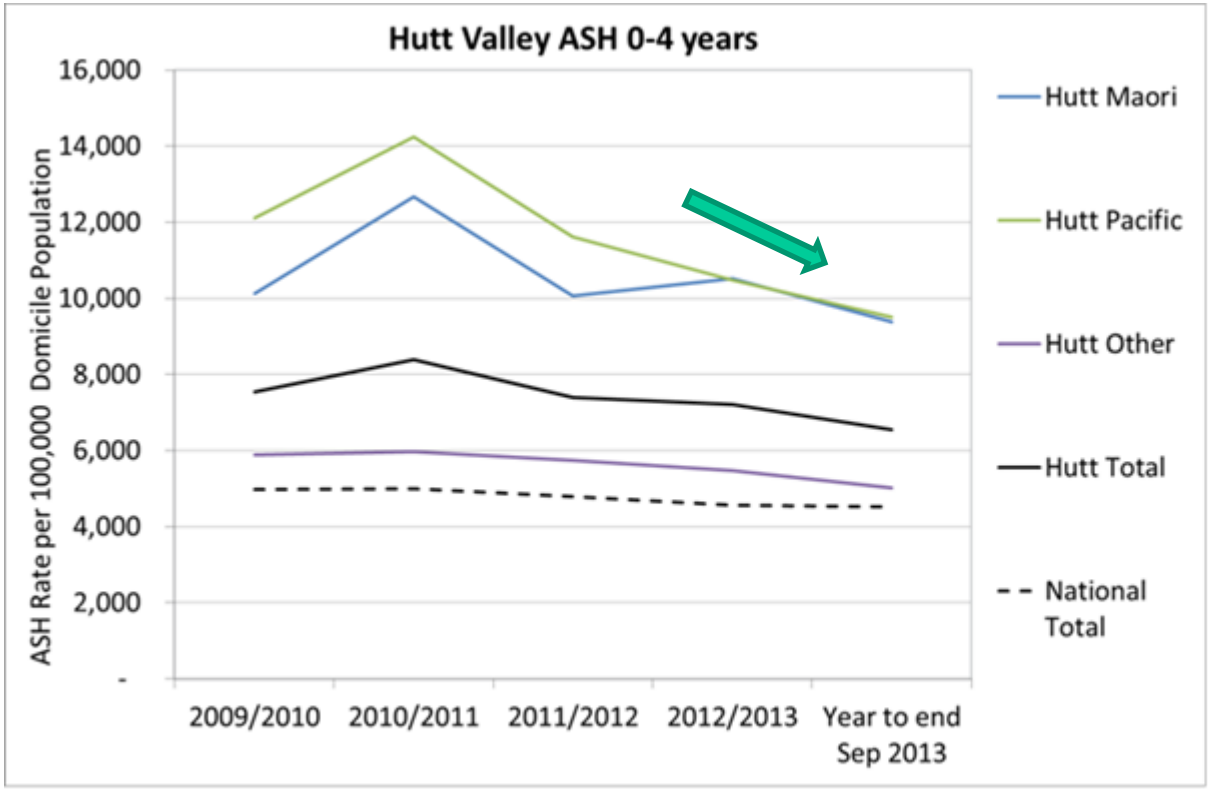
  Oral health checks, breast and cervical cancer screening

- Health literacy, quality of care and cultural competence of providers

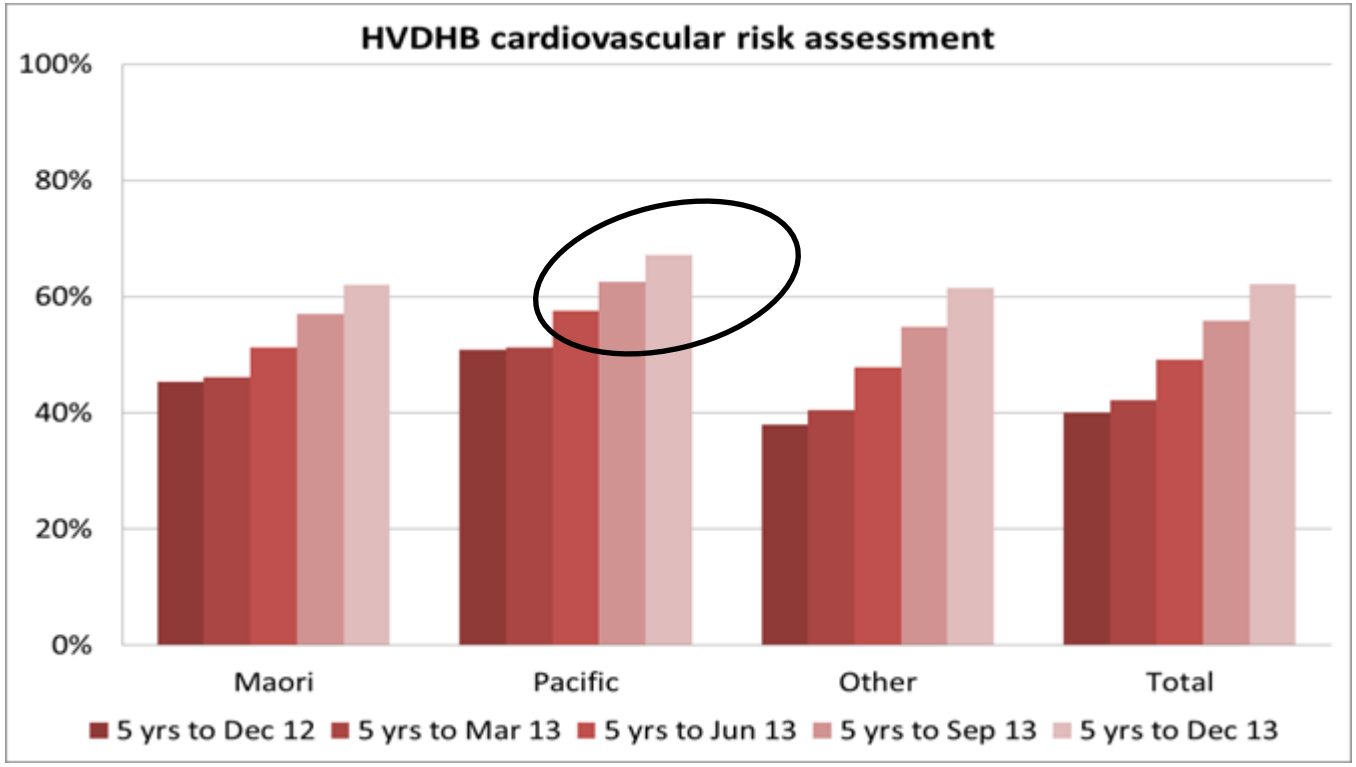
- Higher rates of **DNA** (did not attend) to appointments

What are we doing well?

Ambulatory sensitive hospitalisations for 0-4 years

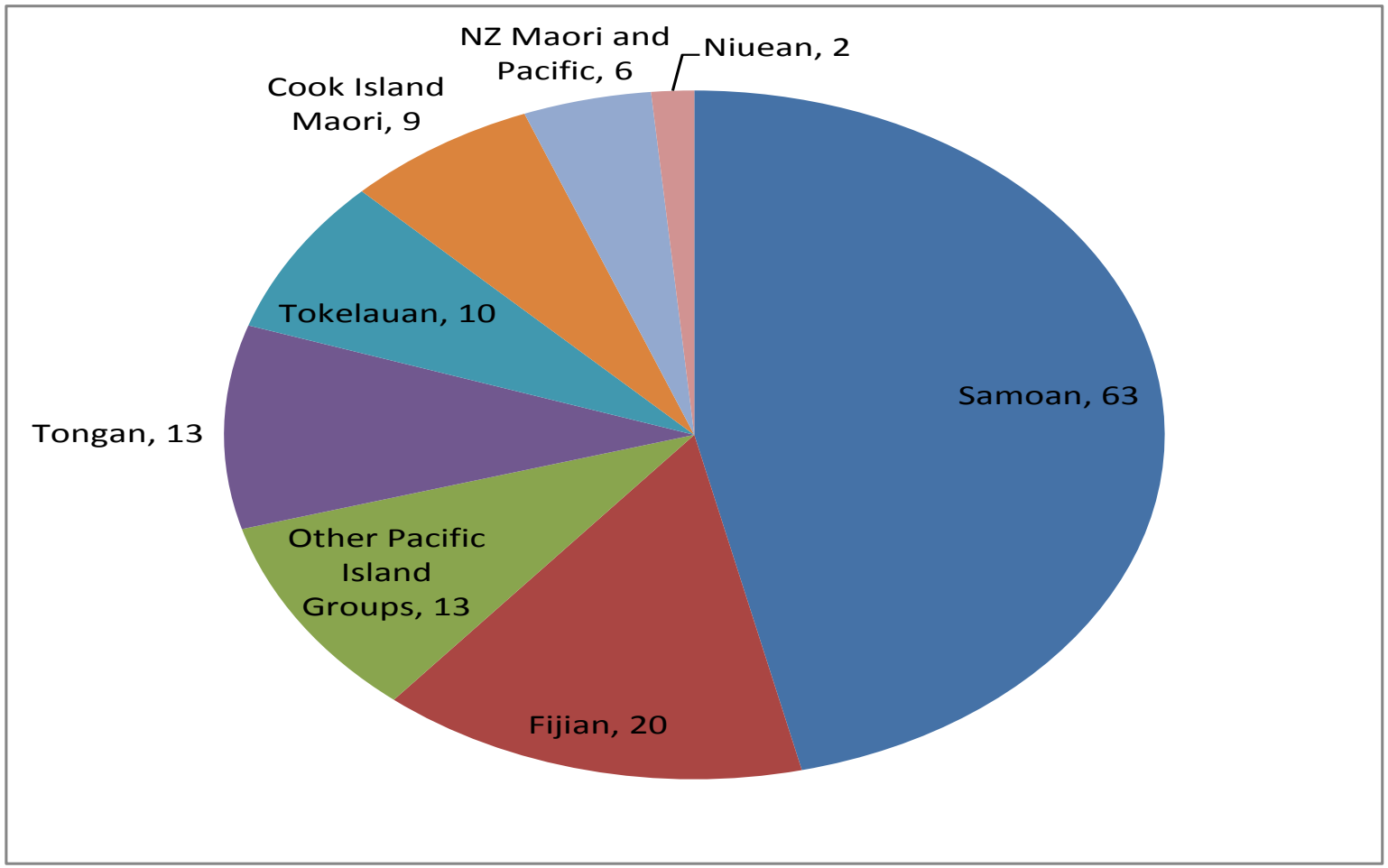


Cardiovascular Disease risk assessment



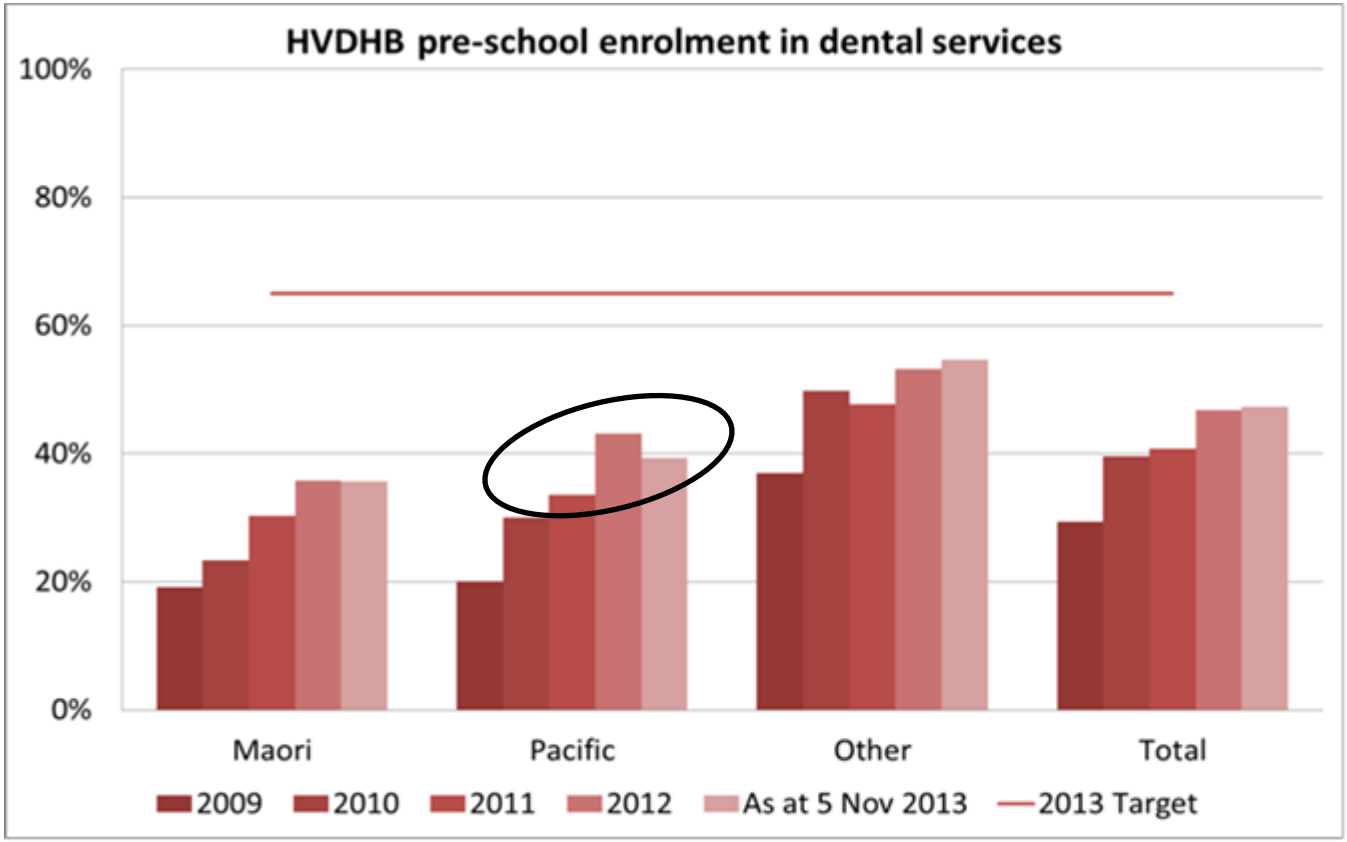
Diabetes management and Immunisations rates improving

Pacific workforce as at January 2014

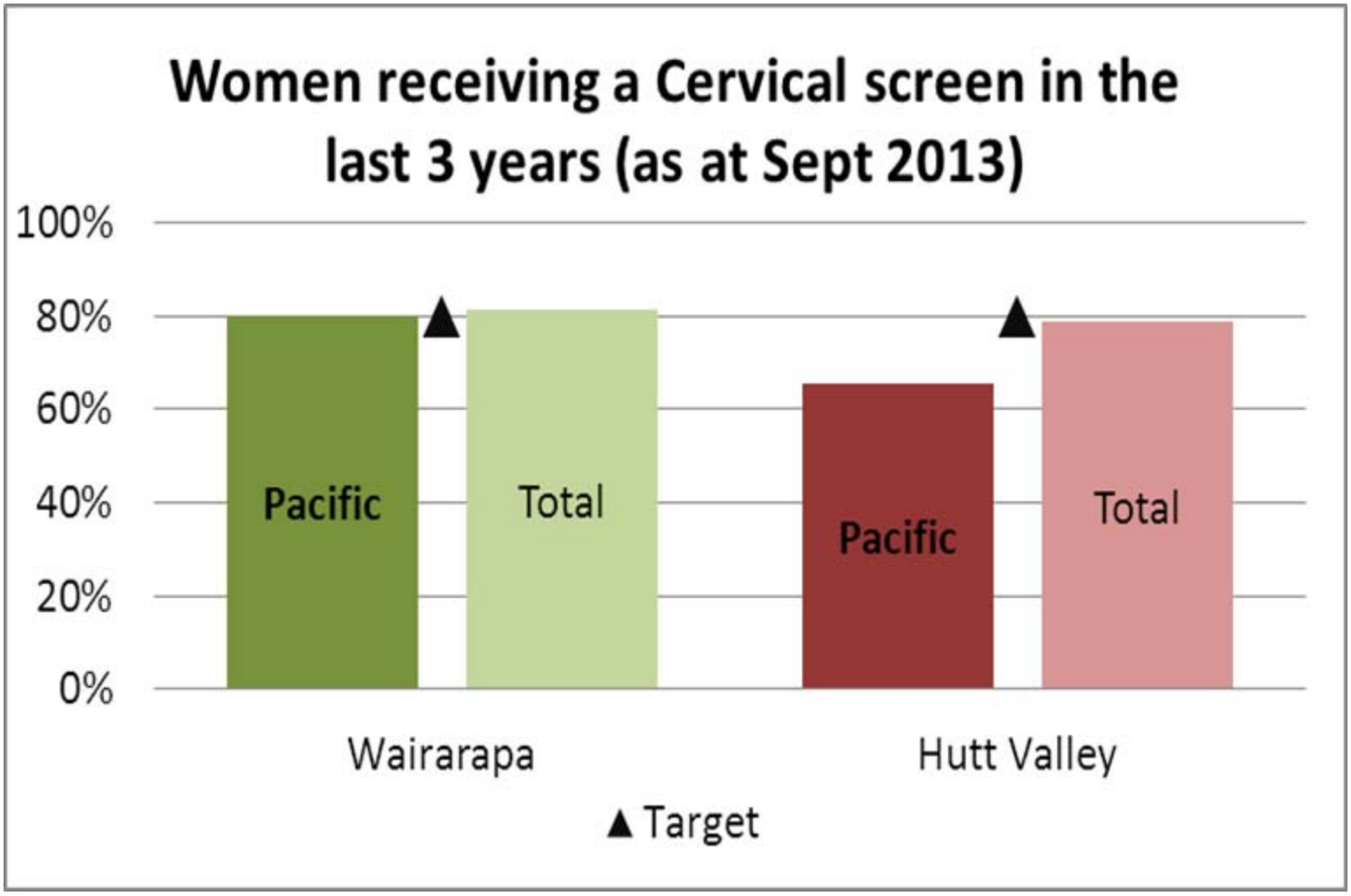


What's not going well?

Pre-school dental enrolment



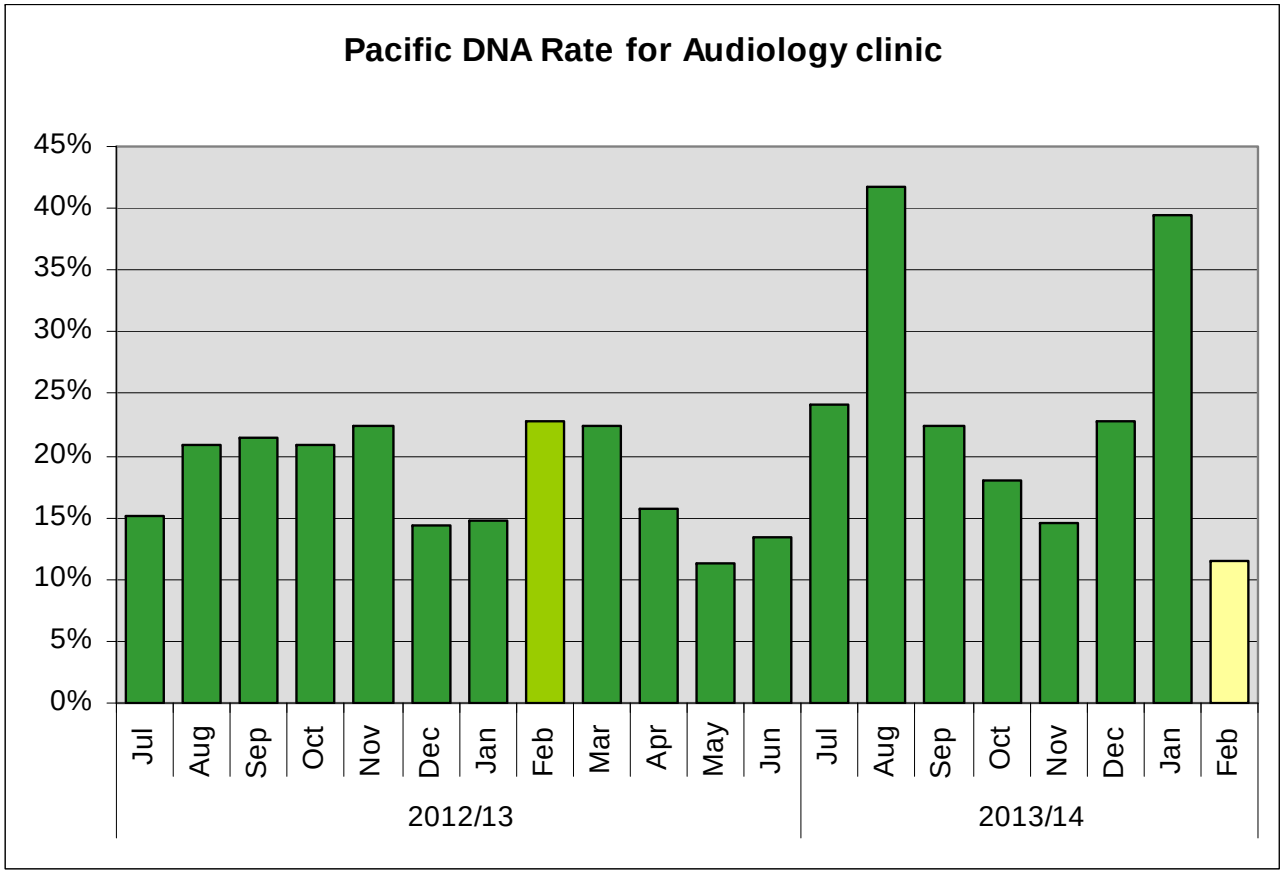
Screening: Breast and Cervical



Action on DNA – Feb 2014

- **Priority** clinics identified:
  - Audiology, ENT, Paeds and Rheumatology
  - Met with managers of each service
- **Reminder** phone calls
  - Connecting in Samoan, Tongan, Tokelauan
  - Grandparents
- **Radio**: adverts and talkback

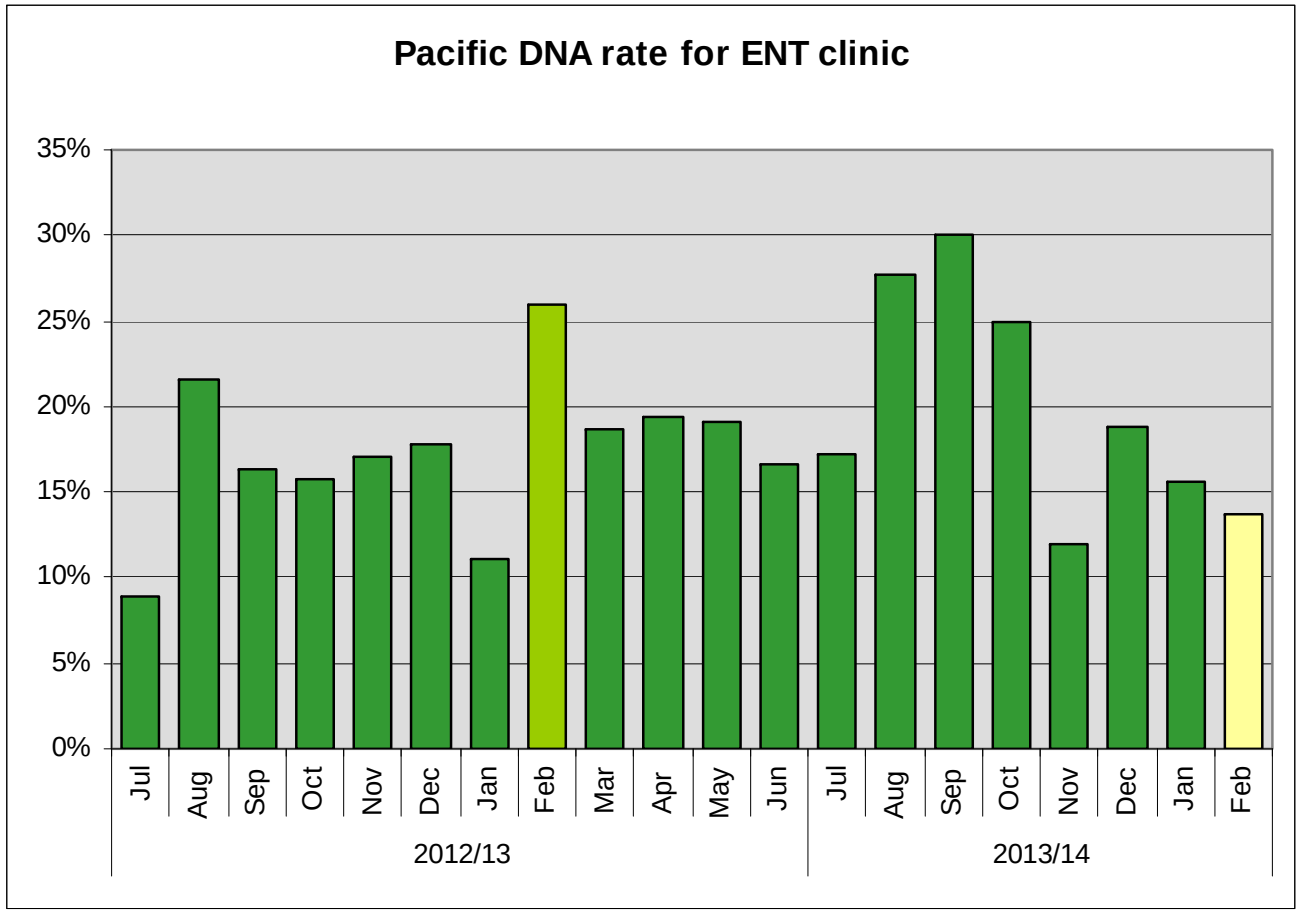
Audiology



11% DNA rate in February, 4 of 35 people didn't attend

Average for 2013/14 was 25% before reminders

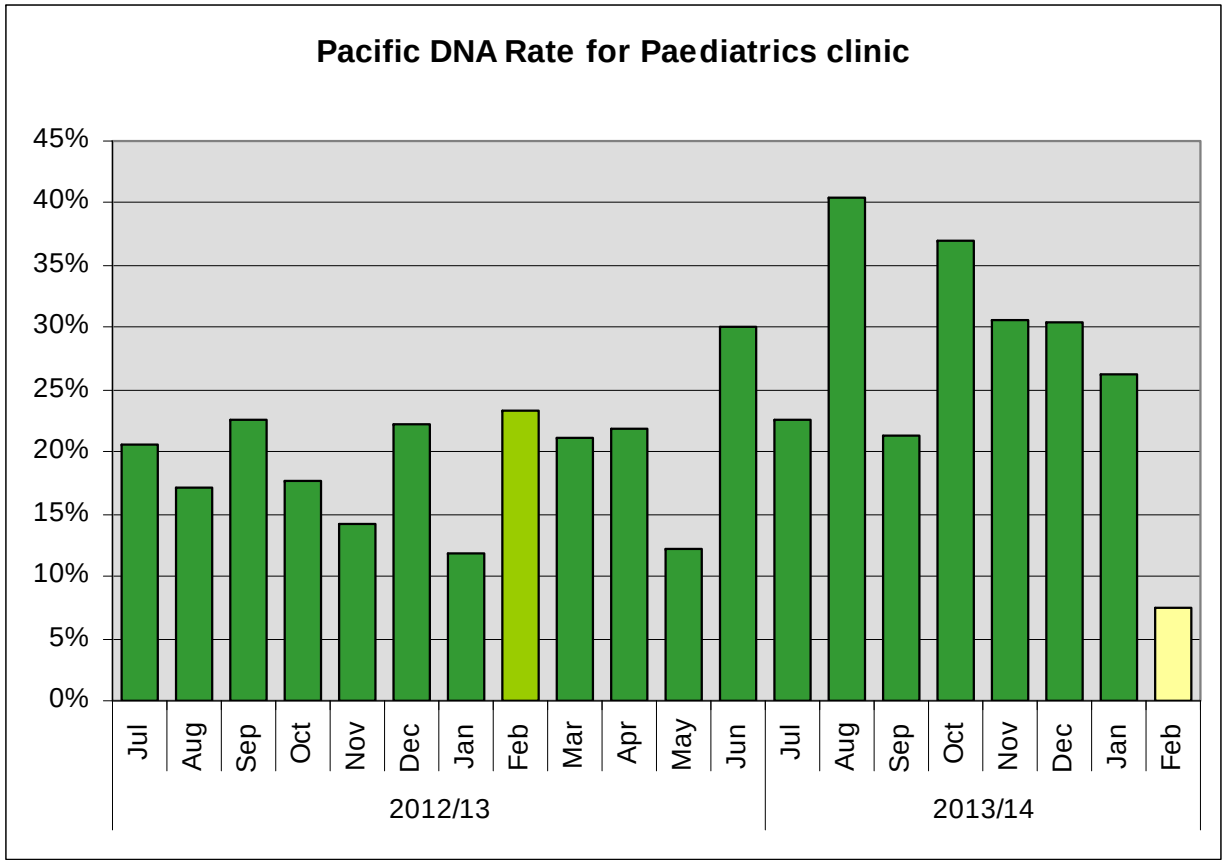
ENT



14 % DNA rate in February, 6 of 44 people didn't attend

Average for 2013/14 was 21% before reminders

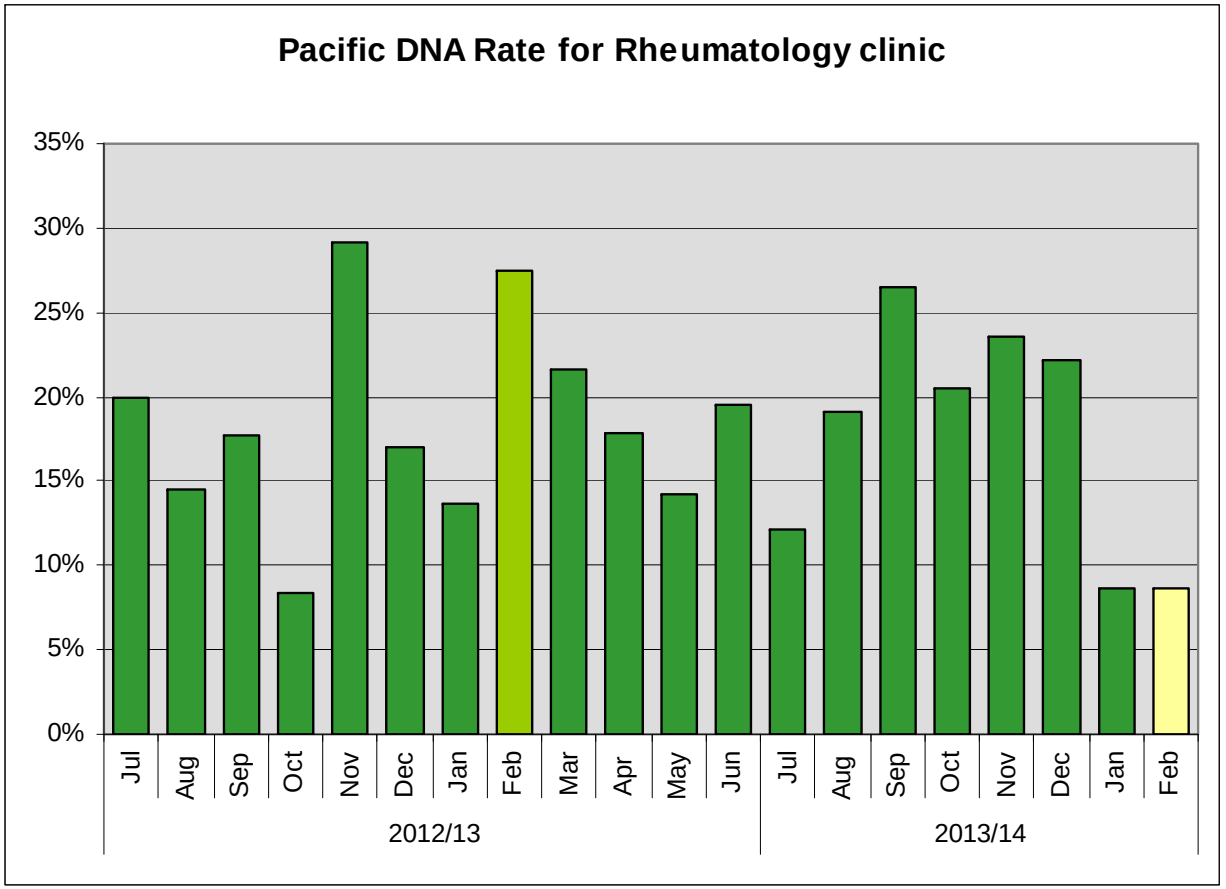
Paediatrics



8% DNA rate in February, 3 out of 40 people didn't attend

Average for 2013/14 was 30% before reminders

Rheumatology



9% DNA rate in February, 4 of 46 people didn't attend

Average for 2013/14 was 19% before reminders

Providers of health services to Pacific population

Pacific led, in community

- Pacific Health Service-Hutt Valley
- Naku Enei Tamariki (NET)
- Vakaola Pacific Navigation Services

PHOs: Te Awakairangi Health Network, Cosine PHO

Regional Public Health

Pacific Health Unit (DHB)

Pacific Health Unit

- Important of Greetings: *To connect*
  - *Talofa lava (**Samoa**), Malo e lelei (**Tonga**), Fakalofa lahi atu (**Niue**), Talofa koutou (**Tuvalu**)*
  - *Mauri (**Kiribati**), Kia Orana (**Cook Is**), Ni Sa Bula Vinaka (**Fiji**), Malo Ni (**Tokelau**)*
- PHU focuses on improving responsiveness of DHBs to the needs of Pacific patients when in our care
- To facilitate and connect all those who are involved in the care of Pacific patient when in the health system
- To give advice, information and support to DHB staff for and with Pacific issues

What could we do differently?

- Connect and have meaningful engagement with Pacific community leaders
- Identify health priorities for Pacific population
- Develop strategies to address and monitor progress
  - Pacific Action Plan
  - Review ability of DHB systems to meet the needs of Pacific communities. For example, recording ethnicity data, dental preschool enrolment
- Workforce development - scholarship initiative

PUBLIC

	BOARD DECISION PAPER
	Date: 10 March 2014

Author	Hiranthi Abeygoonesekera Chief Legal Counsel CCDHB
Endorsed By	Virginia Hope, Chair Hutt Valley DHB and Capital & Coast DHB Derek Milne, Chair Wairarapa DHB
Subject	**Board Governance Manual**

RECOMMENDATION

It is recommended that the Boards **ADOPT** the attached Board manual as being applicable for Wairarapa DHB, Hutt Valley DHB and Capital & Coast DHB.

ADDENDUMS

1. Board Governance Manual

1 INTRODUCTION

All District Health Boards (DHB) are required to have a Board Governance Manual that reflects good practice standards and the range of legislation that applies to them. It was agreed by all three Boards that the CCDHB Board manual should be adopted with some minor changes. It also incorporates legislative changes that will be applicable to the Boards.

2 WAIRARAPA DHB, HUTT VALLEY DHB AND CCDHB BOARD GOVERNANCE MANUAL

The current CCDHB Board Governance Manual has now been revised with the following amendments:

2.1 Removing the term CCDHB and using the term DHB to reference application to Wairarapa DHB, Hutt Valley DHB or CCDHB and acknowledging that the manual applies to all three DHBs.

2.2 Section titled State Sector Act and Public Finance Act amended to reflect recent amendments arising from the Government's state sector reforms, in particular concerning the drive to improve performance at an entity, sector, and system-wide level; promote leadership and workforce capacity; and promote and reinforce standards of integrity and conduct across the state services.

2.3 Inclusion of the amendments, to the Crown Entities Act, that will come into effect from 1 July 2014. These changes relate to a DHB having to adhere to any whole of government direction issued jointly by the Minister of Finance and the Minister of State Services and to encourage greater collaboration between Crown entities and other statutory entities.

In addition, from 1 July 2014, a DHB will only be required to provide a statement of intent to the Minister of Internal Affairs once in every 3-year period.

The content of the statement of intent will change and will:

- Encourage a focus on strategic direction as it will need to cover the next four years; and
- Be less prescriptive about how a DHB explains and reports its strategic objectives.

In addition to the changes in content, the DHB will have to:

- Provide a draft of the statement of intent to the Minister of Internal Affairs at least two months before the start of the financial year; and
- The statement of intent will need to be published on the DHB's website as soon as possible after it has been finalised.

The DHB will also have to produce an annual Statement of Performance Expectations, which will provide the informational base for the annual report. The same process will apply for preparing this statement as for the Statement of Intent.

2.4 Removing repetition and clarifying the NZPHD Act provisions and the Crown Entities Act provisions and generally tidying up wording to create greater clarity.

2.5 Including a separate page reflecting consultation with Maori

In consultation with the Executive Director of Maori Health 3 DHB Riki Nia Nia a separate page setting out the statutory obligations for consultation with Maori has been incorporated. This replaces the single document of the Maori partnership Board MOU as an attachment. The new page confirms the importance of the Board's obligation to work with Maori and acknowledges that the Moari partnership Board approach is one way through which this can occur.

2.6 Amendments to the Standing Orders to reflect the discussions at the Wairarapa DHB and Hutt Valley DHB Boards in relation to having a process to raise matters under the General Business section around whether the Board would like to debate a matter and how that might occur rather than to debate the matter before giving management an opportunity to clarify. It was also acknowledged that this process should not be used to resuscitate decisions that have already been made by the Board. This amendment is reflected in 2.5.1(d) of the Standing Orders. The standing orders have also been changed to reflect the correct legal position that when motions or resolutions are passed that the persons moving and seconding must be recorded. This was not stipulated in the Standing orders previously, but was an accepted practice.

2.7 Confirming that Board members may refer any complaints they receive to the Chief Executive of the DHB.

2.8 Inserting links to websites for more information.

2.9 Adding a glossary, to explain the use of abbreviations in the manual.

2.10 Reformatting the manual, to make provision for each DHB, to insert documents that may be specific to it. This is reflected by having separate Appendices that provide for the inclusion of DHB specific documents.

PUBLIC

HUTT VALLEY DHB / Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**BOARD DECISION PAPER** **February 2014**
Authors	Virginia Hope, Capital & Coast and Hutt Valley DHB Chair Derek Milne, Wairarapa DHB Chair
Subject	**Board Committee Memberships within the Lower North island (LNI)**

RECOMMENDATION

It is recommended that the Board:

a. **AGREE** to co-opt members from either Wairarapa, Hutt Valley and/or Capital & Coast as set out in this paper for the CPHAC/DSAC and HAC committees, as applicable**.**

b. **NOTE** the membership change for the Capital & Coast FRAC committee.

BACKGROUND AND PURPOSE

For the purpose of this paper to to agree to the amendments of co-opted members following discussion at the Capital & Coast DHB Board on 14 February 2014.

(a) Statutory Committees

Board	CPHAC	HAC
CCDHB	David Choat Chris Laidlaw Helene Ritchie Peter Douglas (FRAC Chair)	Sue Kedgley Nick Leggett Derek Milne
HVDHB	Virginia Hope Wayne Guppy (FRAC Chair) Sandra Greig Ron Mark	Virginia Hope John Terris Katy Austin
WDHB	Derek Milne (Chair) Leanne Southey (FRAC Chair) Helen Kjestrup Janine Vollebregt Liz Falkner	Rob Irwin Fiona Samuel Alan Shirley

* CPHAC and HAC will retain the Maori representation and HAC a PHO representative.

(b) Non-Statutory Committee - FRAC

Wairarapa	Hutt Valley	Capital & Coast
Leanne Southey (Chair) Rob Irwin Ron Karaitiana Rick Long Derek Milne	Wayne Guppy (Chair) David Bassett Peter Douglas Virginia Hope Ken Laban David Ogden Jaimes Wood	Peter Douglas (Chair) Judith Aitken Roger Jarrold Darrin Sykes Derek Milne Virginia Hope

PUBLIC

HUTT VALLEY DHB	**BOARD DECISION PAPER**
	Date: 5 March 2014

Authors	Dr Stephen Palmer and Peter Gush, Regional Public Health
Endorsed By	Dr Ashley Bloomfield, Director SIDU and GM Population Health
Subject	Position Statement - Community Water Fluoridation

RECOMMENDATION

Following endorsement from the Community and Public Health Advisory Committee and Disability Support Advisory Committee it is recommended that the Hutt Valley District Health Board **ADOPT** the attached Position Statement regarding Community Water Fluoridation.

1 BACKGROUND

At their February 2014 meeting CPHAC/DSAC endorsed the proposed Board Position statement on Community Water Fluoridation (CWF) and recommended that it be adopted by the three sub-regional Boards.

Decisions regarding CWF currently rest with Territorial Local Authorities (TLAs) with the health sector frequently looked to for advice. The Ministry of Health, on their website, state:

> "The Ministry of Health strongly supports water fluoridation as a safe, effective and affordable way to prevent and reduce tooth decay across the whole population. Most tooth decay is preventable, and water fluoridation is a simple way to prevent it."

Those opposed to CWF frequently make use of the TLA Annual Planning processes to seek a review of a council's decision to fluoridate drinking water, e.g. Kapiti Coast District Council, in response to lobbying from those opposed to CWF, have agreed to consult their community as part of their annual planning process this year. As part of the local body elections in 2013 Hamilton City, Hastings City and Whakatane District councils all held referenda; the communities in all three TLAs voted overwhelmingly to either reinstate or continue with CWF.

2 RATIONALE FOR A STATEMENT ON CWF

(a) CWF is an effective public health measure contributing to the maintenance of oral health, prevention of tooth decay and reduction in health inequalities.

(b) Any reduction in CWF will detrimentally impact on the oral health of our communities; particularly our Maori and Pacific populations (note the reference to the Lee and Dennison 2004 study in the appendix).

(c) A statement on CWF is consistent with, and fulfills each DHB's legal obligations in terms of the New Zealand Public Health & Disability Act to improve, promote and protect the health of the people and communities, and to reduce health disparities by improving health outcomes for Maori and other population groups.

PUBLIC

Position Statement
Community Water Fluoridation

Position Statement

The Hutt Valley District Health Board endorses community water fluoridation as an effective public health measure contributing to the maintenance of oral health, prevention of tooth decay and reduction in health inequalities. Community water fluoridation is a low cost measure that benefits people of all ages with natural teeth and has proven over the last 65 years to be very safe. Local drinking-water supplies that are already fluoridated should remain so. Where technically feasible, where local supplies are not fluoridated, local authorities are encouraged to implement water fluoridation programmes as soon as possible to improve the oral health of their communities.

Background

The effectiveness of community water fluoridation (CWF) has been well documented in the scientific literature over the past 65 years. Before the first community fluoridation programme began in the late 1940s, data from the 1930s and 1940s revealed 50 to 60 percent lower tooth decay rates in children consuming naturally occurring fluoridated water compared with children consuming fluoride-deficient water.

Over the last 65 years, numerous studies have been published making CWF one of the most widely studied public health measures in history. Recent studies prove water fluoridation continues to be effective in reducing tooth decay by at least 25 percent in adults and children, even in an era with widespread availability of fluoride from other sources, such as fluoridated toothpastes. Studies continue to prove that the low levels of fluoride used in water fluoridation are safe.

Caries prevalence and severity was compared in a cross-sectional study of communities with and without CWF in New Zealand (Wellington and Canterbury) using 1996 school dental records data (Lee and Dennison 2004). The results showed children living in fluoridated communities had significantly better oral health compared with those living in non-fluoridated communities. The differences between the two groups were greater for Maori and Pacific children of low socio-economic status[1].

The US Centers for Disease Control and Prevention (CDC) state that “Community water fluoridation is a safe, effective and inexpensive way to prevent dental caries”. The CDC holds community water fluoridation as one of ten great public health achievements of the 20th century alongside such achievements as vaccinations and control of infectious diseases.

The Hutt Valley District Health Board notes professional, scientific and government entities in New Zealand and around the world, including the World Health Organization and the Ministry of Health, endorse CWF. The Ministry of Health recommends the adjustment of fluoride to between 0.7 and 1.0 parts per million in drinking water as the most effective and efficient way of preventing dental caries in communities receiving a reticulated water supply, and strongly recommends the continuation and extension of community water fluoridation programmes where technically feasible[2].

> The Ministry regularly reviews international scientific research on fluoridation to make sure its position is based on evidence, is consistent with best practice, and is appropriate for the New Zealand context. An independent expert panel set up by the National Fluoridation Information Service carries out formal reviews for the Ministry.

[1] M. Lee and P. J. Dennison. "Water fluoridation and dental caries in 5-and 12-year-old children from Canterbury and Wellington." *New Zealand Dental Journal* 100.1 (2004): 10-15.

[2] In *The Drinking Water Standards for New Zealand 2005* the Ministry of Health recommends the adjustment of water fluoride to between 0.7mg/L and 1.0mg/L for oral health reasons. These standards also set a Maximum Acceptable Value (MAV) for fluoride of 1.5mg/L. At this level or below it is considered to be safe to consume drinking-water over a lifetime.

New Zealand as a country adopted CWF relatively early on to help address widespread poor dental health. Before CWF in New Zealand it was commonplace for young adults to have their teeth removed and be fitted with dentures. Following trials in Hastings in the 1950s, CWF was introduced in many drinking-water supplies in the 1950s and 1960s.

Capital and Coast DHB and Hutt Valley DHB have some of the highest proportions of their populations covered by CWF with 96% and 94% respectively. There are only two urban areas not covered by CWF; Paekakariki and Petone; it is likely that CWF is technically feasible for both communities.

For Wairarapa DHB the coverage is only 45% with Masterton City being fluoridated. There are four urban areas where CWF is likely to be technically feasible; Carterton, Greytown, Featherston and Martinborough. Initiating CWF programmes for these communities would bring the coverage up to near 70%.

The Hutt Valley District Health Board is aware that there is a small but active local group of people opposed to CWF who, with assistance from others nationally and internationally, continue to lobby local councils to remove CWF. It is important that local authorities continue to receive evidence-based advice from health professionals at their local DHB, who are committed to improving oral health and the overall health status of their communities.

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa / HUTT VALLEY DHB	**BOARD INFORMATION PAPER**
	Date: 6 March 2014
Author	Graham Dyer, Chief Executive
Subject	**Chief Executive's Report – March 2014**

RECOMMENDATION

It is recommended that the Boards **NOTE** the information contained in this report.

ADDENDUMS

1. Quarter Two 2013/14 Health Targets Results
2. Feedback on Individual DHBs 2013/14 Health Target Results from Target Champions
3. Balanced Scorecard
4. Update on the 3D Hospital Services Plan
5. Regional Public Health Wairarapa Nutrition and Physical Activities
6. Nursing Update
7. Communications Update
8. Official Information Act Requests
9. January Financial Report

1 GOVERNMENT PRIORITIES AND HEALTH TARGETS

1.1 Quarter Two 2013/14 Health Targets Results

The Quarter Two Health Target results have now been published and are included as Appendix One. Wairarapa DHB met or exceeded five of the six targets, and was top performer in the country for more heart and diabetes checks and helping smokers to quit, and first equal for immunisation for eight month old babies. All twenty DHBs shared first place for shorter waits for cancer treatment. Wairarapa ranked fifth for shorter stays in the Emergency Department (ED) and 11th for improved access to elective surgery (we exceeded both these targets).

Hutt Valley DHB met or exceeded four of the six health targets, including shorter stays in ED, improved access to elective surgery and increased immunisation. There have been significant improvements in the result for More heart and diabetes checks with Hutt Valley improving by 6.3% since the last quarter

Attached as Appendix Two is feedback from the Ministry's Target Champions on the DHB's Quarter Two Health Target results.

1.2 PHO Health Targets

Compass Health

The seven Wairarapa General Practices have been successful with the three primary health care health targets for Quarter Two. Wairarapa was again top for More Heart and Diabetes Checks at 84% so

making good progress towards the June 2014 target of 90%. They were also top for Helping Smokers to Quit at 98%, which has exceeded the target of 90% and first equal for eight month old immunisations at 96%. The immunisation results are an example of great collaboration between the general practices, Whaiora Outreach service and primary care base NIR and Immunisation Facilitator roles.

The Compass Health Smoking Cessation and CVD risk assessment campaign is continuing until June 2014 to support achievement of these targets and over the coming months the local PHO team will in particular be working closely with Masterton Medical Limited (MML) to support them to achieve these targets.

Te Awakairangi Health Network (TeAHN)

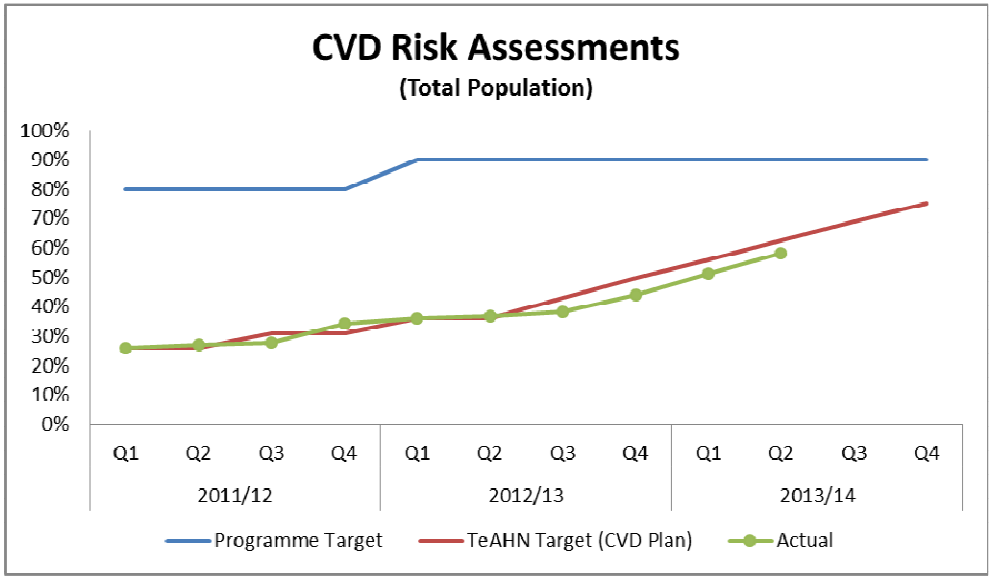
The aim of the Te Awakairangi Health Network's Cardiovascular Disease Risk Assessment (CVDRA) Programme is to increase the rates of cardiovascular risk screening and management for Hutt Valley people, particularly those identified as being at higher risk (Māori, Pacific, Indo-Asian people and/or people living in Quintile 5 areas, referred to as "high needs").

The overall eligible total population for TeAHN's CVDRA programme is 34,072 (composed of High Needs population of 12,227 and 'Other' population of 21,845).

Over the past two and a half years, TeAHN and its predecessor organisations have increased the number of people who have received checks, with significant improvements in each of the past three quarters (to December 2013).

TeAHN CVD risk asseassments						
	CVDRA	Eligible Popn	Programme Goal (%)	Programme Goal (no)	Number achieved	Percentage achieved
2011/12	Q1	32,454	80%	25,963	8,438	26.0%
	Q2	32,735	80%	26,188	8,871	27.1%
	Q3	32,957	80%	26,366	9,162	27.8%
	Q4	33,143	80%	26,514	11,335	34.2%
2012/13	Q1	33,376	90%	30,038	11,982	35.9%
	Q2	33,554	90%	30,199	12,381	36.9%
	Q3	33,668	90%	30,301	12,929	38.4%
	Q4	33,774	90%	30,397	14,928	44.2%
2013/14	Q1	33,933	90%	30,540	17,374	51.2%
	Q2	34,072	90%	30,665	19,864	58.3%
	Q3		90%			
	Q4		90%			

Provisional data indicates that cumulatively (to the end of December 2013) 58.3% of the Total Population of TeAHN who are eligible have received a CVR assessment. This means that TeAHN has met the Ministry of Health (MOH) target of 58% for December 2013. TeAHN has done even better for the High Needs population, achieving 65.2% uptake. TeAHN has therefore met its PPP targets for the High Needs (62.9%) and Total Population (53.9%) indicator for the 2013 year.



1.3 Balanced Scorecard (BSC)

Please find attached as Appendix Three the BSC.

2 IMPROVING PROCESS AND CULTURE

2.1 Clinical and Support Services

A project looking at the provision of a Managed Print Room for the 3DHB's (Wairarapa, Hutt and CCDHB) is progressing steadily. Two preferred providers have recently submitted their RFP's (Request for Proposal) and the steering group will meet next week to evaluate. This project is also looking at the standardisation of forms and processes across the 3DHB's, resulting in considerable savings.

Hutt Valley DHB are the first DHB to trial an automated mailing system with New Zealand Post. This system is currently being used by other Government Departments, including Inland Revenue and the Defence Force. This has been trialled in the Hutt Medical Typing team and will reduce the need for printing and sending mail off site. It has the capability to send electronically all letters directly to NZ Post to print and mail from their facility. Once the trial period has finished, we will look to roll this facility out to other services within Hutt Valley DHB and to Wairarapa DHB.

As part of the recent ratification of the Service and Food Workers MECA, Hutt Valley DHB are leading the way for implementing the NZQA Training Qualifications across both Orderlies and Cleaning Service, with Food Services to follow once their qualifications are finalised. This is an exciting development for these services as it recognises the hard work and dedication that these valuable staff members deliver daily. The staff are extremely enthusiastic about this opportunity to have an NZQA recognised qualification, as many staff have never been given the opportunity to gain formal qualifications. Although there is an initial cost to the DHB for provision of training for these qualifications, this is reimbursed to the DHB once the qualification is achieved.

3. FINANCIAL SUSTAINABILITY

3.1 Financial Result Wairarapa

A favourable result was achieved for January of $24k, accumulating to an unfavourable variance to budget year to date of ($59k). The bottom line result at the end of January was a deficit of ($1,697k) compared to a budget deficit of ($1,638k).

Key results year to date were:

- Funder ($201k) unfavourable
- Governance $94k favourable
- Provider $46k favourable.

3.2 Financial Result Hutt Valley DHB

Unfavourable variance to budget year to date of ($1,348k) has been reported. The bottom line result at the end of January was a deficit of ($3,929k) compared to a budget deficit of ($2,581k).

Key results were:

- Funder ($1,310k) (Dec ($1,543k)) unfavourable
- Governance $37k (Dec $9k) favourable
- Provider ($76k) (Dec ($60k)) unfavourable

4 WORKING WITH OUR NEIGHBOURS

4.1 3DHB Health Services Development (HSD) Programme

Attached as Appendix Four is an update on work undertaken under the 3DHB Health Services Development (HSD) Programme to the end of February 2014, outlining programme highlights, key planned activities and emerging priorities.

4.2 3DHB Executive Director for Maori Health

Riki Nia Nia (Tūhoe, Ngāti Kahungunu) has been appointed to the role of 3DHB Executive Director Māori Health.

This new role brings together the three Māori health teams that currently operate as a virtual team, to co-ordinate our approach to improving health outcomes for Māori across the sub-region, building on the great work already undertaken by each DHB.

Riki brings 17 years of senior leadership experience in the health sector to this role and also currently chairs Tumu Whakarae – the DHB GM Māori National Strategic Reference Group; the Kia Ora Hauora Māori Health Careers Programme steering group, and the Tu Kaha Māori Health Development conference committee. He was previously Director of Māori Health at CCDHB until taking up this role, and his past roles include Director of Māori Health at Wairarapa DHB, and Service Manager of Public Health services at Whanganui DHB.

4.3 Laboratory Services

The Laboratory "One Service" model has gained momentum, with the recent appointment of a Manager across Hutt Valley and Capital & Coast DHBs. The new environment of full partnership in our laboratories will enable us to deliver sustainable, efficient and safe services and provide a platform for our workforce to reach their maximum potential. A planning day has been held to look at the future direction for this service. A competition is currently underway to rename the combined laboratory service. The Laboratory Information System (LIS) project is still on target for Hutt to go live from 5 April 2014.

5. INTEGRATING HEALTH SERVICES INTO A MORE UNIFIED SYSTEM

5.1 Electronic System – Concerto Patient Management System

The school based Public Health Nursing (PHN) team now has one full quarter of information from the new patient management system, which clearly shows the amount of activity that the PHNs have in the schools. There were 578 new referrals (sub regionally) made to the service with a total of 989 open referrals that the PHNs are working with at the end of December 2013. The four top referral conditions were vision, hearing, behavioral and developmental.

These figures do not include the throat swabbing activity for Rheumatic fever which involved 794 swabs taken over the quarter with 54 children having a positive result that required antibiotics.

5.2 Infection Control

At the end of February the infection control teams across the three DHBs looked towards progressing to a single service. One of the first steps in the journey is to create a single infection prevention and control committee, the first meeting of which will take place at the end of March 2014. This will help progress the move towards 3DHB policies and procedures, common data collection and reporting. The executives covering the infection prevention and control teams were present at the meeting, and whilst there is no one identified reporting and delegation it was agreed by both that this needed to happen to progress the move towards 3DHB clinical governance.

5.3 Tihei Wairarapa

The Tihei Wairarapa momentum continues and the team will continue to work hard and ensure that the programme is not impacted significantly by the recent fire at MML. Key focuses for Tihei at present are further rollout of manage my health including the patient portal and using the platform as a shared care planning tool for patients that require a shared care plan. The Integrated Models of Care work continues with a workshop scheduled for the 18 March 2014 to discuss model of care options and prioritisation. The Child Health Executive Group is now called the Child and Youth Service Alliance and covers children and youth. This group have commenced planning priorities for next year and are taking into consideration local and sub-regional needs and developments, these priorities also include the Wairarapa Social Sector Trial. Sub-regional Health Pathways is also a key focus, Dr Tony Becker has been appointed as the local Clinical Editor for the Wairarapa supported by Justine Thorpe, the Tihei Wairarapa Programme Director.

5.4 Hutt INC

Hutt INC (the Alliance Leadership team operating in the Hutt Valley) had its regular monthly meeting on Thursday 27 February 2014. The main items of discussion were:

- Rolling out hernia and rectal bleeding pathways to primary care. This adds to the cellulitis, child gastroenteritis, and COPD pathways already developed and used by Hutt Valley primary and secondary clinicians. The wider sub-regional work around pathways is also progressing well, and will incorporate the Hutt Valley work undertaken to date
- Confirming priority areas for integration work as resources become available, in particular mental health discharge planning, clinical governance across the system, and frail elderly
- Further discussion was had around the implementation of a flexible services pool, where services (and associated funding) are placed (with the agreement of the DHB and PHOs) under the delegated control of Hutt INC. These are expected to include services where patients currently are treated both in the community and hospital, and where leadership of Hutt INC appears to be a strong mechanism for breaking unhelpful silos or facilitating new models of care. Hutt INC agreed the applicable principles, and next steps in determining options for discussion with respective boards.
- Hutt INC is engaged in the Annual Planning process, and will be providing input as the Plan develops.
- Work is underway to develop a POAC programme. Guidance given on the value of sub-regional co-ordination roles, and around identifying current opportunities for improving patent journey through such a role.
- TeAHN, under the sponsorship of Hutt INC, is commencing work on finding ways to improve the sustainability of primary care in the Hutt Valley. Hutt INC recognises that the prevalence of small practice models and aging GP population present a future challenge for the Hutt Valley health system, which needs to be grappled with sooner rather than later. This work is being funded by the MoH following a successful business case by Hutt INC.
- A presentation was received from SIDU on possible areas of work to advance Government priorities in Youth health.

- Advice was sought and provided in relation to several workstreams, including priorities around access to PACS and radiology reports, ways to best engage with secondary clinicians around primary care sustainability, and the use of "Yellow Card" medicines lists.
- Hutt INC was advised that a meeting was to take place immediately following Hutt INC to begin the process of developing a clinical governance approach that brought primary and secondary care together, reflecting the journey of patients across different aspects of the health system.
- Hutt INC will be focused in 2014 on faster implementation of improvements, recognising that the adoption of the Alliance Leadership Team model provides a real platform for change. As part of this sharper emphasis, it has prioritised its work in order to produce a more structured workplan. At this stage, in addition to the work already underway, the next areas for work are arterial fibrillation, frail older people, clinical governance, and mental health discharge planning.

6. OTHER MATTERS OF INTEREST TO THE BOARD

6.1 Overview of Heart Disease and Diabetes.

The Board requested information on what advice Regional Public Health (RPH) are delivering to schools regarding Heart Disease and Diabetes. The child health response to Heart Disease and Diabetes includes the personal health support for individuals as well as a school wide health prevention programme.

The school wide prevention programmes include support to the school for healthy heart, and physical activity programmes from the Public Health Nurse and Public Health Advisor. Nutrition education sessions are also supported and given to the schools. The Child Health team also work with children referred with an obesity problem.

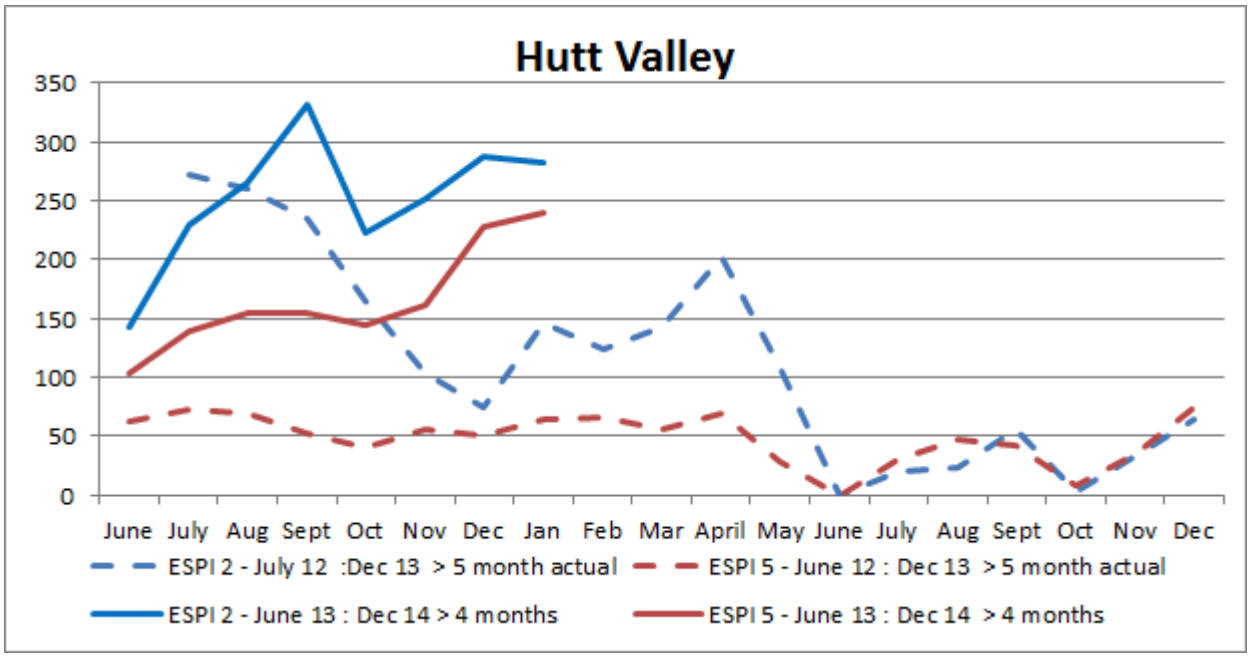
Prior to November 2013 it was possible to refer these children to the Active Families Programme which had been implemented by Sport Wellington but this contract has finished. The aim of this programme was to improve the health and well-being and reduce the burden of disease through better nutrition and regular physical activity. Currently these children will be referred to their own GP for support.

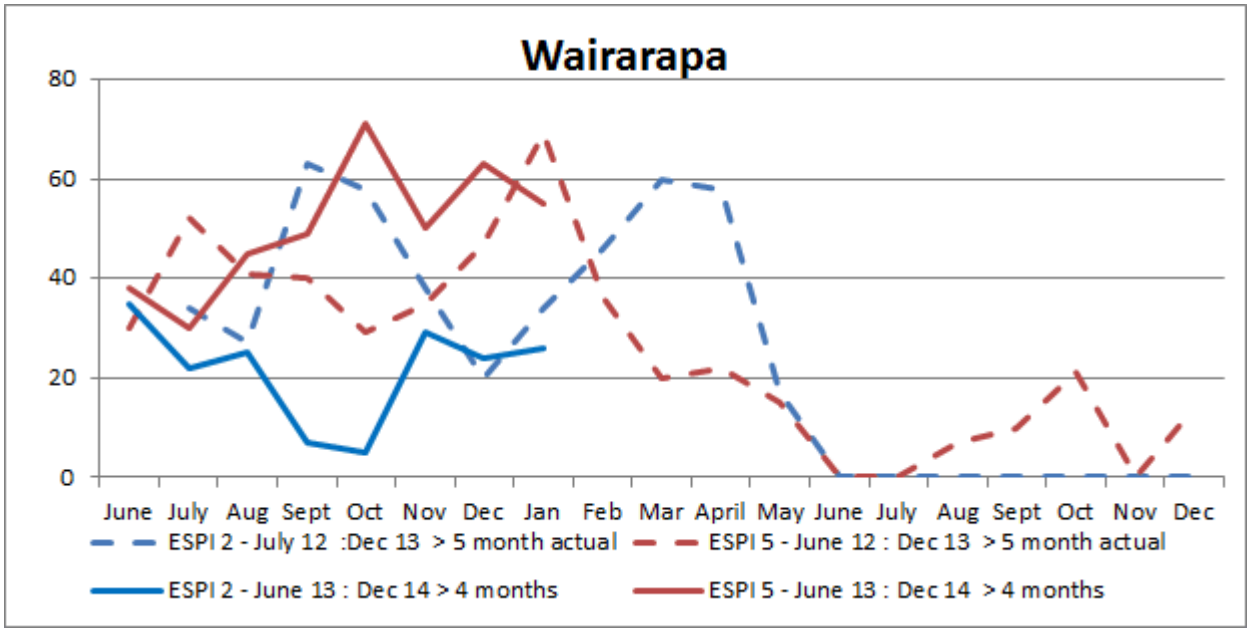
Appendix Five provides more detail regarding these activities.

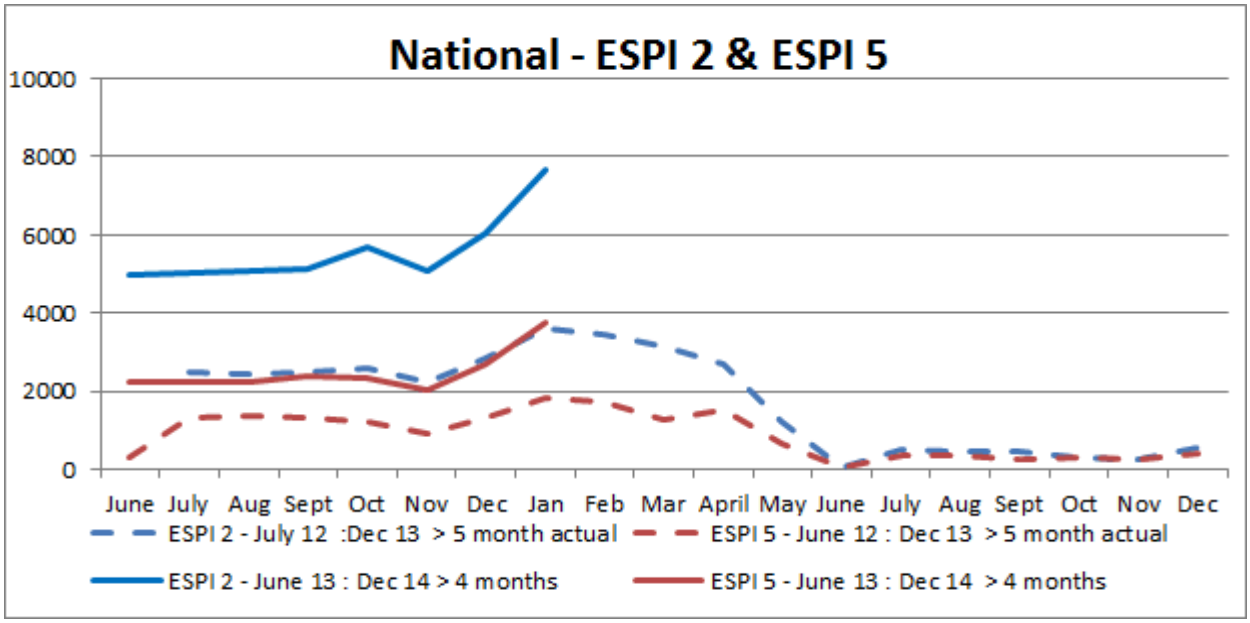
6.2 Elective Services Patient Flow Indicators (ESPIs)

As you know we are currently working towards the next milestone goal of achieving a maximum four month waiting time for first specialist assessment and elective treatment by the end of December 2014.

The following graphs show last year's improvement against the five month elective waiting time goal (dotted lines), and current progress towards four months (solid lines) for Wairarapa and Hutt Valley DHBs, and at a national level. The blue lines relate to the number of patients waiting over the respective time frame for first specialist assessment, and the red lines relate to elective treatment. The most recent data is for January 2014, extracted from National Collections on 3 March 2014.







6.3 Hutt Certification Audit – May 2013

Release of our certification audit data has triggered some adverse media reporting which has presented a very negative perspective of both the report and the Hospital. This is disappointing as it has affected staff morale, and there was significant praise from the auditors on many fronts and the media reports are not reflective of the overall themes of the audit, nor that it is merely a snapshot in time.

In relation to the issue of fleas within the maternity unit in Hutt Valley, the Board will be aware that we took action some time ago to replace carpet with easy to clean lino flooring as we believed that carpet might harbour fleas and make eradication difficult – we raised this with the auditors and advised that the flooring was planned for replacement. Because of the special hospital grade flooring products that were required for longevity, the materials had to be imported from Europe and this has taken some time. However the work has now been completed. We have had a further instance of flea bites being reporting at the time of the flooring works coming to an end; as a result we have ensured that our cleaning schedule is robust (which it is), removed all laundry products from the area and replaced with new, and undertaken deep fumigation of the whole maternity suite. There are no other areas in the Heretuanga block where this has been reported as a problem and the new floors will make our cleaning regime more effective.

6.4 Fire at Masterton Medical

Following the fire at Masterton Medical Limited (MML) on Tuesday 25 February 2014, acute services only were back up and running by 1pm the next day. These services were provided out of MMLs satellite clinic, Hiki Te Ora, across the road in the WINZ building, for the remainder of last week. From Monday 3 March 2014, routine services recommenced from Hiki Te Ora however these are operating at reduced capacity mainly due to the size of the space MML are operating from. B4SC (B4 School Checks) weekly clinics will operate out of Whaiora for the remainder of the month and Flu and Long Term Condition clinics have commenced operation from Waiata House until an alternative premises is secured. Patients referred to the To Be Heard programme (primary mental health) are being seen at the PHO office in Lincoln Road. Specialist nurse clinics are not able to run at MML in the interim due to limited space and Whaiora are looking into their capacity to host extra clinics.

Offers of support from the other six general practices and the community has been overwhelming. Both Compass Health and the SIDU/DHB have been kept informed daily on progress and offered full support where able.

The DHB is supporting MML in finding new accommodation. The most obvious site reviewed is the old Ward 4, where our FOCUS team is housed. The discussion with the Office of Treaty Settlements (OTS) was positive with OTS agreeing to enter into a lease arrangement for up to six months. Our FOCUS team will co locate with MML.

There has been some increase in ED activity, particularly in the less urgent triage 4 and 5 areas, with some of these attributable to access challenges.

6.5 High Court in Taranaki upholds Community Water Fluoridation

In November 2013 New Health New Zealand (Inc.), a private citizens group, took the South Taranaki District Council to judicial review over its decision to extend its community water fluoridation programme to include the towns of Patea and Waverly. The case was heard in the New Plymouth High Court.

New Health NZ took the judicial review on the grounds that they believed the council had:

- no power to fluoridate the water supply;
- if they did have the power (to fluoridate), it was a breach of the right to refuse medical treatment, as per the New Zealand Bill of Rights Act; and
- the council had failed to take relevant consideration in making its decision.

Judge Rodney Hansen released his decision on 7 March and rejected all grounds of the challenge. He concluded that:

- there is implied power to fluoridate in the Local Government Act 2002 and the Health Act confirms that fluoride may be added to drinking water in accordance with drinking water standards issued under that Act;
- fluoridation of water is not medical treatment for the purpose of section 11 of the New Zealand Bill of Rights Act; and
- the Council carefully considered the detailed submissions presented and reached its decision after anxious consideration of the evidence and careful deliberation.

6.6 Opening of Wainuiomata Dental Hub

Wainuiomata's new school dental hub was officially opened on 20 February 2014. Situated at St Claudine's Catholic School in Rata Street, Wainuiomata this three chair purpose built facility will service pre-schoolers and primary school children.

Among the people to attend were, Ray Wallace (Mayor) Hon Dr Paul Hutchinson (National MP for Hunua) Trevor Mallard (Labour MP for Hutt South), Father Alma of the Catholic Church, John Wharehinga, local Kaumatua, members of the Executive Leadership team and management and staff from the bee healthy regional dental service and the school Principal.

The clinic was blessed by the Catholic Church and the Kaumatua and after official speeches, Head Prefects from St Claudine's cut the ribbon with Mayor Ray Wallace declaring the clinic open.

The clinic is expected to be fully running by the 3 March 2014 and the existing dental clinics around various schools in Wainuiomata will be de-commissioned.

6.7 Nursing Update

Attached as Appendix Six is an update from Helen Pocknall, Executive Director of Nursing and Midwifery, which touches on some of the work steams and initiatives that are being undertaken by our nursing workforce.

6.8 Hepatitis A Outbreak – Hutt Valley

Regional Public Health (RPH) is currently investigating an outbreak of Hepatitis A in an extended Pacific family in the Hutt Valley. We were notified of one confirmed case of Hepatitis A on Saturday 22 February who was hospitalised. Five further cases were confirmed by Thursday 27 February, including two children under 5 years old who attend a Pacific Early Childhood Centre (ECC) in the Hutt Valley, one school aged child and three adults. All six cases are from two families and link closely with five other extended family households in the Hutt Valley. The likely source of illness is a recent family trip to Samoa.

RPH have been working closely with the Hutt Valley DHB Pacific Unit to communicate with the families and this has assisted with prompt follow up of cases and contacts.

On 27 February a public health alert was sent to all General Practitioners, Practice Nurses, Pharmacists, After Hours Centres and Emergency Departments in the greater Wellington region (including Wairarapa) advising of the outbreak, the public health follow up and advice on actions to take. We are notifying all family doctors of patients being vaccinated.

The Hep A vaccine is currently not funded, however, PHARMAC was keen to support the DHB to prevent a community wide outbreak and therefore funded the vaccines up to a value of $4,000 (to date we have used $4,078).

6.9 Drinking Water – Wairarapa

In early December 2013, RPH was notified of four drinking water quality breaches associated with small water supplies in the Wairarapa. The presence of contamination was detected in the Mauriceville, Pirinoa, Riversdale and Whareama School supplies. Sampling was conducted by Masterton District Council (MDC) as part of their environmental surveillance. Follow up investigation and sampling was co-ordinated by MDC with advice from RPH. No confirmed illness was associated with these breaches.

For each supply the response was tailored to the particular public health risk, taking into consideration the degree of contamination, current treatment, on-going risks and population characteristics. Of significance was the result from follow up sampling conducted at Mauriceville (registered population 43). This supply is untreated with minimal oversight/ management by the water supplier. The laboratory results revealed on-going and relatively high levels of E.coli (37) prompting the Medical Officer of Health to recommend a “boil water” advisory for the supply, which was successfully initiated. On-going work with this supply is required by both RPH and MDC to clarify options for management in accordance with the Health Act and Drinking-water Standards for NZ.

6.10 Quality Accounts

The General Manager Quality and Risk attended the national feedback forum from the Health Quality and Safety Commission on the quality accounts. The forum also included planning for the next round. Both Wairarapa and Hutt Valley DHBs were identified as being good examples of quality accounts.

6.11 Communications Update

I have included as Appendix Seven the projects and initiatives the DHBs’ Communications Team have been working on locally and in the 2DHB and 3DHB space.

6.12 Official Information Act Requests

Attached as Appendix Eight are details of requests for information the DHB has received under the Official Information Act since the last Board meeting and our responses.

How is My DHB performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

2013/14 QUARTER TWO (OCTOBER–DECEMBER) RESULTS

www.health.govt.nz/healthtargets

Shorter stays in Emergency Departments

		Quarter two performance (%)	95%	Change from previous quarter
1	West Coast	100		0.0
2	Waitemata	96		0.3
3	Whanganui	96		0.6
4	South Canterbury	96		-0.8
5	Wairarapa	96		-0.2
6	Counties Manukau	96		-0.3
7	Tairawhiti	96		0.0
8	Canterbury	95		1.1
9	Auckland	95		0.3
10	Nelson Marlborough	95		0.0
11	Hutt Valley	95		0.3
12	Northland	95		2.7
13	Taranaki	94		0.3
14	Waikato	94		6.9
15	Hawke's Bay	93		0.7
16	Capital & Coast	93		6.2
17	Lakes	93		2.8
18	Bay of Plenty	92		1.5
19	Southern	92		1.3
20	MidCentral	89		4.9
	All DHBs	94		1.7

Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

Improved access to Elective Surgery

		Quarter two performance (%)	100%	Progress against plan (discharges)
1	Lakes	120		354
2	Northland	116		528
3	Counties Manukau	114		1110
4	Waikato	113		845
5	Hutt Valley	109		214
6	Taranaki	107		145
7	Bay of Plenty	106		256
8	Waitemata	103		254
9	MidCentral	102		66
10	Whanganui	102		28
11	Wairarapa	102		16
12	Canterbury	102		147
13	South Canterbury	101		17
14	Southern	101		49
15	Tairawhiti	100		-4
16	Auckland	100		-33
17	Capital & Coast	98		-92
18	West Coast	98		-17
19	Hawke's Bay	98		-71
20	Nelson Marlborough	92		-258
	All DHBs	105		3554

Improved access to elective surgery

The target is an increase in the volume of elective surgery by at least 4000 discharges per year. DHBs planned to deliver 76,231 discharges for the year to date, and have delivered 3554 more.

Shorter waits for Cancer Treatment

		Quarter two performance (%)	100%	Change from previous quarter
1	Northland	100		0.0
1	Waitemata	100		0.0
1	Auckland	100		0.0
1	Counties Manukau	100		0.0
1	Waikato	100		0.5
1	Lakes	100		0.0
1	Bay of Plenty	100		0.0
1	Tairawhiti	100		0.0
1	Hawke's Bay	100		0.0
1	Taranaki	100		0.0
1	MidCentral	100		0.0
1	Whanganui	100		0.0
1	Capital & Coast	100		0.0
1	Hutt Valley	100		0.0
1	Wairarapa	100		0.0
1	Nelson Marlborough	100		0.0
1	West Coast	100		0.0
1	Canterbury	100		0.3
1	South Canterbury	100		0.0
1	Southern	100		0.0
	All DHBs	100		0.0

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy. Six regional cancer centre DHBs provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin. Medical oncology services are provided by the majority of DHBs.

Increased Immunisation

		Quarter two performance (%)	90%	Change from previous quarter
1	South Canterbury	96		2.3
2	Wairarapa	96		-0.6
3	MidCentral	95		1.0
4	Hawke's Bay	95		2.6
5	Auckland	94		-0.2
6	Canterbury	93		-0.2
6	Whanganui	93		5.0
8	Southern	93		-0.9
9	Hutt Valley	92		-1.9
10	Capital & Coast	92		-0.6
11	Waitemata	92		1.4
12	Counties Manukau	90		-0.4
13	Nelson Marlborough	90		-0.3
14	Lakes	90		0.9
15	Tairawhiti	90		2.9
16	Taranaki	89		-0.9
17	Waikato	87		0.7
18	Bay of Plenty	87		-1.2
19	Northland	86		0.4
20	West Coast	84		-1.1
	All DHBs	91		0.2

Increased immunisation

The national immunisation target is 90 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by July 2014 and 95 percent by December 2014. This quarterly progress result includes children who turned eight-months between October and December 2013 and who were fully immunised at that stage.

Better help for Smokers to Quit

		Change from previous quarter	95%	Hospitals
		-8.2		90
		0.4		99
		0.8		95
		-3.0		90
		-0.9		99
		-0.2		93
		-9.2		89
		-1.7		97
		-2.5		93
		-1.3		95
		-1.5		95
		1.5		97
		-0.2		96
		-0.1		97
		0.9		96
		-6.7		86
		-0.1		96
		-1.2		98
		1.1		97
		0.3		95
		-0.8		95

		Quarter two performance (%)	Primary care 90%	Change from previous quarter
1	Wairarapa	97		-0.6
2	South Canterbury	86		2.8
3	Whanganui	82		7.6
4	MidCentral	81		3.8
5	Hawke's Bay	80		-0.3
6	Nelson Marlborough	78		4.8
7	Bay of Plenty	77		2.8
8	Northland	77		0.2
9	Capital & Coast	74		6.3
10	Taranaki	71		4.4
11	Counties Manukau	69		10.0
12	Waikato	68		5.5
13	Southern	64		4.2
14	Hutt Valley	63		-0.9
15	Auckland	60		9.4
16	West Coast	60		2.0
17	Tairawhiti	59		2.8
18	Waitemata	55		8.3
19	Lakes	55		-6.8
20	Canterbury	49		12.1
	All DHBs	66		6.0

Better help for smokers to quit

The target is 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking.

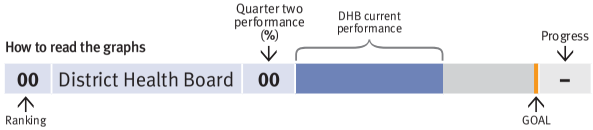
More Heart and Diabetes Checks

		Quarter two performance (%)	90%	Change from previous quarter
1	Wairarapa	84		1.1
2	Auckland	83		3.4
3	Counties Manukau	83		2.7
4	MidCentral	82		6.7
5	Capital & Coast	80		2.5
6	Taranaki	80		4.6
7	Bay of Plenty	80		7.4
8	Northland	80		3.9
9	Waikato	77		1.9
10	Waitemata	76		4.4
11	Tairawhiti	75		4.1
12	Lakes	74		6.0
13	Hawke's Bay	74		0.6
14	Whanganui	73		-4.7
15	South Canterbury	72		4.1
16	West Coast	66		2.2
17	Nelson Marlborough	64		5.8
18	Southern	64		0.4
19	Hutt Valley	62		6.3
20	Canterbury	45		9.1
	All DHBs	73		4.0

More heart and diabetes checks

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved by July 2014.

How to read the graphs



Health target results are sourced from individual DHB reports, national collections systems and information provided by primary care organisations.

This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

New Zealand Government

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**BOARD NOTING PAPER** **Date: 9 March 2014**

Author	Cate Tyrer, General Manager Quality and Risk
Subject	**Emergency Management Update**

RECOMMENDATION

It is recommended that the Board

a. **RECEIVES** the report

b. **NOTE** that there are contingency plans in place in the event of a major incident

c. **NOTE** that there are improvements in resilience being achieved through a 2D and 3D approach

ADDENDUMS

a. 3DHB emergency management work plan, Hard copy Emergency Management workplan
b. Presentation moving to a 2DHB/3DHB environment

1 INTRODUCTION

This paper is to provide the Board with an assurance that there are contingency plans in place for the Wairarapa and Hutt Valley DHB in the event of a major incident. Severe weather events, earthquakes and fire related events are just some of the incidents that have impacted on all three DHBs over the last twelve months. After any major incident we review the contingency plans and ways in which we can improve our resilience whether across the sub region or locally.

Developing a 3DHB emergency management work plan (addendum) provides the foundation of the organisations' approach to achieving increased resilience, giving assurance that all DHBs have robustly assessed the emergency management requirements.

1.1 Health Emergency Plans (HEP)

Traditionally the HEP provided clear instructions on the management of any emergency management incident, the plans are located on the intranet and accessible to all. With the move to a single service model the plans are under review and will be linking to support the 3DHB response whilst also maintaining the local resilience and links with our communities.

Some of the2DHB/ 3DHB developments currently underway to support the emergency management are:

- Considering the development of 3DHB Fire Safety/Hazardous Substances New Organisms (HSNO) position
- Reviewing the terms of reference of the monthly 3DHB emergency management meeting
- Improving the communication infrastructure across the 3DHB hospitals and PHOs with radios and joined up cascade communication trees.
- Branching out more into the proactive emergency management within the subregional community by working with SIDU on key projects like vulnerable people and infant feeding.

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Emergency management by nature is an iterative process and one which we are constantly reviewing to ensure that we meet the current standards.

The Hutt Emergency Planning Manager recently attended Christchurch on behalf of both Wairarapa and Hutt along with other key DHB staff to gain an understanding of how Canterbury DHB responded to the earthquakes. The two key lessons identified were the importance of:

- Having a robust Emergency Department Mass Casualty plan
- Interaction between the DHB and community providers during incident response

This experience and learning has helped to shape the emergency management workplan.

PUBLIC

Wairarapa DHB · Hutt Valley DHB · Capital & Coast District Health Board	**BOARD INFORMATION PAPER**
	Date: 7 March 2014

Author	Dr Ashley Bloomfield – **Director, Service Integration & Development (SIDU)**
Endorsed By	
Subject	**CHPAC-DSAC REPORT BACK**

RECOMMENDATION

It is recommended that the Board

a. **Notes** the contents of this report;

b. **Considers** the position statement on community water fluoridation, which the Committees have endorsed and recommend that the Board adopts.

ADDENDUMS

a) Equity Indicators Quarterly Report

1 PURPOSE

This paper reports back on the combined Wairarapa, Hutt Valley and Capital & Coast District Health Boards CPHAC and DSAC Committees meeting held 24 February 2014 at Upper Hutt City Council. Please note that all CPHAC-DSAC papers are on Board Books.

2 SIDU DIRECTOR'S REPORT

This report updates the Board on key areas of work for which SIDU is responsible; highlights follow.

A clinical pathways platform, HealthPathways, is being implemented across the three DHBs. This was originally developed by Canterbury DHB in 2007 and encompasses the process for developing agreed pathways between primary and secondary care and the website that provides general practice teams with quick and clear information about the agreed models and pathways of care. There is strong interest from primary and secondary care clinical staff in this process

At a previous meeting, the Committees asked to be updated on the implementation of interRAI in aged residential care (**ARC**) facilities. InterRAI is a comprehensive clinical assessment tool that is validated and able to be applied consistently by trained clinicians. It is a key element in ensuring appropriate care is provided for older people. In summary, across the three DHBs there are 20 facilities (from a total of 62) that have one or more RNs who have attained competency. All other facilities are on the pathway towards attaining competency for at least one RN.

A sub-regional youth health services stocktake, gaps analysis and proposed actions from 2013/14 have been developed in close collaboration with local providers and key stakeholders, including Primary Health Organisations (**PHOs**) and Youth One Stop Shops (**YOSS**), across the sub-region. Information from community and youth workshops has also informed the project. They form an excellent basis for a sub-regional approach to strengthening services for youth, which is informing the annual planning process.

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In September the Minister of Health announced a new Very Low Cost Access (**VLCA**) General Practice Sustainability Initiative. The initiative includes a $4 million per annum fund to help support VLCA practices most in need of sustainability support. This is on-going funding available from 1 January 2014. There is also one-off funding of $1.5 million to fund employment of 48 new graduate nurses for 12 months in Very Low Cost Access Practices with 50% or more high needs enrolees. These placements are expected to commence in February or earlier.

The total funding across the region is $289,352.00 per annum, with the breakdown shown in Table 5 below.

Table 5 Breakdown of additional VLCA funding for each DHB

DHB	2013/2014
Wairarapa DHB	$14,552
Capital and Coast DHB	$189,987.00
Hutt Valley DHB	$84,813.00
Total	$289,352.00

The Nurse graduate funding is one-off funding for a 12 month placement of a new graduate nurse beginning 1 January 2014 and ending 31 December 2014. The total funding for the region is $250,000.00.

In the public excluded section of the meeting, the Committees were updated on the procurement process for community referred laboratory services, the development of a single sub-regional diagnostic imaging service and the ongoing implementation of the Community Pharmacy Services Agreement, the national agreement for dispensing by pharmacies. All three DHBs have realised significant savings since the development of the new agreement two years ago, prior to which dispensing costs were increasing at around eight percent per annum.

3 QUARTERLY EQUITY INDICATORS REPORT

The Committees noted the most recent performance against equity monitoring indicators and the activities underway to improve performance (report attached in appendices). Updated data for headline measures show:

- Although there have been small incremental improvements in dental service enrolment for pre-schoolers in Capital & Coast and Hutt Valley DHBs, more work is required to accelerate the improvement for Maori and Pacific children;
- Completion rates for cardiovascular risk assessments in primary care have been reasonably equitable; however, the significant gains recently have been larger for non-Maori, non-Pacific in Capital & Coast in particular and it will be important to maintain equity in the push to reach the 90% target;
- Maori and Pacific attendance at specialist assessment appointments has improved at Capital & Coast and Wairarapa hospitals, whereas the initial improvement achieved at Hutt following the implementation of U-Book has not been sustained and rates have increased slightly. Hutt Valley DHB has commenced work to improve clinic attendance with a consultation process which involved patients, clinicians and administrative staff.

4 PROPOSED POSITION STATEMENT ON COMMUNITY WATER FLUORIDATION

The Committees endorsed the attached Position Statement and recommends its adoption to the Wairarapa, Hutt Valley and Capital & Coast District Health Boards.

PUBLIC

5 SUB-REGIONAL DISABILITY PLANNING

A planning group comprising of members of SRDAG has been set up to revisit the priorities from the June 2013 forum. The follow up forum will be May 23rd 2013 12.30 to 4.00pm. All participants from the previous forum are invited back and any who did not attend will also be welcome – all Board members are invited.

The focus of the forum will be to evaluate progress and to look at a map for future work on integration of disability issues and expertise into the wider change agenda for the sub region.

A three DHB Annual Plan for Disability Responsiveness is currently being prepared as well as a focus on inclusion of disability initiatives into the other planning priorities for each DHB where possible.

6 CARE AND SUPPORT SERVICES FOR OLDER PEOPLE

The Committees received an update on work on care and support services for older people and noted the following 2014 focus and priority areas:

- Continued development of the whole of health system approach for older people care; *Priorities* – Dementia care pathway, Frail elderly pathway;
- Development and monitoring of equity measures for older people, utilising interRAI and other validated tools; *Priorities* – Equity measures, development of interRAI measures;
- Implementing funding models that support changing models of care and manage cost growth for DHBs; *Priorities* – Needs Assessment Service Coordination (NASC) and Home and Community Support Services (HCSS) contracts.

HUTT VALLEY DHB	**DECISION PAPER**
	Date: March 2014
Author	Virginia Hope
Subject	**Resolution to Exclude the Public**

RECOMMENDATION

It is recommended that the Public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table.

The grounds for the resolution is the Committee, relying on Clause 32(a) of Schedule 3 of the Act believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists under the Official Information Act 1982 (OIA), in particular:

Agenda Item	Reason	Reference
Chief Executive Report	Project the privacy of the naturals persons and to enable a Minister of the Crown or any department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities	Section 9(2)(a) (i)
Sustainability Plan		
Board Representation	Opportunity to discuss availability including personal commitments	Section 9(2)(a)
Governance Manual	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Lab Information Systems (LIS)		
Draft Annual Plan	Subject to ministerial Approval	Section 9(2)(f) (iv)
Draft RSP		
Draft 2014/15 Budget	To enable a Minister of the Crown or any department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities	Section 9(2)(i)
Funder Commitment List 2014/15		
Loan Rollover		
Insurance Premium		
PHO Funder Delegation		

CRISP	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Board Work Plan		

DISTRICT HEALTH BOARD

BOARD GOVERNANCE MANUAL

2014

VERSION 4, updated 28 February 2014

REGISTER OF CHANGES

Date	Requestor	Request	Reason	Change Y/N	Date of Change	Completed on Date
18 March 2013	Chair	Amend mileage allowance	To reflect the updated IRD rate	Y		18.3.13
30 April 2013	Chair	Update Delegation, Board to CEO appendix	Policy update, approved by the Board at its April 2013 meeting	Y	12.4.13	30.4.13
30 April 2013	Chair	Update the CPHAC and DSAC Terms of Reference	Approved by the Board at its April 2013 meeting	Y	12.4.13	30.4.13
14 June 2013	Chair	Amend Standing Orders	To note items without the need to vote, and to allow the Board to pass and vote on resolutions on noting papers if needed, approved by the Board at its June 2013 meeting	Y	14.6.13	14.6.13
5 August 2013	Secretary	Amend annual fees payable to Board, Deputy Board and Members as per	Fees increased as from 1 July 2013	Y	1.7.13	5.8.13

		letter from Minister Ryall to CCDHB Board chair dated 26 July 2013	(Noted: Page 91 of manual)			
22 October 2013	Secretary	Amend page 36 of the manual to indicate the differences in fees paid for HAC, FRAC and CPHAC/DSAC	Fee schedule changed as per letter dated 9 August 2013 from the Minister approving the fee rate for CPHAC/DSAC meetings which are being held contemporaneously	Y	22.10.13	22.10.13
19 December 2013	Secretary	Amend page 31 to current letter of expectation (from 2008 to July 2012)	Update manual	Y	19.12.13	19.12.13

Table of Contents

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 Hutt Valley DHB, Wairarapa DHB and CCDHB with guidance and information they may require to assist them to meet their governance responsibilities. Reference to the term DHB is a reference to Hutt Valley DHB, Wairarapa DHB or CCDHB unless specifically stated otherwise. 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 latest 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
- 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 adopts measures that recognise and respect the principles of the Treaty of Waitangi in the health and disability support sector. The measures are a response to the Crown's desire to have greater Māori participation in the health and disability support sector with a view to improving Māori health outcomes.

The NZPHD Act was amended in October 2010 to support reforms in the health sector. 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	
Government policy directions	DHBs *must give effect to* government policy when directed by the responsible Minister (i.e. the Minister of Health) (s.103)
Whole of government directions	DHBs must give effect to a whole of government direction from the Minister of State Services and the Minister of Finance (s.107, 110)
Planning and reporting	DHBs must prepare a Statement of Intent once every three years (to include statements of strategic intentions) and an annual Statement of Performance Expectations. A DHB's Annual Report must report progress in relation to its strategic intentions, and a full report in relation to its performance expectations (s. 139 to 153)
Appointed Board members	Appointed by the Minister of Health (s.28)
Term of Board members	Appointed members hold office for 3 years or fewer (s.32)
Removal of appointed Board members	May be removed by the Minister of Health at his or her discretion (s.36)
Remuneration of Board members	Determined by the Minister of Health in accordance with the Cabinet Fees Framework[1] (s.47)

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)
- s.170(1) (in relation to any outputs covered by a Crown funding agreement)
- 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 general expectation, as expressed by the Chief Ombudsman for instance, is for official information to be released (either pro-actively or in response to a request), unless there are clear grounds to withhold it under the OIA. For further guidance, see:

www.ombudsmen.parliament.nz/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.

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

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 Crowns Entity 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.

Please note that 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 CE Act]:

(a) that specify the persons who are eligible to receive services funded under the NZPHD Act and

(b) that the Minister considers necessary or expedient in relation to any matter relating to the DHB and

(c) that are consistent with the objectives and functions of the DHB.

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

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 Crown Entities Act 2004].

Each DHB 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 Crown Entities Act 2004 (which concerns entity-specific directions), or under section 107 of the Crown Entities Act (which concerns whole of government directions).

Each DHB 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 33 A and 33 B 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-dec08), 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.

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.

Guidance for departments on how to monitor an entity is available at: www.ssc.govt.nz/guidance-depts-crown-entities-may06.

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[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.

[1] s.28 of the NZPHD Act discusses shares in bodies corporate or interests in associations.

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[2]:

- 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.

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

[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

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 ongoing background study.

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; 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.

Useful guidance on sensitive expenditure can be found in the Auditor-General's guide Controlling sensitive expenditure: guidance for public entities (www.oag.govt.nz/2007/sensitive-expenditure).

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 2.

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

[3] Schedule 3 clause 29(1) NZPHD Act

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.

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 its 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 (see section 4), 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:

- 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.

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
- ongoing 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.

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

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 of conduct is attached as appendix 4

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 expectations are set out in: www.ssc.govt.nz/govt-expectations-pay-employment.

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"[4].

The DHB's Operational Policy Framework further specifies the financial requirements for DHBs. An annually updated version of the DHB's Operational Policy Framework can be found through the following website: www.nsfl.health.govt.nz/.

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.

Regional Service Plans (RSP) were formally required for the first time in 2011/12.

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 & 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 prioirities.

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

From the 2014/15 financial year, 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:

- District Health Boards: Learning from 2010-2013 Statements of Intent http://www.oag.govt.nz/2011/dhb-soi-preparation
- Performance Measurement: Advice and examples on how to develop effective frameworks www.ssc.govt.nz/performance-measurement
- The Auditor-General's observations on the quality of performance reporting (especially see Appendix II) www.oag.govt.nz/2008/performance-reporting
- Forecast non-financial performance information reports: Guidance for entities www.oag.govt.nz/2009/forecast-non-financial-performance/
- Planning and Managing for Results: Guidance for Crown Entities www.ssc.govt.nz/planning-for-results-crownentities
- Preparing the Statement of Intent: Guidance and Requirements for Crown Entities www.ssc.govt.nz/guidance-crown-entities-soi
- DHB Operational Policy Framework: www.nsfl.health.govt.nz

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. It sets out the ongoing expectations that the Minister of Finance and the Minister of State Services have of all statutory Crown entities, including DHBs. These expectations include 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.

The process of setting expectations will change from 1 July 2014, when Crown entities will be required to prepare an annual Statement of Performance Expectations, to which the Minister will have an opportunity to contribute.

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/.

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 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**

Terms of office for DHB Board members: Appointed members

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

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

Elected members

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

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.

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/co09/5.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 sub committee 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.

Attach as appendix letter from Minister re Board and committee payments.

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 "Board Remuneration and Expenses" is attached at Appendix 6.

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.

Appendix 1 | Standing Orders for the Board and Board Committees

STANDING ORDERS

FOR THE BOARD AND BOARD COMMITTEES

OF WAIRARAPA DHB, HUTT VALLEY DHB AND CCDHB

February 2014

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.

CE Act 2004 means the Crown Entities Act 2004.

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

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

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.

NZPHD Act 2000 means the New Zealand Public Health and Disability Act 2000.

Public excluded information includes:

Information which is:

i) currently before a public excluded session; or

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

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

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

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

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

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

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

Working day means any day of the week other than:

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

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

1.2 Application of Standing orders

1.2.1 These Standing Orders shall, so far as applicable, extend to the proceedings of all 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 e-mailed or faxed.

1.8 Committees

1.8.1 Standing or Special Committees

The Board may:

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

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

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

1.8.2 Committees subject to the direction of the Board

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

1.8.3 Appointment or removal of committee members

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

1.8.4 Members of committees

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

The Board must endeavour, where appropriate, to ensure representation of 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.

2.7.5 Silence when a motion is put shall be deemed to be a vote in support of the motion.

2.7.6 Votes for and against particular motions shall not be recorded, unless requested by a Board or committee member or the Chair.

2.7.7 When a motion has been seconded, and opened by the Chair for discussion, an amendment may be moved and seconded by any member.

2.7.8 Board members 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.

2.7.9 No member shall speak on any question after it has been put by the Chair, or during a vote.

2.7.10 In the case of a tied vote, the Chair has no second or casting vote, and the question or motion is decided in the negative.

(refer clauses 29, Schedule 3 and clause 31, Schedule 4 of the Act).

2.7.11 A resolution reflects the will of the majority, and members should not criticise the resolution unless the member is taking steps to revoke the resolution.

2.7.12 Any resolution may be rescinded by a subsequent resolution at a subsequent meeting without recourse to procedural motions.

2.7.12 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 In any teleconference no resolution of the Board or committee may be voted on and no decision of the Board or committee, as the case may be, may be made.

5.3.2 Each member taking part must acknowledge their participation and be able to hear each of the other members taking part. Members may not leave a teleconference unless they first obtain permission to do so from the presiding member.

5.3.3 A written record of a teleconference must be made by the member who presided in it.

5.4 Application of model standing orders

5.4.1 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 2: Code of Conduct for Board Members

CODE OF CONDUCT

FOR THE BOARD AND BOARD COMMITTEES

OF WAIRARAPA DHB, HUTT VALLEY DHB AND CCDHB

February 2014

1. CODE OF CONDUCT

This Code of Conduct has been agreed to by all Board members of the HHutt valley DHb, Wairarapa DHB and 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 recognise 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 & Disbilty 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, Maori health issues, Treaty of Waitangi issues and Maori 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 (ie 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, eg 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".

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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 Maori to participate in, and contribute to, strategies for Maori 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.

Appendix 3 | Statutory Committees

Wairarapa DHB, Hutt Valley DHB and CCDHB
Community & Public Health Advisory Committees (CPHAC) : Terms of Reference

Terms of Reference (All three DHB's have the same 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[4]

(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.

[4] Clause 2 of Schedule 4 to the NZ Public Health and Disability Act.

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.

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 the Wairarapa DHB, Capital & Coast DHB and Hutt Valley 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 Maori, 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, Maori involvement and clear documentation of process.

g. To provide advice on provider development strategies consistent with service planning and provision priorities, including for Maori and Pacific providers.

h. To monitor the DHB's planning and funding performance through the Service Integration and Development Unit (SIDU) 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 SIDU 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, and must include at least one member from the Board and at least one co-opted member from each of the other two sub regional Boards.

6. Membership

Membership of the Committee shall be as directed by the Boards. 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 CCDHB

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[5]

(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.

[5] Clause 3 of Schedule 4 to the NZ Public Health & Disability Act.

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).

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 Service Integration and Development Unit (SIDU) 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 SIDU 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.

3. 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.

4. 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.

5. Membership

Membership of the Committee shall be as approved by the Board. The Committee has the ability to co-opt expert advisors as required.

6. 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 CCDHB
Hospital Advisory Committees: Terms of Reference

All three DHBs have the same 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 Boards 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 sub-regional DHB provided services.
   a. To assess the performance of the sub regional 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 sub-regional DHBs including the way in which funding models might be reconfigured to support more appropriate service delivery.
iii. To give the Board(s) 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(s)
vi. To recommend approval of policies relative to the good governance of DHBs 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 DHBs. 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(s) 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(s).

6. Membership

Membership of the Committee and all matters of procedure are provided for in Schedule 4 of the Act together with the Board(s) 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, and must include at least including one member from the each Board and at least one co-opted member from each of the other two sub-regional Boards.

8. Standing Orders

Adopted Standing Orders for Statutory Committees will apply.

9. 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(s) meeting with any recommendations arising from the Hospital Advisory Committee presented for consideration.

10. Procedure

Schedule 4 of the NZ Public Health & Disability Act will apply to the business and procedure of the Committee.

CCDHB Finance Risk and Audit Committee: Terms of Reference

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.

2.2 The Committee's responsibilities relate to two primary business areas:

- Risk, Safety and Quality Management
- 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.
- Compliance of THE DHB'S's risk management systems with public sector Risk management standards as set out in "*Guidelines for Managing Risks in the Australian and New Zealand Public Sector*: "SAA/NZ HB 143:1999.

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 Audit

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

- Provide assurance to the Board that all audit processes required by the Board or by statute are completed
- Ensure that there is an open avenue of communication between the Internal Auditor, the external auditors and the Board. The Internal Auditor and external auditors have direct access at any time to each other and the Committee.
- Consider, in consultation with the external auditors and the Internal Auditor, the audit plans and scope of the external auditors and internal auditors, ensuring that co-ordination of audit effort is maximised.
- Work with other 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

7.2.2 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.

7.2.3 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.

7.2.4 Specific Responsibilities of the Committee shall be:

7.2.4.1 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.

7.2.4.2 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.

7.2.4.3 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.

7.2.4.4 Internal Audit

Consider and review with management and the Internal Auditor:

- significant internal audit reports and summary of internal audit activity.
- any difficulties encountered in the course of internal audit, and any restrictions placed on internal audit scope of work or access to required information or personnel.
- the internal audit plan of future audits to be conducted.
- any changes which have been required in the previously approved internal or external audit plan.
- the internal audit department's Charter.

Consider the appropriateness of the internal audit function from time to time.

7.2.4.5 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.

Hutt Valley DHB | Finance Risk and Audit Committee: Terms of Reference

The Board hereby confirms the terms of reference of its Finance & 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 FUNCTIONS AND OBJECTIVES

The primary function and objective of the Committee is to assist the Board in the discharge of its functions, duties and responsibilities in relation to achievement of Hutt Valley DHB's mission and objectives.

Other Committee functions and objectives are to:

- Monitor the financial performance of the various arms of the DHB with a particular emphasis on the consolidated results.
- Oversee and appraise the effectiveness and quality of all audits conducted whether by internal audit or external auditors. It should however be noted that the primary and direct reporting line for internal audit is to the Chief Executive Officer.
- Maintain open lines of communication between the Board, the internal auditors and the external auditors. To exchange views and information as well as confirm their respective roles, authorities and responsibilities.
- Refer clinical issues and other matters not of a financial nature to the appropriate statutory sub committee.

2.0 MEMBERSHIP

The committee shall be comprised of a minimum of three Board members and external members to be determined by the Board from time to time.

Representatives of internal and external audit will attend meetings at the invitation of the Chairman of the Committee. The Chief Executive Officer and Chief Financial Officer will normally represent management again at the invitation of the chairman.

All Board members are entitled to attend and participate in the meetings.

Remuneration of members for attendance at Committee meetings will be at prescribed rates for official committee meetings.

3.0 MEETINGS

The Committee shall normally meet monthly and while agenda items are at the discretion of the Chairman, meetings are scheduled to be held specifically to:

- monitor and review the DHB consolidated financial results on a monthly basis
- meet with the external auditors to assess the financial performance of the DHB
- review progress against internal audit plans and budgets

- review progress against Planning & Funding "provider" audits carried out by the Technical Advisory Service (TAS)
- review the annual report and statutory accounts prior to the Board meeting
- review the financial aspects of capital expenditure requirements including the robustness of strategic modelling for the Board
- monitor the financial impact of the IT projects including any major operational aspects
- provide oversight of major capital projects such as the Emergency Department/Theatre Redevelopment.

In addition, the Chairman is required to call a meeting of the Committee if requested to do so by any Committee member, the Chief Executive Officer or external auditors.

The quorum for any Committee meeting shall be a majority of Board members present and normal Committee voting procedures apply.

The CFO is responsible for circulating the meeting agenda and supporting material to all committee members at least 2 working days prior to the meeting date.

The Chairman has absolute authority to regulate meeting process, and conduct of attendees to ensure effective and efficient decision making.

The Official Information Act 1982 and Privacy Act 1993 requirements will apply to any requests for minutes of business conducted.

4.0 ACCESS AND AUTHORITIES

The Committee shall have unlimited access to, and authority to seek information from both the internal and external auditors to fulfil its objectives, duties and responsibilities.

The Committee shall also have the ability, and is authorised, to take such independent professional advice as it considers necessary.

The Committee shall have no executive powers with regard to its findings and recommendations.

5.0 DUTIES AND RESPONSIBILITIES

The Committee's duties and responsibilities are to:

(a) **General**

Consider and respond to any matters:

- relating to its functions, objectives, duties and responsibilities
- referred to it by the Board
- referred to it by the Chief Executive Officer

(b) **Audits**

- Make recommendations, as necessary, to the Board on the appointment of external and internal auditors.
- Review external audit plans and fees.
- Review annual internal audit plans and budgets.

- Review Planning & Funding provider audit plans.
- Evaluate the overall effectiveness of internal and external audit.

(c) **Internal Controls**

- Monitor the adequacy of internal controls by reviewing reports from internal audit and external auditors and management responses to correct deficiencies.
- Monitor tasks and exposures.
- Review the results of post-implementation audits of capital expenditure.
- Monitor compliance with all financial statutory responsibilities.

(d) **Financial Reporting**

- Review draft annual financial statements and submit recommendation on acceptance to the Board.
- Review adequacy of accounting policies, review and recommend to the Board all significant changes in accounting policy.
- Obtain reports from external audit, internal audit or management on any regulatory, accounting or financial reporting issue of significance.

(e) **Special Investigations**

- Identify and recommend to the Board and/or Chief Executive Officer any special investigations deemed necessary to fulfil Committee functions, objectives, duties and responsibilities.

6.0 REPORTING

The minutes of all Committee meetings shall be circulated and made available to members of the Board at the next Board meeting.

7.0 APPLICATION OF STANDING ORDERS

The DHB's standing orders will apply to the proceedings of this committee.

CCDHB 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; &
- 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 4 | Policies

Wairarapa DHB, Hutt Valley DHB and CCDHB Board Policy - Remuneration and Expenses

Policy Facilitator: Financial Controller Authorised by: CFO, Board Chair	Version no.: 3.2 Issue date: tbc Review date: tbc	Policy no. BRD **BRD-02**

Board fees and expense reimbursement policy

Table of contents

Related documents

Legislation

- New Zealand Public Health and Disability Act 2000;
- Cabinet Fees Framework per the Crown Entities Act 2004;
- Income Tax Act 2007 (amended).

THE DHB documents

- Delegation of authority policy
- Sensitive expenditure policy
- Travel policy

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 Cabinet Fees Framework per 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:

- THE DHB Board members
- External members of Statutory Advisory Committees

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 actual 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 THE DHB and another organisation (*e.g.* HVDHB), then a fair and pragmatic apportionment shall be made between organisations and, only that part attributable to THE DHB, 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 Chair of FRAC.

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.

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 Committee;
- Hospital Advisory Committee.

The fees relating to attendance at the combined CPHAC and DSAC Committee meetings are currently:

Position	Annual fee	Attendance fee
Chair	$4,237	$427.50
Board Members	$3,500	$350
External Members	$3,500	$350

The fees relating to attendance at the HAC Committee meetings are currently:

Position	Annual fee	Attendance fee
Chair	$3,125	$312.50
Board Members	$2,500	$250
External Members	$2,500	$250

- These 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;
- For Board 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 deputising, in the absence of the Chair, they will receive the corresponding Chair rate for that particular meeting.

`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.

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 THE DHB bulk discount arrangements.

Taxis

Where appropriate or more economical, taxis may be used. THE DHB 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). THE DHB may also provide vouchers for this purpose.

Air travel

This requires specific advance approval by the Board Chair. Under normal circumstances air travel should be economy class. Tickets should be booked via the Board Support Team so as to obtain discounted rates.

Conferences and overseas travel

These require specific advance approval by the Board Chair. Travel should be by economy class and booked via the Board Support Team.

Meals and accommodation

Costs may be incurred in accordance with the general guidance in the *Travel Policy*.

Office expenses

As a general rule, THE DHB 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):

1 to 5,000 km	77 cents per km
5,001 km and over	actual expenses or log book required

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 (refer definition section);
- 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 claim reimbursements should be submitted using the Expense reimbursement 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.

Appendix 5 | DHB GLOSSARY

Acronyms	Description
3D HSD	3D Health Services Development
A&D	Alcohol & Drug
A&E	Accident and Emergency Department
A&R	Audit and Risk
AAU	Acute Assessment Unit
ACA	Access Criteria for First Assessment
ACC	Accident Compensation Corporation
ACEM	Australian College of Emergency Medicine
ACHS	Australian Council on Healthcare Standards
ACLS	Advanced Cardiac Life Support
ACNM	Associate Clinical Nurse Managers
ACP	Alternative Commercial Proposal
ADHD	Attention Deficit and Hyperactivity Disorder
ADS	Acute Day Service
ADT	Admission, Discharge, Transfer
AH	Allied Health
AHB	Area Health Board
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
AMP	Asset Management Plan
ANCC	American Nurses Credentialing Centre
AOHRCS	Adolescent Oral Health Regional Coordination Centre
AP	Annual Plan
APC	Annual Practising Certificate
APEX	Association of Professional & Executive Employees
APOC	Acute Packages of Care
AR	Annual Report
ARC	Aged Residential Care
ASMS	Association of Senior Medical Staff
AT&R	Assessment Treatment and Rehabilitation

Acronyms	Description
ATOD	Alcohol, Tobacco and Other Drugs
AUT	Auckland University of Technology
AVS	Accredited Visitor Service
AWOL	Absent without Leave
B4SC	Before School Checks
BC	Business Case
BF	Breast Feeding
BFHI	Baby Friendly Hospital Initiative
BP	Business Plan
BSC	Breast Screening Central
BSC	Balanced Scorecard
BSE	Bovine Spongiform Encephalomyelitis; also Breast Self Examination
BSI	Blood Stream Infections
BSMC	Better Sooner More Convenient
C&CS	Corporate & Clinical Support Directorate
CAFS	Child & Family Service
CAIT	Crisis and Acute Intervention Team
CAMHS	Child, Adolescent Mental Health Services
CAPEX	Capital Expenditure
Cascaded	Filtered down
CATT	Community Assessment & Treatment Team
CATT	Crisis Assessment Treatment Team
CAU	Children's Assessment Unit
CBA	Cost Benefit Analysis
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCMAU	Crown Company Monitoring Advisory Unit
CCMHS	Capital Coast Mental Health Service
CCON	Critical Care Outreach Nurse
CCP	Clinical Career Pathway (updated – refer to PDRP)
CCU	Coronary Care Unit
CDEM	Civil Defence & Emergency Management
CEA	Collective Employment Agreement
CEC	Collective Employment Contract

Acronyms	Description
CEG	Coordinating Executive Group
CEO	Chief Executive Officer
CFA	Crown Funding Agreement
CHC	Child Health Centre (no longer used)
CHE	Crown Health Enterprise
CHF	Congestive Heart Failure
CHFA	Crown Health Financing Agency
CHOD	Clinical Head of Department
CHS	Community Health Services
CIC	Capitation Information Cleansing
CIMS	Coordinated Incident Management System
CIO	Chief Information Officer
CIS	Clinical Information System
CLF	Clinical Leadership Forum
CLG	Clinical Leadership Group
CMA	Chief Medical Advisor
CME	Continuing Medical Education
CMHT	Community Mental Health Team
CMI	Chronically Medically Ill
CMO	Chief Medical Officer
CMS	Content Management System
CNL	Clinical Nurse Leader
CNM	Clinical Nurse Manager
CNS	Clinical Nurse Specialist
COO	Chief Operating Officer
COPD	Chronic Obstructive Pulmonary Disease
CORD	Chronic Obstructive Respiratory Disease
CPHAC	Community and Public Health Advisory Committee
CPI	Consumer Price Index
CPR	Cardio Pulmonary Resuscitation
CQI	Continuous Quality Improvement
CRCEO	Central Region Chief Executive Officers
CREDS	Central Region Eating Disorder Services
CRISP	Central Region Information Systems Plan
CRMHAN	Central Region Mental Health & Education Network

Acronyms	Description
CRRC	Crisis Respite & Recovery Centre
CRTAS	Central Regional Technical Advisory Service
CSC	Community Services Card
CSG	Community Steering Group
CSSD	Central Sterile Supplies Department
CSU	Central Sterilising Unit
CT	Computerised Technology
CTA	Clinical Training Agency
CWD	Case Weighted Discharges
CWDs	Caseweights
CYF	Children, Youth and Family
DAA	Designated Audit Agency
DAH	Director of Allied Health
DALY	Disability Adjusted Life Years
DAMHS	District Area Mental Health Services
DAO	Duly Authorised Officer
DAP	District Annual Plan
DBT	Dialectical Behaviour Therapy
DDG	Deputy Director General
DEMT	Director of Emergency Medicine Training
Detox	Detoxification Service
DFR	Dispensing Fee Revenue
DG	Director General
DGH	Director-General of Health
DHB	District Health Board
DHBNZ	District Health Boards of New Zealand
DHBSS	DHB Shared Services (supersedes District Health Boards New Zealand)
DID	Disabilities Issues Directorate
DIVA	Data Integrity Validation Activity
DN	District Nurse
DNA	Did Not Attend
DOA	Dead On Arrival
DON	Director of Nursing
DONM	Director of Nursing and Midwifery
DOSA	Day of Surgery Admission

Acronyms	Description
DPU	Day Procedure Unit
DRG	Diagnostically Related Grouping
Drivers	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSD	Disability Services Directorate
DSP	District Strategic Plan
DSS	Disability Support Services
DSU	Decision Support Unit
DSU	Dental Surgical Unit
DSU	(Perioperative) Day Surgery Unit
DSW	Department of Social Welfare
DT	Dental Therapist
EAP	Employee Assistance Programme
ECG	Electrocardiogram
ECT	Electro-convulsive Therapy
ED	Emergency Department
EDAHT&S	Executive Director Allied Health Technical & Scientific
EDISP	Electronic Dental Information System Project
EDSU	Extended Day Surgery Unit
EDT	Electronic Document Interchange
EEG	Electroencephalogram
EENT	Eyes, Ears, Nose and Throat
EEO	Equal Employment Opportunity
e-GIF	Electronic Government Interoperability Framework
ELR	Electronic Laboratory Reporting
ELT	Executive Leadership Team
EMC	Emergency Management Coordinator
EMT	Executive Management Team
EN	Enrolled Nurse
ENT	Ears, Nose and Throat
EOC	Emergency Operations Group
EPMU	Engineering, Printing & Manufacturing Union
EPOA	Enduring Powers of Attorney
EQ	Equipment
ERA	Employment Relations Act

Acronyms	Description
ERMA	Environmental Risk Management Agency
ESD	Environmentally Sustainable Design
ESPI	Elective Services Performance Indicators
EVA	Economic Value Added and Agreement
EWS	Early Warning Score
F&P	Funding & Planning
FACEM	Fellow of the Australasian College of Emergency Medicine
FACEM	Fellow of Accident & Emergency Medicine - (A Dr at Consultant level)
FACS	Facilitated Access to Co-ordinated Services
FFE	Fixtures, Fittings and Equipment
FFS	Fee for Service
FFT	Future Funding Track
FRAC	Finance Risk & Audit Committee
FRACP	Fellow of the Royal Australasian College of Physicians
FRS	Financial Reporting Standards
FS	Family Start
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
FU	Follow up Visit
FY	Full Year
GA	General Anaesthetic
GDB	General Dental Benefit
GDP	Gross Domestic Product
GIS	Geographical Information System
GM	General Manager *or* Group Manager
GMS	General Medical Services Benefit
GMT	General Management Team
GP	General Practitioner
GPL	General Practitioner Liaison
GPO	General Practice Obstetrician
GPP	Government Purchasing Policy
GPT	General Practice Team
GSE	Government Special Education
GSG	General Surgical & Gynaecology

Acronyms	Description
H&DC	Health and Disability Commissioner
HAC	Hospital Advisory Committee
HALE	Health Adjusted Life Expectancy
HASIE	Health & Safety in Employment
HBL	Health Benefits Limited
HCA	Health Care Assistant
HCHC	Hutt City Health Centre
HDB	High Dependency Beds
HDC	Health & Disability Commissioner
HDU	High Dependency Unit
HEHA	Healthy Eating, Healthy Action
HFA	Health Funding Authority (now disbanded)
HHC	Home Health Care
HHMT	Hutt Health Management Trust
HHS	Hospital and Health Service
HIH	Hospital in the Home
HINZ	Health Informatics New Zealand
HISAC	Health Information Strategy Advisory Committee
HISO	Health Information Standards Organisation
HMD	Hospital Monitoring Directorate
HMD	Health Monitoring Directorate
HNA	Health Needs Analysis or Health Needs Assessment
HOD	Heads of Department
HOP	Health of Older People
Hotel Services	Catering and Cleaning
HP	Health Promotion
HPCAA	Health Practitioners Competence Assurance Act
HPO	Health Protection Officer
HPS	Health Promoting School(s)
HQSC	Health Quality Safety Commission
HR	Human Resources
HRC	Health Research Council
HSC	Health Specialty Code
HUHU	High User Health Card
HV	Home Visit

Acronyms	Description
HVDHB	Hutt Valley District Health Board
HWIP	Health Workforce Information Programme
HWIS	Health Workforce Information Systems
I&E	Income & Expenditure
IANZ	International Accreditation New Zealand
IBA	Our Patient Management System
IBA	Information Builders of Australia
ICAFS	Infant, Child, Adolescent & Family Mental Health Service
ICC	Integrated Collaborative Care
ICD	International Classification of Diseases
ICO	Intermediate Care Officer
ICP	Integrated Campus Plan
ICU	Intensive Care Unit
IDAC	Infectious Diseases Advisory Committee
IDD	Intellectual Dual Diagnosis
IDF	Inter District Flow
IDP	Indicators of DHB Performance
IEA	Individual Employment Agreement
IEC	Individual Employment Contract
IFHC	Integrated Family Healthcare Centre
IFHN	Integrated Family Healthcare Network
IIA	Income in Advance
ILG	Information Liaison Group
IM	Information Management
IMAC	Immunisation Advisory Council
IMG	Independent Monitoring Group
interRAI	International Residential Assessment Instrument
IP	Inpatient
IPA	Integrated Practitioner Association
IPAC	Independent Practitioners' Association Council
IRR	Internal Rate of Return
IRS	Industrial Relations Strategy
IS	Information Systems / Information Services
ISO	International Standards Organisation
ISP	Independent Service Provider

Acronyms	Description
ISSC	Information Systems Steering Committee
ISSP	Information Systems Strategic Plan
IT	Information Technology
ITO	Industry Training Organisation
IV	Intravenous
IVF	In-Vitro Fertilisation
JV	Joint Venture
Kaupapa	The programme
KM&T	Knowledge Management and Transfer
Kotahitanga	Integrity of thought and action
KPIs	Key Performance Indicators
KRA	Key Result Area
LAG	Local Advisory Group
LAMP	Leadership and Management Programme (run through DHBNZ)
LECG	Law and Economics Consulting Group
LJU	Level J Unit
LMC	Lead Maternity Carer
LOS	Length of Stay
LPI	Leadership Practices Inventory
LTC	Long Term Conditions
LTSA	Land Transport Safety Authority
Manaakitanga	Respectful and caring
MAP	Management Action Programme (run through DHBNZ) or Ministry Approved Plan
MAPO	Maori Co-Purchasing Organisations
MAPU	Medical Assessment Patient Unit
MC&C	Medicine, Cancer & Community Directorate
MCNZ	Medical Council of New Zealand
MDC	Masterton District Council
MDO	Maori Development Organisations
MDT	Multidisciplinary Team
MECA	Multi Employer Collective Agreement
MeNZB	Meningococcal B Immunisation Programme
MERAS	Midwifery Employee Representation & Advisory Service
MF (score)	Missing Filled *(score) (dental services)*

Acronyms	Description
MH	Mental Health
MHC	Mental Health Commission
MHDU	Maori Health Development Unit
MHINC	Mental Health Information National Collection
MHS	Mental Health Services
MH-Smart	Mental Health Standard Measures of Assessment and Recovery
MI	Myocardial Infarction
MMH	Manager of Mental Health
MMHA	Maori Mental Health, Adult
MMHC	Maori Mental Health, Child
MMR	Measles-Mumps-Rubella
MNIS	Maternity & Newborn Information System
MOA	Memorandum of Agreement
MOA	Mapusaga o Aiga mo Tagata Pasefika (MoA Trust)
MOH	Ministry of Health
Mohiotanga	Knowledge and understanding leading to innovation and learning
MOSS	Medical Officer Special Scale
MOW	Meals on Wheels
MPDS	Maori Provider Development Scheme
MRI	Magnetic Resonance Imaging
MRSA	Multiple Resistant Staphylococcus Aureus
MRT	Medical Radiation Technologist
MSD	Ministry of Social Development
MSG	Maternity Steering Group
MSU	Mid Stream Urine Test
MSW	Medical Surgical Ward
MT	Management Team
MUCA	Multi Union Collective Agreement
MVS	Meningococcal Vaccine Strategy
NA	Needs Assessment
NASC	Needs Assessment and Service Coordination
NB	Newborn
NBRS	National Booking Reporting System
NCG	National Service Framework Co-ordination Group
NCIWR	National Collective of Independent Women's Refuges

Acronyms	Description
NCSP	National Cervical Screening Programme
NDPG	National Data Policy Group
NDU	Nursing Development Unit
NDU	National Distribution Union
NEAC	National Ethics Advisory Committee
NENZ	Nurses Executive New Zealand
NETP	Nursing Entry to Practice
NGO	Non Governmental Organisation
NHI	National Health Index or National Health Indicator
NHPPD	Nursing Hours per Patient Day
NICU	Neonatal Intensive Care Unit
NIISG	National Influenza Immunisation Strategy Group
NIR	National Immunisation Register
NMDS	National Minimum Date Set
NMPC	Nursing and Midwifery Practice Committee
NPAT	Net Profit After Tax
NPP	National Pricing Programme
NPV	Net Present Value
NRH	New Regional Hospital
NSF	National Service Framework
NSSP	National Cervical Screening Programme
NSU	National Screening Unit
NUPE	National Union of Public Employees
NWR	Non-work Related
NWTP	National Waiting Times Project
NZAOT	New Zealand Association of Occupational Therapists
NZBS	New Zealand Blood Service
NZCA	New Zealand Coding Authority
NZCOM	New Zealand College of Midwives
NZDS	New Zealand Disability Strategy
NZGG	New Zealand Guidelines Group
NZHIS	New Zealand Health Information Service
NZHPA	New Zealand Healthcare Pharmacists Association
NZHS	New Zealand Health Strategy

Acronyms	Description
NZIFRS	New Zealand International Financial Reporting Standards
NZMM	New Zealand Materials Managers
NZNO	New Zealand Nurses' Organisation
NZPHDA	New Zealand Public Health & Disability Act 2000
NZPHO	New Zealand Public Health Observatory
NZQF	New Zealand Quality Forum
O&G	Obstetrics and Gynaecology
OAG	Office of Auditor-General
OCP	Output Collection Programme
OCT	Organisational Culture Inventory
OD	Overdue
OECD	Organisation for Economic Cooperation & Devel
OIA	Official Information Act
OMD	Ownership Monitoring Directorate *(ex CCMAU)*
OP	Outpatient
Op EMT	Operation Executive Management Team
OPD	Outpatient Department
OPF	Operational Policy Framework
OPF	Operational Policy Framework
OPMHS	Older Persons Mental Health Service
OPRS	Older Persons Rehabilitation Service
OSH	Occupational Safety and Health
OSJ	Order of St John
OT	Occupational Therapist
OTS	Opioid Treatment Service
P&L	Profit & Loss
PACS	Picture Archival Computer System
PACS	Picture Archiving Communication
PACU	Post Anaesthetic Care Unit
PAFT	Parents As First Teachers
PAM	Performance & Accountability Monitoring
PATHS	Providing Access to Health Solutions Programme
PBFF	Population Based Funding Formula
PC	Personal Care

Acronyms	Description
PCO	Primary Care Organisation
PDR	Performance Development Review
PDRP	Professional Development and Recognition Programme
PET	Pre-eclampsia Toxemia
PFA	Public Finance Act 1989
PFC	Patient Focused Care
PHC	Primary Health Care
PHC	Public Health Commission
PHI	Public Health Intelligence
PHN	Public Health Nurse
PHO	Primary Health Organisation
PHOAG	Primary Health Organisation Advisory Group
PHU	Public Health Unit
PIB	Proposal for Inclusion in Budget
PICU	Psychiatric Intensive Care Unit
PIP	Project Implementation Plan
PIU	Pacific Island Unit
PN	Practice Nurse
PNS	Practice Nurse Subsidy
POCT	Point of Care Testing Proposal
PPE	Personal, protective equipment.
PPPR Act	Protection of Personal and Property Rights Act
PQ	Parliamentary Question(s)
PSA	Public Service Association
PSLG	Patient Safety Leadership Group
PSSG	Primary Secondary Strategy Group
PT	Physiotherapist
PTO	Patient Transfer Officer
PUC	Purchase Unit Cost
PV	Price Volume
PWDAG	Pacific Women Data Advisory Group
QHNZ	Quality Health New Zealand
QIPS	Quality Innovation & Patient Safety Directorate
QRU	Quality Resource Unit
QS	Quantity Surveyor

Acronyms	Description
Rangatiratanga	Self determining and taking responsibility
RC	Responsible Clinician
RCSP	Regional Clinical Services Plan
RDA	Resident Doctors Association
RFF	Regional Funding Forum
RFP	Request for Proposal
RG	Referral Guidelines
RHA	Regional Health Authority
RHMU	Residual Health Management Unit
RHSS	Regional Health Surveillance System
RLC	Regional Leadership Committee
RMA	Resource Management Act
RMO	Resident Medical Officer
RN	Registered Nurse
ROI	Registration of Interest
ROT	Registered Occupational Therapist
RPH	Regional Public Health
RSM	Referred Services Management
RSP	Regional Services Plan
RTD	Returned
RTS	Regional Tertiary Services
RWL	Residual Waiting List
SAATS	Sexual Assault Assessment and Treatment Service
SAC	Severity Assessment Criteria
SAPU	Surgical Assessment Patient Unit
SAT	Self Assessment Tool
SAU	Surgical Admission Unit
SBL	Surgical Booking List
SBVS	School Based Vaccination Service
SC	Service Continuums or Service Co-ordination
SCBU	Special Care Baby Unit
SDS	School Dental Service
Sentinel event	Physical or psychological injury
SF	Schizophrenia Fellowship
SFG	Service Framework Group

Acronyms	Description
SFWU	Service and Food Worker Union
SHPA	Society of Hospital Pharmacists Australia
SIA	Services to Improve Access
SIDS	Sudden Infant Death Syndrome
SIDU	Service Integration & Development Unit
SLA	Service Level Agreement
SLT	Speech Language Therapist
SMM	Safe Medication Management
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SOI	Statement of Intent
SP	Strategic Plan
SPA	Support Package Allocation
SPNIA	Service Planning and New Health Intervention Assessment (Framework)
SRCLG	Sub-Regional Clinical Leadership Group
SRS	Specialist Rehabilitation Service
SSC	State Services Commission
SSH	Selina Sutherland Hospital
SSRI	Selective Serotonin reuptake inhibitors (a group of antidepressants
SSSG	Shared Support Services Group
SSU	Short Stay Unit
SSU	Sterilizing Services Unit
Stakeholder	Groups and individuals who have a direct or indirect Interest in the District Health Board and its activities
STR	Standard Discharge Ratio
STV	Single Transferable Vote
SW	Social Work
SWC	Surgery, Women & Children's Directorate
TAC	Travel and Accommodation
TAG	Technical Advisory Group
Tangata Whaiora	Consumers
TAP	Technical Advice Programme - for drinking water
TAS	Technical Advisory Service
TAT	Turnaround Times
Taumatatanga	Excellence

Acronyms	Description
TBA	To be advised
TBC	To Be Confirmed
Tikanga	The essence of Māori values and traditions
TLA	Territorial Local Authorities
TMP	Top Management Programme (run through DHBNZ)
TOP	Termination of Pregnancy
TOR	Terms of Reference
TOW	Treaty of Waitangi
TWA	Te Whare Ahuru (Acute In-Patient Service – Mental Health)
UHHC	Upper Hutt Health Centre
UPC	User Park Charge
VfM	Value for Money
VHT	Vision Health Technician
VNT	Visiting Neurodevelopment Therapist
WAICAP	Wairarapa Care of Aged Persons
WaiDHB	Wairarapa District Health Board
Wairuatanga	Holism with spirituality as the underlying essence
WAS	Wairarapa Ambulance Service
Wash-up Process	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.
WAVE	Working to add value through E information *(Information Technology term)*
WBS	Wairarapa Building Society
WCPHO	Wairarapa Community Primary Health Organisation
WCSAP	Wairarapa Clinical Services Action Plan
WCTAG	Well Child Technical Advisory Group
WDHB	Wairarapa District Health Board
Whakamiharotanga	Acknowledging our achievements
Whanaungatanga	Creating relationships and partnership
WHO	World Health Organisation
WIES	Weighted Inlier Equivalent Separation
WIPA	Wellington independent Practitioners Association
WOOPS	Wairarapa Organisation for Older Persons
WPH	Wairarapa Public Health
YAG	Youth Action Group

Acronyms	Description
YLD	Years Lost to Disability
YLL	Years of Life Lost
YOT	Youth Offending Teams
YTD	Year to Date

Appendix 6 | Engaging with Maori

The 3 LNI DHBs are committed to optimising and improving the health outcomes of its combined population groups. All DHBs have obligations to consult and engage with Māori and these obligations are met at WDHB, HVDHB and CCDHB through:

- Māori membership on the boards of the DHBs
- Māori membership on Board committees
- Consultation with the Maori Partnership Board or other appropriate bodies
- Operationalising engagement by:

    - supporting Māori providers and designated Māori specific positions at the operational level
    - having relevant Māori consumer input to improve front line services

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Date	03/03/2014
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Follow up Date	
Action	
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27 February 2014

Mr Graham Dyer
Chief Executive Officer
Hutt Valley District Health Board
Corporate Office
Private Bag 31 907
LOWER HUTT 5040

Dear Graham

Health target results for quarter two of 2013/14 are now finalised. I am very pleased to advise that this quarter the following targets have been met at the national level:

- Improved access to elective surgery - *national result 105 percent*
- Shorter waits for cancer treatment - *national result 100 percent*
- Increased immunisation - *national result 91 percent*
- Better help for smokers to quit (hospitals) - *national result 95 percent.*

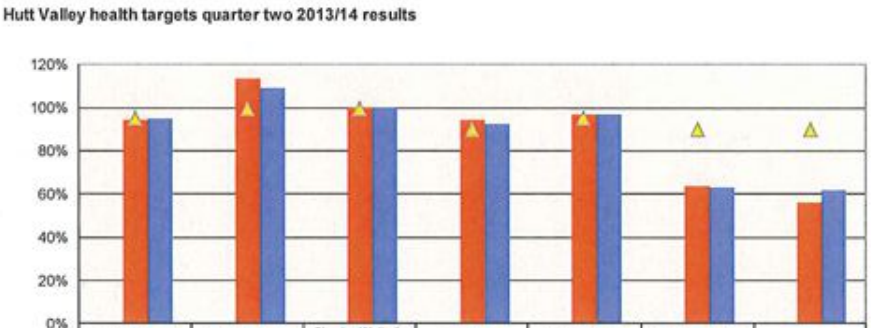
National performance for the Shorter stays in emergency departments target has reached 94 percent, this is the highest national result for this target to date.

While good progress has been made at a sector level, continuing focus is needed by DHBs to improve performance for the Better help for smokers to quit (primary care) target and the More heart and diabetes checks target.

National performance for the Better help for smokers to quit (primary care) target is 66 percent this quarter. Although this result is a 6 percent increase on our quarter one result, only one DHB met the target, and we remain some way off the target goal of 90 percent.

National performance for the More heart and diabetes checks target improved to 73 percent this quarter; although sector momentum has been positive, no DHBs have met the target.

Your DHB results for each target are summarised below.



	Shorter Stays in Emergency Departments	Improved Access to Elective Surgery	Shorter Waits for Cancer Treatment (radiotherapy and chemotherapy)	Increased Immunisation (8-month-olds)	Better Help for Smokers to Quit - Hospitals	Better Help for Smokers to Quit - Primary Care	More heart and diabetes checks
Ranking quarter two 2013/14	11	5	1	9	7	14	19
Quarter one 2013/14	94.6%	113.3%	100.0%	94.2%	96.8%	63.7%	55.8%
Quarter two 2013/14	94.9%	109.0%	100.0%	92.3%	96.7%	62.8%	62.1%
National goal	95.0%	100.0%	100.0%	90.0%	95.0%	90.0%	90.0%

The Ministry's Target Champions have provided feedback on your quarter two results. Please refer to the health targets material on the Ministry website for additional detail, including time series information and performance by ethnicity www.health.govt.nz/healthtargets

Mike Ardagh, Target Champion, Shorter stays in emergency departments
It is pleasing that you have continued to achieve the Shorter stays in emergency departments target in quarter two.

Clare Perry, Target Champion, Improved access to elective surgery
Hutt Valley DHB has continued to perform strongly during the second quarter of 2013/14, with 2602 people having elective surgery as at the end of December. This is 214 discharges (9 percent) more than planned, and is a very good result. Well done.

Andrew Simpson, Target Champion, Shorter waits for cancer treatment
I am pleased to see that Hutt Valley DHB continues to achieve the Shorter waits for cancer treatment health target in quarter two. I look forward to working with you over the next few months as we plan for, and then begin to deliver, the new Cancer health target.

Pat Tuohy, Target Champion, Increased immunisation
I appreciate the efforts made by Hutt Valley DHB and its immunisation sector, but note that coverage decreased to 92 percent. Now is the time to increase coverage to reach 95 percent by December 2014 as I believe this is achievable. Please pass on our appreciation to the immunisation teams.

Karen Evison, Target Champion, Better help for smokers to quit
I am disappointed that Hutt Valley DHB's primary care result did not change significantly from quarter one, and that the DHB continues to perform below the national result. I suggest that you work closely with Dr John McMenamin during quarter three to establish more sustainable systems and processes.

In regard to your hospital result, I am pleased that the DHB exceeded 95 percent again this quarter. Please pass on my thanks and congratulations to all of your hospital staff for their continued commitment.

Helen Rodenburg, Target Champion, More heart and diabetes checks
Your result this quarter at 62.1 percent is again a great improvement on last quarter with an increase of 6.3 percent. You are making significant progress and the PHOs have some very good initiatives underway. I look forward to seeing this improvement being sustained over the coming months. Well done.

The Ministry will publish target results in five national newspapers, the New Zealand Herald, Waikato Times, The Dominion Post, The Christchurch Press, and the Otago Daily Times on Tuesday, 25 February 2014. As occurs each quarter, a wider package of supporting information has been sent to DHB General Managers Planning and Funding, and to Communication Managers.

You will receive an update on quarter two PHO performance against the primary care focused targets shortly.

As you are aware, the Minister of Health confirmed the health target set for 2014/15 in his recent letter of expectations. A shift in the focus for the cancer target towards Faster Cancer Treatment was signalled, however the other targets remain stable allowing you to build on your existing approaches to target achievement. I look forward to seeing concrete and measurable actions that support delivery of the 2014/15 health targets in your draft 2014/15 planning documents in March.

Yours sincerely

Chai Chuah
Acting Director-General of Health

cc Dr Virginia Hope, Chair, Hutt Valley District Health Board

Hutt Hospital Operational Services

Monthly Balanced Scorecard January 2014

KEY PERFORMANCE INDICATORS 2013/2014

PATIENT EXPERIENCE

	Jan-14		Period	
	Target	Month	YTD	QTR3
Shorter Stays in Emergency Departments	95%	**95%**	95%	**95%**
Improved Access to Elective Surgery	100%	**105%**	109%	**105%**
Better Help for Smokers to Quit	95%	**96%**	97%	**96%**
	Target	Month	Target	YTD
Mental Health Relapse Prevention Plans	95%	**90%**	95%	**91%**
HONOS Compliance - Inpatient	75%	**91%**	75%	**82%**
HONOS Compliance - Community	55%	**68%**	55%	**69%**
Bed Days due to Cellulitis (Avg LOS)	3.0	**3.1**	3.0	**2.7**
Surgical Site Infections Reported	1	**2**	7	**3**
Patient Falls Causing Harm	12	**13**	84	**110**
Medication Errors	20	**20**	140	**153**
Pressure Injuries	3	**2**	21	**13**

WAITLISTS

	Waitlist Patients (ESPI5 and ESPI2)			
	Target	Month	Booked	Unbooked
Waiting >150 days for Treatment (ESPI5)	0	**76**	52	24
Waiting >150 Days for Outpatient FSA (ESPI2)	0	**62**	10	52

HEALTHY WORKPLACE

	Jan-14		Period	
	Target	Month	Target	YTD
Hospital Staff Turnover % (Headcount)	10%	**17.9%**	10%	**10.6%**
Sickness Absence - % Paid Hours Worked	2.3%	**1.4%**	2.3%	**2.7%**
Number of Staff having >24 Mths O/S Leave			180	**188**
Physical Assaults [NEW]	U/D	**2**	U/D	**43**
Blood and Body Fluid Exposure [NEW]	U/D	**2**	U/D	**11**
Slips, Trips and Falls [NEW]	U/D	**3**	U/D	**17**
Appraisal rate [NEW]			50%	35%

MOH Performance Measures | MOH Health Targets

PROCESS & EFFICIENCY

	Jan-14		Period	
	Target	Month	Target	YTD
Inpatient Acute Readmission Rate Dec-13	8.0%	**8.8%**	8.0%	**8.6%**
Mental Health Readmission Rate Dec-13	8.0%	**7.4%**	8.0%	**9.5%**
Acute Inpatient Length of Stay	3.9	**4.0**	3.9	**3.9**
Elective Inpatient Length of Stay (Surgical)	3.2	**2.7**	3.2	**3.0**
Elective/Arranged Day of Surgery Admission	95%	**94%**	95%	**95%**
Ward Bed Utilisation - Daily (Incl Weekends)	85%	**83%**	85%	**88%**
Ward Bed Utilisation - Weekdays Only	85%	**85%**	85%	**90%**
Funded Theatre Sessions Utilised	95%	**89%**	95%	**86%**
Theatre Session Utilisation (Time in Theatre)	85%	**79%**	85%	**79%**
Theatre Sessions Starting on Time	90%	**90%**	90%	**90%**
Acute Patients impacting on Elective Sessions	43	**23**	301	**262**
Cancelled on Day of Surgery - Patient	10	**11**	81	**69**
Cancelled on Day of Surgery - Hospital	12	**7**	95	**7**
Cancelled on Day of Surgery - Percentage	5.0%	**4.9%**	5.0%	**4.7%**
Outpatient DNA (FSA & Followup)	275	**415**	2389	**3627**
Outpatient DNA (FSA & Followup) - DNA Rate	6.0%	**9.1%**	6.0%	**9.1%**

Ward Utilisation is General Wards Only: Surgical, Medical, Rehab, Orthapaedic, Plastics Wards

VALUE FOR MONEY

	Jan-14		Period	
	Target	Month	Target	YTD
Total Caseweight	1719	**1653**	12210	**12970**
Elective Caseweights	488	**517**	3667	**4003**
Acute Caseweights	1230	**1136**	8543	**8967**
Outpatient FSA Volumes	1340	**1047**	9809	**8428**
Outpatient FU Volumes	2980	**2582**	21727	**23331**
Hospital FTEs inc overtime	1560	**1558**	1572	**1551**
Hospital Operating Costs ($'000)	15,943	**16,248**	110,389	**111,769**
Hospital Personnel inc outsourced ($'000)	12,014	**12,221**	81,467	**81,930**

KEY: N/A = Not available U/D = Under Development

Key Issue | Alert | Good News

3DHB Health Service Development Programme Report 4th March 2014

February Programme Highlights;

Sub Regional Diagnostic Radiology Project – Good momentum has been made in the last month with the Steering Group agreeing the key work plan and key actions to progress sub regional services design. The Steering Group has been expanded to include Wairarapa and primary care representation for the sub region, nominated by the Alliance Leadership Teams (ALTs). Key points to note include:

- Key communications for both staff and the ALTs have been developed and will be released shortly
- An operations group is being established to progress the detailed design of operating as a single radiology service
- The steering group are reviewing requests for capital and FTE across sub regional radiology services to ensure any future invest fits with the sub regional direction
- A concept paper is being finalised for consultation with the all staff building on previous workshops held before Christmas.

Based on the work from radiology workshops and consistent with broader 3DHB work, this project will explore how we might best develop and implement a sub-regional diagnostic imaging service across three DHBs to enhance patient flows and make the best use of our existing resources. In late March and early April, we will be consulting with radiology staff about what it means to be a single radiology service and how we can make this happen. This will include consulting on a possible structure for a sub-regional diagnostic imaging service across three DHBs.

Non Melanoma Skin Cancer – SIDU is providing support to progress this sub regional project looking at the design of a Sub-regional Non Melanoma Skin Cancer Service that would include the following components:

- Provide equity of care and access to all patients across the sub-region for non melanoma skin cancer
- Provide an equitable pathway of referral
- Service design informed by the best clinical outcome for patients through the best use of existing resources.

Sub Regional Child Health Project – The two sub regional work streams looking at acute care and primary/secondary interface are meeting fortnightly with project briefs completed for both work streams and work programmes now being developed. The project team are conscious that primary cares involvement is critical in all the service design work. The overarching demographics, projected demand and health services planning information have been requested, along with the full service specification and contracted services by each DHB for child health.

3D HealthPathways launch – The Sub-regional HealthPathways programme was launched on the 20th and 21st February at Westpac stadium and was attended by over 160 staff across the three DHBs and five PHOs. Despite the Canterbury team being unable to get into the event due to fog, a live video and meeting link was established and the first day of the launch was completed with the Canterbury team remotely from Christchurch. There is now significant momentum with this programme of work with the Governance Group, Clinical Editors, Clinical Lead and the project team now focussing on preparing for the launch of the 3D HealthPathways website and preparation for the first 20 sub-regional pathways which will include the 15 or so ENT pathways already developed and some of the already developed Hutt DHB pathways. An ongoing programme of work will now commence looking at the rapid localisation of existing pathways across the three DHBs combined with the larger service design work occurring in services such as Child Health and Radiology.

Key Planned Activities/Emerging Priorities;

- *Sub Regional Diagnostic Radiology* – communications, concept paper preparation.
- *Clinical Pathways* – Launch of the 3D HealthPathways website, finalisation of 20 sub regional clinical pathways in preparation for the launch of the 3D HealthPathways website, prioritisation of a work programme for the remainder of the year.
- *Non Melanoma Skin Cancer* – Developing project scope and pulling together a sub regional steering group.
- *Child Health* – progressing service design and background data to support the case for change.
- *Clinical Leadership Group* – review of terms of reference and discussion regarding purpose and function in the sub regional environment.

Emerging Priorities - Dermatology, ICU/HDU, Anaesthetics, Secondary Obstetrics.

New Risks/Concerns and Mitigation;

N/A

Communication;

- 3D HealthPathways launch being prepared.

Appendix Six - RPH Wairarapa involvement in Nutrition and Physical Activity Initiatives

Initiatives in Schools and Early Childhood settings	**Aim**	**RPH Wairarapa Involvement**
Early Childhood Health Bus Project.	The aim of this project is to improve health literacy through increasing health knowledge levels and health interpretation skills at an early childhood level for children, parents and teachers.	The development, implementation and review of the programme throughout 2013. The overarching goal of improved health literacy levels incorporates the following goals: (1) That children in early childhood have an increased knowledge of health related issues and are able to interpret basic health information when confronted with it; (2) that parents can interpret health information so they can make the right choices for their children and whānau, and (3) that teachers are also able to interpret health information in order to advise parents and assist tamariki and whānau to make better choices. These goals with health literacy at the forefront of the programme's thinking aim to improve health literacy levels three-fold. Several high need Early Childhood Centres are interested in this project for their centres in 2014.
Nutrition education sessions as requested by school and/or early childhood settings.	The aim of this work is to improve health literacy through increasing health knowledge levels and health interpretation skills for students.	Provides education, training and support to students for the development of healthy nutrition practices and sufficient physical activity.
Initiatives in community		
Wairarapa Baby Friendly Community Initiative (BFCI).	Increased breastfeeding rates for our most vulnerable families and greater community engagement in supporting families to breastfeed for as long as possible.	Coordinate and participate in Baby Friendly Community Initiatives (BFCI) e.g. 'The Big Latch' event to be held in August 2014.
Active Families Programme implemented by Sport Wellington Wairarapa.	To improve the health and well-being and to reduce the burden of disease through better nutrition and regular physical activity.	RPH Wairarapa monitored the contract which finished November 2013.

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa / HUTT VALLEY DHB	**BOARD INFORMATION PAPER**
	Date: March 2014

Author	Helen Pocknall, Executive Director of Nursing and Midwifery
Endorsed By	Graham Dyer, Chief Executive
Subject	**Nursing Update**

RECOMMENDATION

It is recommended that the Boards

a. **Note** the information provided.

1 NURSING

1.1 Medical Floor Update (Hutt)

Good progress is being made regarding the programme of work for the medical floor. Actions completed from recommended action plan are as follows:

- RN recruitment 3.0 FTE - roster fully staffed from April 2014
- Clinical Nurse Educator position appointed on one year secondment from CCDHB
- Clinical Nurse Manager position (3rd advertisement) – have had applications but no suitable candidates so far. Interviewing one candidate on Friday 28th February, 2014 and a further on 7th March. The interim manager's contract ends on 30th March, 2014. At this point she does not wish to continue in the position
- Coordinator study day held on 29th January; second study day to be held on March 26th, 2014
- All ACNM positions recruited to and on the roster from March 3rd, 2014 (3.0FTE)
- Some environmental changes actioned , e.g. damaged vinyl sealed or replaced, painting of door frames and doors)

1.2 Integration of Practice Development Unit and Education Team across Wairarapa and Hutt

- Formal notification has been given to staff in the Practice Development Units (PDU) and in nurse educator roles across Wairarapa and Hutt Valley DHBs as well as other key stakeholders, of the intention to more formally integrate the two teams and educator functions. Integration will assist in ensuring the best use resources and utilisation of skills and expertise from within both teams across both sites. The intended outcome is that there will be one PDU and one education team for two DHBs and two sites.

1.3 Nurse Practitioners (Wairarapa and Hutt)

- One of the senior nurses for respiratory services based at the Hutt has recently achieved Nurse Practitioner status. The nurse has been in a Nurse Practitioner in Training role within the service for some time.
- Two Wairarapa Primary health care nurses will be submitting their portfolios in order to achieve NP status later in 2014.

PUBLIC

1.4 Nursing Entry to Practice Programme (NETP) (Wairarapa and Hutt)

- Graduation for the 2013 Hutt cohort was celebrated on 29 January (Wairarapa's celebration occurred in December). The 2014 cohort of new graduate nurses commenced in January with 31 in the Hutt Valley (22 Provider Arm, 5 Mental Health 4 external) and 7 in the Wairarapa (Provider Arm only). They have begun their post graduate paper through Victoria University.
- Approval for extra new graduates (Board paper December 2013) was finalised and graduates in the Wairarapa have been placed in Acute Services (3), Paeds (1), MSW (2), Peri-Op (1) and Rehab (1). The ethnicity of the graduates is as follows: NZE-4, NZM-2, Pacific Islander-1
- The ethnicity of the graduates for Hutt Valley NETP is as follows: Indian – 1, NZE/P – 16, Philippines – 1, NZM – 3, Samoan – 1, South African – 1, Australian – 1.

1.4.1 NETP Graduate Nurse Funding Support (Hutt Hospital Foundation Trust)

Supporting the employment of NETP graduate nurses, including in primary health care and aged residential care has been identified as a priority both nationally and locally. With this in mind, Hutt Valley DHB agreed with the Hutt Hospital Foundation Trust to dedicate some of the Primary Health Nurse Education Fund (administered through the Hutt Hospital Foundation Trust) toward helping the employment of graduate nurses in primary health care. At the same time Te Awakairangi Health Network also agreed to support employment of NETP graduate nurses through extra funding.

A promotional campaign to encourage the employment of NETP graduate nurses across the Hutt Valley community was launched together with Te Awakairangi Health Network. Overall this campaign was successful with the employment of four nurses in the community. This includes three graduate nurses in general practice – Upper Hutt Health Centre, Whai Oranga Health Centre and Hutt Union and Community Health Service (HUCHS). Two of the three general practices met the criteria to receive funding support toward the employment of a NETP graduate nurse through the Hutt Hospital Foundation Trust and also through Te Awakairangi Health Network. HUCHS received full funding to employ a graduate nurse through the Ministry of Health's Very Low Access Practice (VLCA) funding.

One graduate nurse has been employed in an Aged Residential Care Facility – Shona McFarlane, and they also were successful in receiving additional funding support from the Ministry of Health.

2.0 Nursing Innovations (Hutt)

2.1 Hutt Hospital Foundation Trust - Primary Health Nurse Innovation Fund 2013/14

The Primary Health Nurse Innovation Fund is funded through the Hutt Hospital Foundation Trust to support the implementation of nursing innovations in the Hutt Valley as well to improve access to Hutt Hospital provided education. In December 2013 the Innovation selection panel approved two local applications. These include:

1. **Ka ū Ki te Pai–Breastfeeding Service** – provided by Tamariki Ora, Te Runanganui Taranaki Whanui O te Upoko A Maui.

- This innovative project will offer the establishment of an ongoing breastfeeding support service that targets high need population, across different communities in the Hutt Valley. Support will be provided from Tamariki Ora, Pacific Health and Plunket-Well Child nurses.

- A Lactation Consultant will be employed to provide this service with the goal being to increase the rates of breastfeeding. It is anticipated this will contribute to a reduction in avoidable hospital admission rates at Hutt Valley District Health Board (HVDHB). Research indicates that children that are breastfed have less respiratory infections, pneumonia and gastroenteritis, reduced chance of obesity and diabetes, and improved nutrition.
- The Hutt Valley breastfeeding statistics show a consistently low breastfeeding rate compared to the National average (New Zealand Breastfeeding Authority, 2013) with Māori having significantly lower rates than the rest of the population, and this is of concern. It is anticipated this project will help improve these statistics.

- Some key objectives of the project include: to provide a whanau-led approach to health and wellness; to increase knowledge base and professional expertise around breastfeeding with whanau in the Hutt Valley; adopting an early intervention approach to better act as a portal, identifying high need and to refer appropriately across the range of health and social services; to work collaboratively across Well child/Tamariki ora/health and a social sector service in the Hutt Valley in ensuring that breastfeeding remains high in the agenda.
- The project will be commencing in February 2014 and will be implemented through to December 2014.

2. **Respiratory Care Bundles** – this project is a joint application with the Respiratory Service (Nurse Practitioner) Hutt Valley DHB and Gain Health Centre, Upper Hutt.

- The purpose of this project is to design and pilot a Chronic Obstructive Pulmonary Disease (COPD) and asthma 'care bundle' to use in primary care (Gain Health Centre to pilot) to reduce admissions to secondary care.
- The primary aim is to reduce the number of avoidable urgent General Practitioner consults, Emergency Department presentations and hospital admissions for those with COPD and asthma.
- Secondary aims include: to increase the number of COPD and asthma patients with a personalised self management plan; to improve inhaler technique and adherence in those with COPD and asthma; to improve knowledge in respiratory nursing and support for Practice Nurses at Gain Health and to establish if a primary care 'care bundle' is of value.
- The project commences in February 2014 through to December 2014, and its progress and potential transferability to Primary Health Care in the Hutt Valley is of great interest.

2.2 Harry Kent Estate Fund

The Harry Kent Estate Fund was established through the Hutt Hospital Foundation Trust in late 2013 for District Nurses.

- In 2013 a bequest was left specifically to District Nurses in support of their professional development. The Fund is administered through the Hutt Hospital Foundation Trust. Together with the Hutt Hospital Foundation Trust the processes for promotion of the Fund, application and selection have been developed by the PDU.
- Harry Kent was a Hutt Valley resident who wanted to thank District Nurses for the care and support they provided to his wife through her failing health. In his Will he requested a trust fund be formed specifically for District Nurses to support their professional development.
- The Harry Kent Estate Fund Committee will manage the Harry Kent Estate Fund and this includes the Executive Director of Nursing and Midwifery (Wairarapa and Hutt Valley DHBs), Nurse Consultant Primary and Community, a Hutt Hospital Foundation Trust representative and the Nursing Director Medical and Community Health.

- The Committee selection panel met in February 2014 for the first time to approve applications. At that time only one application had been received and this was approved. The low uptake was considered to be due to the time of year, including District Nurses being on Christmas and New Year leave.
- The Harry Kent Estate Fund will continue to be promoted to District Nursing, with the selection panel meeting twice a year, or more frequently if required.

3.0 Health Workforce NZ Post Graduate Education (Wairarapa and Hutt)

Hutt:–

A total of 64 nurses are receiving HWNZ postgraduate Nursing Funding this academic year. Of that number there are in Primary – 10, Aged Care – 2, Hospital – 52 nurses being supported. There have been seven withdrawals with four not able to be replaced. We have eight on the waiting list for semester two.

Wairarapa:–

A total of 20 nurses are receiving HWNZ Postgraduate Nursing Funding. This number consists of Primary- 8, Aged Care- 2, Hospital-11 nurses. There have been four withdrawals from papers with only two able to be replaced.

4.0 Falls (Wairarapa and Hutt)

- The Clinical Lead for Falls at the Health Quality and Safety Commission visited Hutt Valley mid-January, managing to speak with some of the Falls Committee members and Clinical Nurse Managers. As a result the Falls Committee has a plan for this year which will involve improving documentation and the roll out of the Signalling System. The Wairarapa Falls Committee is also planning the roll out of the signalling system.
- The Regional Falls Prevention Working Group have reconvened and held its first teleconference. The lead DON from Hawkes Bay will approach the Central Region Patient Safety Campaign Group for set up costs for the Patient Signalling System on behalf of 5 out of the 6 Central Region DHBs (CCDHB has already successfully secured this funding).
- All DHBs aim to have the roll out of the Signalling System as the main focus of the HQSC April Falls campaign

5.0 Care Capacity Demand Management Project (CCDM) (Hutt)

- The Coronary Care Unit was selected as the Pilot Ward for Part 1 of the CCDM Programme. Part 1 is intended to capture all the activities undertaken by all staff that work in an area. There was excellent buy-in to and engagement with this from all staff; nurses, doctors, allied health, clerical and health care assistant staff. The data is still being entered and then will be analysed for patterns and trends. Training occurred for key stakeholders in January on how to use the data gathered from TrendCare to inform FTE calculation. A full "Churchill" exercise will be undertaken in the coming months. This is a desk top exercise which mimics all the activity that occurs across the hospital on a particular day.
- It is hoped to have a second ward participating in Part 1 by June.

6.0 Sub-region (3 DHBs)

6.1 Palliative Care

- A series of activities are occurring across all three DHBs with the first meeting of the newly formed Palliative Care Clinical Network taking place last month. This network has evolved as the result of an initial sub regional EOI submitted to Health Workforce New Zealand to become a pilot network.

This initiative has attracted substantial funding over the three year period. Both nursing and medical staff from Hutt and Wairarapa are actively involved in the fledgling network.

- Nurse Educators across the three DHBs and Hospices are working together to integrate policies and procedures and training for staff. They will be supporting one another to deliver training and education in each of the three DHBs.

6.2 Nursing Leadership

- Sub regional DHB nursing leaders met briefly this month to consider how we will work more closely together and to discuss what the priorities will be for nursing at a sub regional level. A draft Terms of Reference and Work plan is under development as a result of the meeting. These will be finalised over the next month.

Appendix Eight - Wairarapa and Hutt Communications Update March 7 2014

1 External communications / Media

Health Highlights

Revised design implemented, including Board photo line-up and Chair's column highlighting key items discussed by the Board.

Both February pages focused on new Board and Quality Accounts; New Build and Maternity website (Wairarapa), Heart and Diabetes checks and Maternity Governance Group (Hutt).

Media releases/responses 24 January – 7 March 2014

Wairarapa	Hutt Valley
Sub-regional disability strategy External audits Board members powhiri Farewell Jenny Skeet New Clinical Nurse Specialist MML fire (x6) Tai Gemmel response	IDF blow-out Coroners cases Sweetened Drinks policy Influenza

2 Primary Care, including Tihei Wairarapa and Hutt Inc

- Monthly advertising of the 'ED or GP' message, listing after-hours services and Healthline.
- Wairarapa –supporting MML with external communications. Includes Facebook, intranet and website updates, external stakeholders comms, media releases and advertising.

3 Working with our neighbours

Sub-Regional (3DHB)

- Concept paper proposing a 3DHB Communications function accepted, joint workplan being used, consultation paper being developed.
- Communications re: FPSC – working with HBL secondees on communications strategy.
- 3DHB HSD online presence updated – included in 2DHB dual-branded website project. Working with Clinical Leadership Group on communications strategy.
- Communications Advisor appointed fixed term to Common Operating Environment project (based in Wellington)
- Single print room service project – two proposals being evaluated.
- Commencing annual Flu vaccination campaign

2DHB

- Shared website successfully launched 2 March. Positive feedback. Baseline data Website stats for HuttValleyDHB.org.nz (Jan 24 2014 – March 6 2014) 22,985

website visits, 12,407 unique visitors. 01:39 average duration of visit. 63.18% bounce rate (viewed home page only), 59% returning visitors, 41% new visitors

- Facebook presence updated on both sites. Twitter set up for Hutt.
- New Communications Advisor commenced at Hutt. 2DHB appointment.
- Clinical and Corporate photographer commenced Hutt
- Further workshop regarding labour/management partnership, now working on communications strategy.

4 Internal communications

All staff memos

Monitoring our progress (balanced score card)
Tele-presence demonstrations
Coroners findings
New Theatre manager
Dual website launch
Weekly staff eLink (emailed/printable newsletter) continues on both sites (shared and local content).
3DHB Executive Director Maori appointed

Intranet stories 26 January – 7 March 2014

Shared	
New sector guidelines on preventing workplace bullying Nurse preceptor survey Windows 7 upgrade Collabor8 report back 3DHB Executive Director Maori Health appointed Breathless symposium Action on Alcohol conference New Pharmac agreement for supply of wound care products	Disaster communications conference Telehealth invitation to demonstration and workshops Joint Wairarapa / Hutt website SSI webinar Palliative Care forum Health Pathways update CRISP programme update
Wairarapa	**Hutt Valley**
Maternity newsletter Regional Public Health newsletter Clinical Update study days New role in Acute Services Service desk partnership with Capital & Coast HIIRC newsletter Masterton Medical update Treaty of Waitangi workshops Breaking new ground (new build) Weightwatchers@work Medication alert Website developments Powhiri welcomes new Board members	Enrol for 70th anniversary dinner" New piano donated to Te Whare Ahuru New finance system being tested Meningococcal disease Management Essential training Need to talk to someone? EAP access New school dental hub opened in Wainuiomata Bringing Buck back to the Hutt HR update on policies Surgical site infections Reminding patients to attend Diabetes introductory course

2014 Research Grants Raffle winner Tania Grieve – 2DHB Theatre manager Waitangi Day Marae tours Road closure – Rimutaka hill 48 years of nursing Changes in perioperative department Palliative Care lecture	Plastics reunion Winscribe update Improving health during pregnancy NETP graduates Z fundraiser raises $16,000 Retirement after 37 years Public Health diploma course HR – repost on appraisals Hutt City Triathlon

7 Other Communications projects

Wairarapa	**Hutt Valley**
Palliative Care – Kahukura/Hospice Wairarapa partnership – patient documentation Shared intranet/workspaces Promoted and distributed Quality Accounts Maternity Website promotion Patient information and brochure development	70th anniversary Maternity Early Warning Score Patient information and brochure development Updating image libraries Investigating LinkedIn Integration of photographic systems (apple/PC)

Appendix Nine - Official Information Act requests received and responded to since the last Board meeting - Hutt Valley DHB

<table>
<tr><th>No</th><th>Requester</th><th>Date received</th><th>Information Requested</th><th>Status</th></tr>
<tr><td>OIA 114</td><td>Cherie Howe Herald on Sunday</td><td>14.01.14</td><td>All information including but not limited to:
- The number of hospital admissions (whether as a day patient, or overnight/s) for those aged under 16 for alcohol, or suspected, alcohol poisoning in each of the last three calendar years
(2011, 2012, 2013). This should include a breakdown of those admissions by the patient's age.
- The number of children/youths aged under 16 who were referred for further treatment for alcohol issues, including, but not limited to, alcohol counselling or rehabilitation in each of the last three calendar years. This should include a breakdown of referrals by the patient's age.
Response:
<table>
<tr><th></th><th>Wairarapa DHB</th><th>Sex</th><th>Age</th><th>Hutt Valley DHB</th><th>Sex</th><th>Age</th></tr>
<tr><td>2013</td><td>1</td><td>F</td><td>13</td><td>1</td><td>F</td><td>13</td></tr>
<tr><td></td><td></td><td></td><td></td><td>1</td><td>F</td><td>14</td></tr>
<tr><td></td><td></td><td></td><td></td><td>1</td><td>M</td><td>15</td></tr>
<tr><td>2012</td><td>Nil</td><td></td><td></td><td>Nil</td><td></td><td></td></tr>
<tr><td>2011</td><td>Nil</td><td></td><td></td><td>Nil</td><td></td><td></td></tr>
<tr><td>Total</td><td>1</td><td></td><td></td><td>3</td><td></td><td></td></tr>
</table>
N.B. We are keen to help by sharing the information we have on this important subject, however we cannot be 100% certain that every case is captured. We are in due course updating our data systems, and hopefully, by the end of the year we will have a broader range of data available.</td><td>Completed 11.02.2014</td></tr>
<tr><td>OIA 115</td><td>Annette King MP</td><td>21.01.2014</td><td>How many DHB staff earn less than the living wage?
Response:
From the DHB's perspective, we pay all employees the minimum prescribed rates which are set by existing collective agreements which incorporate the minimum wage.
We have 96 staff (excluding casuals) who are paid a base hourly rate which is below $18.40 per hour at the present time. The amount is their hourly rate (base salary) and does not calculate the effect of other payments such as penal rates.</td><td>Completed 13.02.2014</td></tr>
<tr><td>OIA 116</td><td>Annette King MP</td><td>04.02.2014</td><td>Request:
The total number of orthopaedic elective surgeries done where funded by the DHB from July 2008 to December 2013 and
The total number of orthopaedic elective surgeries contracted out by the DHB and to whom</td><td>Completed 13.02.2014</td></tr>
</table>

from July 2008 to December 2013

Response:

Hutt Public Hospital	Auckland City Hospital	**8**
	Gisborne	**1**
	Hutt	**3126**
	Kenepuru	**139**
	Manukau SuperClinic	**8**
	Middlemore	**10**
	North Shore	**1**
	Palmerston North	**3**
	Waikato	**1**
	Wairarapa Hospital	**3**
	Wellington	**257**
Public Hospital Total		**3557**
Private Hospital	Auckland Surgical Centre	**1**
	Boulcott Clinic	**90**
	Bowen	**8**
	Southern Cross Wellington	**2**
	Wakefield	**7**
Private Hospital Total		**108**
		3665

OIA 117	Andrea O'Neal Dom Post	11.02.2014	I'm seeking information on how many hospital gowns and towels have been taken home by patients and not returned, in each of the last 5 years. If we could categorise this by Hutt & Wairarapa DHBs that would be great. The total number of gowns and towels in circulation in the DHBs would be helpful to put it in context. I would also like to know the cost to replace a gown and a towel, and how much the DHBs spend on those items a year.	In Progress
OIA 118	David Clark MP Dunedin North	13.02.2014	Request: The amount of mental health funding that was retained for provision delivered by DHB directly, for the 2009/10,2010/11,2011/12, and 2012/13 financial years A list of all the changes made by your DHB to the community provision of mental health since 2009 Is your DHB required to ring-fence mental health funding now? If so, please provide a breakdown showing the way which mental health funding is spent For the community organisations that have received mental health funding from your DHB, please provide a breakdown of spending by organisation and by type of provision for the 2009/10, 2010/11, 2011/12 and 2012/13 financial years.	In progress
OIA 119	Rebecca Stevenson Fairfax	17.02.2014	Request I am seeking information about New Zealand hospitals and issues with sub-standard fire safety systems under the Official Information Act 1982. Is Hutt Valley DHB aware of any issues with sub-standard fire safety systems including passive fire protection systems at any of its sites? What sort of defects/faults have been found? Where/which facilities have been found to have sub-standard fire safety systems including compromised passive fire protection systems? What is being done about these sub-standard systems? What is the estimated cost to fix the systems? When did Hutt Valley DHB become aware of the first hospital with issues with its fire safety systems? When did the dhb become aware of further hospitals/sites with sub-standard fire safety systems? Dates and all detail available please. Is there a danger to the public using these hospitals in case of fire? Can the dhb release all correspondence between it and contractors/fire engineers/certifiers related to sub-standard systems? Has the dhb commissioned any reports/enquiries/inspections into fire safety at its hospitals? If so, what are they, can I please see them. What emergency planning has been done in relation to these sub-standard fire safety	In Progress

			systems, including passive fire protection, and the evacuation of patients in case of fire? Is any action - including seeking compensation/remedial work - being taken against contractors/fire engineers/certifiers for sub-standard fire safety systems in the dhb's hospitals?	
OIA 120	Nikki MacDonald Dom Post	20.02.2014	This is a request under the Official Information Act Please forward a copy of your most recent register/declaration of gifts to staff. If possible, please send the information in electronic form, as an excel spreadsheet. Please also answer the following questions: Does your DHB engage in drug-company-sponsored continuing medical education onsite? Does your DHB allow drug reps to visit staff in the hospital/on dhb grounds?	In Progress
OIA 121	Mike Dooley	20.02.2014	1/ When does your DHB place a patient on the 5 month waiting list for surgery 2/ Do you require a patient to attend an Education class for joint replacement 3/ Is your joint education class compulsory before surgery will be done. 4/ If your Education class is compulsory please supply the reasoning behind this 5/ If your education class is compulsory would you decline a person surgery	In Progress
OIA 122	Annette King MP	24.02.2014	How many patients are currently waiting for ultrasound and how long are patients waiting?	In Progress
OIA 123	Annette King MP	24.02.2014	The number of nursing vacancies as of 28 February 2014? The number of senior medical officer vacancies as of 28 February 2014? Details of the length of time it is taking to fill vacancies?	In Progress
OIA 124	Annette King MP	25.02.2014	Request : All Mix and match Part II reports of 'Trend Care' from January 2013	In Progress
OIA 125	Iain Lees-Galloway MP for Pstn Nth	05.03.2014	I request the following information out for each of financial years 2012-13, 2011-12 and 2010-11. 1. The number of surgical mesh implants carried out. 2. The number of complaints received about surgical mesh implants. 3. The number of surgical mesh implant removals carried out. 4. Any policies or reports prepared regarding the use of surgical mesh	In Progress
OIA 126	Alani Vailahi NZ First	27.02.2014	All briefing notes, reports, memoranda, and other relevant papers that relate to complaints revieved by the DHB regarding elder abuse from 1 January 2013 to 31 January 2014	In Progress

Finance Report

January 2014

Graham Dyer
Chief Executive

Judith Parkinson
Finance Manager

FINANCIAL PERFORMANCE OVERVIEW

Unfavourable variance to budget year to date of ($1,348k) has been reported. The bottom line result at the end of January was a deficit of ($3,929k) compared to a budget deficit of ($2,581k).

Key results were:

- Funder ($1,310k) (Dec ($1,543k)) unfavourable
- Governance $37k (Dec $9k) favourable
- Provider ($76k) (Dec ($60k)) unfavourable

Material Variances Year to Date to January 2014

The key variances to budget were:

- Interest income: favourable $510k due to higher cash balance than expected in the budget.
- Infrastructure Depreciation: favourable $967k site improvements were valued downwards partly offset by building revaluations upwards.
- Pharmaceuticals: ($427k) the financial Impact of Pharmac's Hospital Medicines List (HML) national decision to provide equity of medicines across all DHBs.
- Blood: ($640k) savings target not met however the Ministry of Health has indicated projected savings in community pharmaceuticals offset by cost of haemophilia blood products which will be realised in the funder arm by June.
- IDF inflows: ($746k), Acute ($682k) 101 less cases than budgeted with lower CWD of 146.53 resulting in lower revenue mainly due to plastics ($582k).
- IDF outflows: ($2,234k), Acute ($1,466k) 187 more cases than budget. This result includes some specialties which are significantly over budget because of high volumes in particular cardiology, oncology and specialist neonates. There have been 18 cases so far this year attracting more than 15 CWD, there were a total of 25 in the whole of last year. There were none in January.

The following table provides a summary of the financial performance of the DHB at the end of January 2014.

Table 1. Statement of Financial Performance:

$000s	Month			Year to Date			Annual	
	Actual	Budget	Variance	Actual	Budget	Variance	Budget	YTD Variance Analysis
Revenue								
MoH Revenue	33,121	31,713	1,407	224,685	222,101	2,584	381,542	Funder $966k additional revenue represented by: $376k for Ministry funded PHO programmes $116k sleepover settlements with mental health providers and funding for cancer nurse co-ordinators $154k home based support services The additional funding is offset by additional costs. $90k base funding changes relating to dementia bed-day price, green prescription and diabetes funding Provider $1.618m additional revenue represented by: $1.374m Recovery from the MOH of capital charge year to date due the calculation based on net movement of the revaluation of buildings at 30 June 13. $121k NSU - breast due to higher volumes $276k Additional funding for regional public health contract for Health for Life $90k and $181k relating to Rheumatic Fever Throat Swabbing and PHU funding.
IDF Inflows	5,655	5,661	(6)	38,879	39,626	(746)	67,930	IDF inflows include an agreed service change relating to a mental health contract ($404k), $267k Plunket contract which has been offset by reduced external provider payments; **Elective: $181k** Caseweights are above budget by 39. Higher volumes for plastics offset by lower volumes in orthopaedics, rheumatology and general surgery. **Acute: ($682k)** Caseweights are below budget by 101, plastics is down by 125 caseweights slightly offset by emergency medical services and dental which are above budget.
Other Revenue	1,030	1,306	(276)	8,877	7,971	907	14,585	Funder $720k relates to the previous year and includes higher than expected electives initiative revenue, lower IDFs payable and higher reimbursement of air ambulance costs. Provider $187k more revenue represented by: $510k Additional interest received due to higher cash balances $286k recovery of RPH Wairarapa staff being paid from Hutt Payroll ($267k) ACC revenue ($216k) for electives that were budgeted to be received from Capital and Coast which is now not happening ($182k) Community Radiology: Electronic Requesting Form system is delayed coupled with savings targets not achieved
Total Revenue	**39,806**	**38,681**	**1,125**	**272,442**	**269,697**	**2,745**	**464,057**	
Expenditure								
Personnel Costs (incl. Outsourced)	14,677	13,808	(869)	95,099	94,155	(944)	158,603	**Medical: $80k** vacancies offset by additional overtime and usage of outsourced personnel; **Nursing:** ($1,861k) additional nursing costs are due to various savings initiatives not being realised due to higher occupancy, particularly in general medical throughout the year but also in a number of other areas over the planned xmas shutdown period; **Allied Health: $695k** 15 FTE savings across all directorates; **Support: ($277k)** Mainly over FTEs in food services and cleaners in base and overtime. No budget for cleaners for theatres built in 2011; **Management and Admin: $419k** 15 FTE under YTD across all directorates, Savings initiatives achieved.
Other Operating Costs	5,958	5,835	(123)	42,509	41,692	(817)	71,618	($640k) for Blood savings including the Pharmac Haemophilia to be realised by the funder in external provider payments; ($427k) financial Impact of Pharmac's Hospital Medicines List (HML) national decision to provide equity of medicines across all DHBs; $967k Site improvements were valued downwards partly offset by building revaluations upwards;
External Provider Payments	13,320	13,166	(154)	91,502	91,405	(97)	156,647	This includes the expected 525k savings from haemophilia blood products through Pharmac
IDF Outflows	6,166	6,432	266	47,261	45,026	(2,234)	77,188	($963k) Acute: IDF outflows: ($1,466k) higher than planned by 187 acute cases (315 caseweights) including Cardiology, Oncology and Specialist Neonates specialties. Includes 9 cases YTD with > 20 CWD each compared to 11 for all last year there were none in January. Elective: $503k, 108 CWD lower than budget with Orthopaedics being 101 less CWD than budget;
Total Expenditure	**40,122**	**39,242**	**(880)**	**276,371**	**272,278**	**(4,093)**	**464,057**	
Net Surplus / (Deficit)	**(316)**	**(561)**	**246**	**(3,929)**	**(2,581)**	**(1,348)**	**1**	

Table 2. Forecast Statement of Financial Performance

$000s	Actual Month	Forecast Month	Variance	Full Year Forecast Variance	Annual Budget	Full Year Forecast	Variance
Revenue							
Ministry of Health	33,120	32,160	960	Capital charge recovery from increase in net assets through revaluation as 30 June 13	381,542	384,457	2,915
Inter District Flows	5,655	5,661	(6)		67,930	67,183	(747)
Other DHB	209	245	(36)	Salaries charged to Hutt DHB are recovered from the Wairarapa until public health budgets are merged with Hutt in 2014/15 forecast to be $670k at year end.	2,344	2,761	417
Government (Non DHB)	335	458	(123)	Additional electives revenue from capital & coast of $1.3m as part of the savings initiatives will not now be achieved, offset by $461k in additional electives agreed.	7,059	6,036	(1,023)
Other	487	622	(135)	Interest revenue has been forecast to increase due to higher cash balances	5,182	6,397	1,215
Total Revenue	**39,806**	**39,146**	**660**		**464,057**	**466,834**	**2,777**
Expenditure							
Personnel Costs (incl Outsource	14,676	14,110	(567)	Additional nursing costs due to acute medical presure and reduced Xmas shut down. Delays in FPSC mean expected finance staff savings will not be realised.	158,603	160,003	(1,400)
Other Operating costs	5,958	5,878	(80)	Additional costs for outsourced clinical, pharmacy and blood products. This is offset in provider payments where savings in blood products are recognised.	71,618	73,893	(2,274)
Other Provider Payments	13,321	13,686	365	Savings for blood products through the funder	156,647	155,780	867
Inter District Outflows	6,166	6,273	108	($1m) additional IDF costs for inpatient and outpatient activity	77,188	78,698	(1,510)
Internal Allocations	(1)	36	36		(0)	(0)	0
Total Expenditure	**40,120**	**39,983**	**(138)**		**464,057**	**468,373**	**(4,316)**
Net Surplus / (Deficit)	**(314)**	**(837)**	**523**		**1**	**(1,539)**	**(1,539)**

$000s	Actual Month	Forecast Month	Variance		Annual Budget	Full Year Forecast	Variance
Funder	670	339	332		4,345	4,004	(341)
Governance and Administration	3	(129)	132		0	3	(3)
Provider	(883)	(1,046)	163		(4,344)	(5,546)	(1,202)
Total	**(210)**	**(837)**	**627**		**1**	**(1,539)**	**(1,539)**

Table 3. Statement of Financial Performance – by Area (current month)

$000s	DHB Funder				Governance & Administration				DHB Provider				Hutt Valley DHB			
	Actual	Budget	Var	Last Yr	Actual	Budget	Var	Last Yr	Actual	Budget	Var	Last Yr	Actual	Budget	Var	Last Yr
Revenue																
Govt & Crown Agency	35,810	35,624	187	34,823	272	272	-	261	3,526	2,618	908	2,131	39,347	38,251	1,095	36,964
Other	-	-	-	10	-	-	-	-	459	429	30	413	459	429	30	423
Internal			-				-		15,391	15,326	66	15,089			-	
Total Revenue	**35,810**	**35,624**	**187**	**34,833**	**272**	**272**	**-**	**261**	**19,377**	**18,373**	**1,004**	**17,633**	**39,806**	**38,681**	**1,125**	**37,387**
Expenditure																
Personnel Costs	-	-	-	-	3	7	3	97	14,345	13,649	(696)	13,122	14,348	13,656	(693)	13,219
Outsourced Staff			-		-	-	-	13	329	153	(176)	185	329	153	(176)	198
Outsourced Services	263	263	-	251	168	167	(0)	27	326	325	(1)	305	494	492	(1)	332
Clinical Supplies			-		0	0	(0)	0	2,191	2,032	(159)	2,723	2,191	2,032	(159)	2,723
Infrastructure	-	-	-	-	151	174	23	49	3,122	3,137	15	2,960	3,273	3,311	38	3,009
Provider Payments	34,878	34,924	46	33,870	-	-	-	-			-		19,486	19,599	112	18,781
Internal Allocations			-		14	17	2	14	(15)	(17)	(2)	(14)	(0)	0	0	(1)
Total Expenditure	**35,140**	**35,187**	**46**	**34,121**	**336**	**365**	**28**	**200**	**20,299**	**19,279**	**(1,020)**	**19,280**	**40,122**	**39,242**	**(880)**	**38,260**
Surplus/(Deficit)																
Before Overheads	**670**	**437**	**233**	**712**	**(64)**	**(92)**	**28**	**61**	**(922)**	**(906)**	**(16)**	**(1,646)**	**(316)**	**(561)**	**246**	**(873)**
Corporate Overheads			-		37	37	-	35	(37)	(37)	(0)	(35)	-	(0)	(0)	-
Surplus/(Deficit)	**670**	**437**	**233**	**712**	**(101)**	**(129)**	**28**	**26**	**(885)**	**(870)**	**(16)**	**(1,612)**	**(316)**	**(561)**	**246**	**(873)**

Table 4. Statement of Financial Performance – by Area (YTD)

$000s	DHB Funder				Governance & Administration				DHB Provider				Hutt Valley DHB			
	Actual	Budget	Var	Last Yr	Actual	Budget	Var	Last Yr	Actual	Budget	Var	Last Yr	Actual	Budget	Var	Last Yr
Revenue																
Govt & Crown Agency	250,646	250,281	365	246,179	1,907	1,907	-	1,820	17,650	16,320	1,330	16,392	268,365	266,670	1,695	262,636
Other	575	-	575	426	-	-	-	12	3,502	3,027	475	3,575	4,077	3,027	1,050	4,013
Internal			-				-		110,153	110,235	(82)	108,602			-	
Total Revenue	**251,221**	**250,281**	**940**	**246,605**	**1,907**	**1,907**	**-**	**1,831**	**131,305**	**129,582**	**1,723**	**128,570**	**272,442**	**269,697**	**2,745**	**266,649**
Expenditure																
Personnel Costs	-	-	-	-	35	44	9	858	92,648	93,072	424	90,712	92,683	93,116	433	91,570
Outsourced Staff			-		17	-	(17)	13	2,399	1,039	(1,360)	1,850	2,416	1,039	(1,377)	1,863
Outsourced Services	1,838	1,838	-	1,755	1,173	1,170	(2)	206	3,588	2,763	(825)	2,580	4,761	3,933	(827)	2,786
Clinical Supplies			-		0	0	0	5	16,278	15,540	(738)	16,333	16,278	15,541	(738)	16,338
Infrastructure	-	-	-	-	330	380	50	272	21,140	21,839	698	21,369	21,470	22,218	748	21,641
Provider Payments	248,916	246,666	(2,250)	244,786	-	-	-	-			-		138,763	136,432	(2,332)	136,184
Internal Allocations			-		119	117	(2)	116	(119)	(117)	2	(138)	-	0	0	(22)
Total Expenditure	**250,754**	**248,504**	**(2,250)**	**246,541**	**1,674**	**1,711**	**37**	**1,471**	**135,935**	**134,136**	**(1,799)**	**132,706**	**276,371**	**272,278**	**(4,093)**	**270,361**
Surplus/(Deficit)																
Before Overheads	**467**	**1,777**	**(1,310)**	**64**	**233**	**196**	**37**	**360**	**(4,630)**	**(4,554)**	**(76)**	**(4,136)**	**(3,929)**	**(2,581)**	**(1,348)**	**(3,712)**
Corporate Overheads			-		252	252	-	234	(252)	(252)	(0)	(234)	-	(0)	(0)	-
Surplus/(Deficit)	**467**	**1,777**	**(1,310)**	**64**	**(18)**	**(55)**	**37**	**126**	**(4,378)**	**(4,302)**	**(76)**	**(3,902)**	**(3,929)**	**(2,581)**	**(1,348)**	**(3,712)**

Table 5. IDF Inflows Variance Summary

	IDF Inflows Variance	
$000s	YTD	Variance Analysis
Elective Inpatients	181	Elective caseweights (CWD) are up by 39. Higher CWD for plastics offset by lower CWD in rheumatology, orthopaedics and general surgery.
Acute Inpatients*	(682)	Acute CWD are down by 147. Emergency medical services and dental are slightly up but acute plastics surgery is down by 125 CWD.
Regional Mental Health Contracts	(471)	Contract changes - offset by reduced external provider payments.
Plunket contract	312	Additional funding which is offset by external provider payments
Agreed changes and wash-ups	(86)	
Total Variance in IDF Inflows	**(746)**	Note: 53% of IDFs originate from CCDHB

***IDF acute inflows are below plan for: Midcentral (down 27%), Capital & Coast (down 12%) and Whanganui (down 53%)**

Table 6. IDF Outflow Variance Summary

	IDF Outflows Variance	
$000s	YTD	Variance Analysis
Elective Inpatients	503	Elective IDF outflows are under budget by 108 CWD. Orthopaedics, Neurosurgery, Cardiology and Cardiothoracic are under budget offset by Ophthalmology and Urology
Acute Inpatients*	(1,466)	Acute IDF outflows are over budget by 315 CWD. This result includes some specialties which are significantly over budget because of high volumes in particular cardiology, oncology and specialist neonates. There have been 9 cases YTD totalling more than 20 CWD compared to 11 last year of which 5 were in the first 6 months.There were none in January. The only significant flow is to Counties Manukau for a single burns case which is 46 CWD
Other	(1,271)	Wash-ups and other agreed changes
Total Variance in IDF Outflows	**(2,234)**	Note: 93% of IDFs are from CCDHB

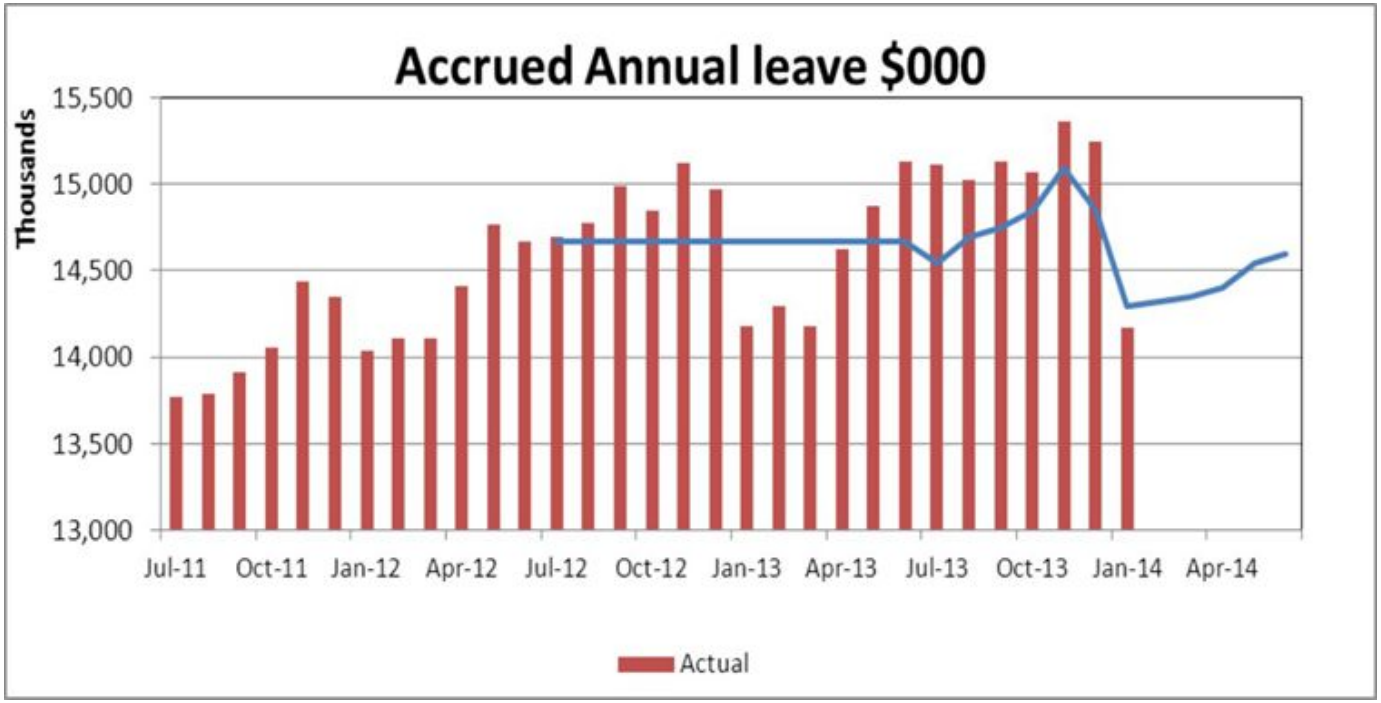
***IDF acute outflows are above plan for: Auckland (up 31%), Capital & Coast (up 12%)**

Table 7. Personnel Costs (including Outsourced) Variance Summary

	Contract FTEs				Costs (000s)				
	YTD Actual	YTD Budget	Variance	Full Year Budget	YTD Actual	YTD Budget	Variance	Full Year Budget	Reason for Variance
Total Personnel Costs									
- Base Budget	1,750.93	1,843.35	92.42	1,885.03	76,489	79,159	2,670	133,869	**Medical**: $80k vacancies offset by additional overtime and usage of outsourced personnel;
- Allowances and Overtime	41.36	30.22	(11.14)	21.30	10,026	9,063	(963)	15,172	**Nursing**: ($1,861k) additional nursing costs are due to various savings initiatives not being realised due to higher occupancy, particularly in general medical throughout the year and overall xmas shutdown period shorter than planned;
- Other Costs	-	-	-	-	6,975	7,406	431	12,694	
- Leave Accrual	-	-	-	-	(807)	99	906	170	**Allied Health**: $695k 15 FTE savings across all directorates;
- Savings Initiatives		(70.28)	(70.28)	(69.68)		(2,611)	(2,611)	(5,077)	**Support**: ($277k) Mainly over FTEs in food services and cleaners in base and overtime. No budget for cleaners for theatres built in 2011;
Sub-total	**1,792.29**	**1,803.29**	**11.00**	**1,836.65**	**92,683**	**93,116**	**433**	**156,828**	**Management and Admin**: $419k 15 FTE under YTD across all directorates, Savings initiatives achieved.
- Outsourced	20.09	12.40	(12.30)	12.30	2,416	1,039	(1,377)	1,773	
Total Personnel Costs	**1,812.38**	**1,815.69**	**(1.30)**	**1,848.95**	**95,099**	**94,155**	**(944)**	**158,601**	

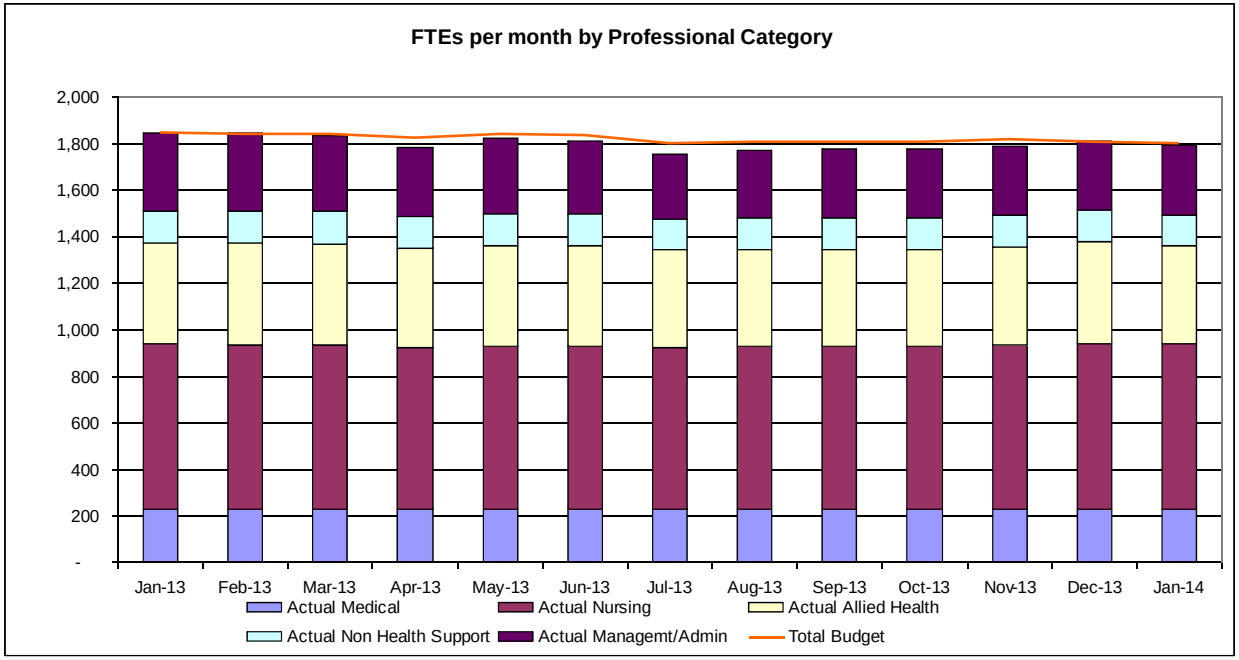
Annual Leave

The following graph shows the historical trends in annual leave for the last two years. The reduction in the accrual is close to budget and reflects the amount of annual leave taken over the Christmas period.



Note the reduction in budget in January which is incorporated into the sustainability plan

Chart: FTE Trends by Professional category



		Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
Actual	Medical	229	228	229	230	228	228	226	226	225	226	228	230	231
	Nursing	709	707	706	692	701	700	699	702	702	702	705	707	707
	Allied Health	436	435	435	430	433	433	418	419	419	420	422	422	423
	Non Health Suppor	139	139	139	135	138	138	134	134	135	136	136	136	134
	Managemt/Admin	336	334	327	294	320	316	278	288	294	295	298	299	298
Total	**Actual FTE**	**1,848**	**1,844**	**1,835**	**1,781**	**1,821**	**1,815**	**1,754**	**1,769**	**1,776**	**1,778**	**1,789**	**1,794**	**1,792**
	Budget	1,845	1,843	1,841	1,824	1,838	1,837	1,802	1,805	1,806	1,808	1,818	1,807	1,803

Note : SIDU 22FTE moved to CCDHB July 2013: Public Health 5.59 FTE from Wairarapa transferred to Hutt payroll from Nov 2013.
Other increases include 14.93 FTE filling vacancies (including some longstanding vacancies in TWA). 5.81 FTE 2DHB shared staff now partly paid for by Hutt previously in Wairarapa.

Table 8: Statement of Financial Position

($000s)		Actuals			2013/14 Budget		Variance Analysis (Actuals Current month vs. Actual Last month)
		Jan	Dec	Variance	Jan	Variance	
Assets							
Current assets	Bank	9,788	12,016	(2,228)	(1,536)	11,324	Mainly due to GST payments for Nov & Dec being paid towards end of Jan.
	Bank - Non-Hutt DHB funds	7,597	5,626	1,971	5,172	2,425	New funds received from NHMG net off by payments made on behalf of the grants.
	Accounts receivable	15,424	11,975	3,449	11,438	3,986	Accrual of capital charge recoverable of $1.37m and other RPH & HWNZ contracts.
	Stock	1,492	1,486	6	1,389	103	
	Prepayments	1,215	1,132	83	1,620	(405)	More leases being prepaid this month.
	Total current assets	**35,516**	**32,235**	**3,281**	**18,083**	**17,433**	
Fixed assets	Fixed assets	200,384	201,071	(687)	181,012	19,372	Reduced due to depreciation charged.
	Work in progress	5,443	4,276	1,167	6,742	(1,299)	Mainly due to more costs incurred for Citrix Farm, LIS and COH projects.
	Total fixed assets	**205,827**	**205,347**	**480**	**187,754**	**18,073**	
Investments	Investments in associates	1,280	1,280		3,972	(2,692)	Timing delays in the investment in Central Region's Technical Advisory Ltd (CRTAS) as compared to budget.
	Trust funds invested	1,155	1,086	69	1,063	92	
	Total Investments	**2,435**	**2,366**	**69**	**5,035**	**(2,600)**	
Total Assets		**243,778**	**239,948**	**3,830**	**210,872**	**32,906**	
Liabilities	**Liabilities**						
Current liabilities	Accounts payable and accruals	35,073	33,192	1,881	32,849	2,224	Higher AP control account this month due to timing of invoices & payments.
	Non-Hutt DHB liabilities	7,597	5,626	1,971	5,172	2,425	New funds received from NHMG partly net off with payments made on behalf of the grants.
	Crown loans and other loans	10,914	10,974	(60)	11,492	(578)	
	Capital charge payable	621		621	464	157	6-monthly capital charge was paid in Dec. Balance is accrual for current month.
	Current employee provisions	19,699	20,303	(604)	17,976	1,723	Lower leave provision after the year end holiday breaks taken.
	Total current liabilities	**73,904**	**70,095**	**3,809**	**67,953**	**5,951**	
Non-current liabilities	Crown loans	68,500	68,500		68,500		
	Other loans	1,826	1,826		1,833	(7)	
	Long term employee provisions	6,944	6,944		6,812	132	
	Trust funds	1,154	1,086	68	1,063	91	
	Total non-current liabilities	**78,424**	**78,356**	**68**	**78,208**	**216**	
Total Liabilities		**152,328**	**148,451**	**3,877**	**146,161**	**6,167**	
Net assets		**91,450**	**91,497**	**(47)**	**64,711**	**26,739**	
Crown equity	**Crown equity**	**44,877**	**44,611**	266	**45,817**	(940)	Capital injection received during the month.
Reserves	**Reserves**	**80,192**	**80,192**		**50,368**	29,824	
Retained earnings	**Retained earnings**						
	Opening retained earnings	(29,691)	(29,691)		(28,863)	(828)	
	Surplus/(deficit)	(3,929)	(3,613)	(316)	(2,611)	(1,318)	
	Retained earnings - total	**(33,620)**	**(33,304)**	**(316)**	**(31,474)**	**(2,146)**	
Total Equity		**91,449**	**91,499**	**(50)**	**64,711**	**26,738**	

Note – Investment in associates includes Central Region Technical Advisory Service (TAS) and Health Benefits Ltd (HBL)

Table 9: Statement of Cash flows

Description	Year to date actual ($000)	Year to date budget ($000)	Variance- Over/(under) budget ($000)	Notes - Explanation for major variances - current month over budget
Operating activities				
Receipts	268,450	270,518	(2,068)	Higher budgeted revenue from Crown and other DHBs.
Payments				
Payments to employees	94,203	93,494	709	
Payments to suppliers	169,286	167,129	2,157	Higher payment to providers.
Capital charge paid	3,765	3,206	559	Higher capital charge payout due to assets revaluation.
GST (Net)	500	-	500	No GST payment last month as GST due in Dec was paid in Jan.
Payments - total	**267,754**	**263,829**	**3,925**	
Net cash flow from operating activities	**696**	**6,689**	**(5,993)**	
Investing activities				
Receipts				
Proceeds from Asset sales	(3)	-	(3)	
Payments				
Investment in associates	-	1,452	(1,452)	
Purchase of fixed assets	4,430	8,225	(3,795)	Delay in the purchase of MRI scanner and Citrix Farm & LIS projects.
Net cash flow from investing activities	**(4,433)**	**(9,677)**	**3,792**	
Financing activities				
Receipts				
Loans	-	-	-	
Equity injection	800	-	800	Not budgeted for.
Receipts - total	**800**	**-**	**800**	
Payments				
Repayment of loans	294	-	294	Capital repayments of financing leases
Equity repayments	-	-		
Interest payments	1,496	2,358	(862)	Lower interest for finance leases & Crown(CHFA) loans.
Payments - total	**1,790**	**2,358**	**(568)**	
Net cash flow from financing activities	**(990)**	**(2,358)**	**1,368**	
Net Inflow/(outflow) of Hutt Valley DHB funds	**(4,727)**	**(5,346)**	**619**	
Opening cash	24,650	8,982	15,668	
Movement in Non-Hutt Valley DHB funds:				
Primary Healthcare IT Grants fund	(1,579)	-	(1,579)	
National Haemaphiliac Management Group Fund	(783)	-	(783)	
NZ Universal List of Medicine Fund	(183)	-	(183)	
Net cash flow of Non-Hutt Valley DHB funds	**(2,545)**	**-**	**(2,545)**	Payments made on behalf of other Funds not budgeted for.
Ending cash	**17,378**	**3,636**	**13,742**	
Summary ending cash position				
Hutt DHB funds	**9,781**	3,636	6,145	
Non-Hutt Valley DHB funds	7,597	-	7,597	
Total	17,378	3,636	13,742	

BACK TO MAIN REPORT

Table 10. Capital Expenditure (Asset) summary report

Strategic Capex	Full year capital budget ($000)	YTD approved capex ($000)	YTD Actual Spent ($000)	Capital budget unspent ($000)	Remaining budget available to be allocated ($000)
Emergency Department & Theatre (ED&T)	156	156	58	98	-
Digital Mammography	1,294	1,294	370	924	-
Finance & Procurement Supply Chain (FPSC) System	736	736	226	510	-
Novell Netware to MS Exchange	168	168	172	**(4)**	-
Laboratory Information Systems ($1,000k from Prior Year)	1,022	1,022	955	67	-
Child Oral Health (externally funded initiatives)	3,466	3,466	918	2,549	-
Central Region Information Systems Plan (PMS, EMR, PACS, RIS, ED, eReferrals, WhiteBoard) Programme	2,168	-	-	2,168	2,168
Citrix Farm	1,000	1,000	591	409	-
e-Pharmacy	500	-	-	500	500
MRI Scanner	2,300	-	-	2,300	2,300
Non specified	1	-	-	1	1
	12,812	**7,843**	**3,291**	**9,521**	**4,969**
Baseline Capex					
Buildings & Plant	4,282	1,282	281	4,001	3,000
Clinical Equipment	2,660	1,920	630	2,030	739
Other Equipment	100	5	-	100	95
Information Technology	1,630	1,547	1,125	505	83
Intangible Assets (Software)	1,000	-	-	1,000	1,000
	9,672	**4,755**	**2,036**	**7,636**	**4,917**
Total Capex	**22,484**	**12,597**	**5,327**	**17,157**	**9,886**

Table 11. Treasury Summary Report

1) Short term funds / investment

HBL banking activities for the month

	Current month	Last month
Average balance for the month	$27,643	$29,153
Lowest balance for the month	$12,523	$15,519
Average interest rate	3.89%	3.89%
Net interest earned for the month	$91,025	$95,821

2) Debt

Term debt - Crown (formerly CHFA) loans	Repayment date	Amount	Interest rate
Core loan	15-Dec-17	$19,000	6.535%
Loan 1	15-Apr-14	$4,500	5.490%
Loan 2	15-Dec-18	$4,500	5.970%
Loan 4	15-Apr-16	$2,000	5.520%
Loan 5	15-Apr-16	$5,000	5.020%
Loan 6	15-Mar-19	$5,000	5.685%
Loan 7	15-Apr-15	$4,000	4.500%
Loan 8	15-Dec-18	$5,450	5.090%
Loan 9	15-Dec-15	$5,450	4.240%
Loan 10	15-Dec-18	$6,000	3.710%
Loan 11	15-Apr-14	$6,000	2.915%
Loan 12	15-Jun-20	$5,000	3.355%
Loan 13	15-May-21	$5,100	3.450%
Loan 14	30-Jun-16	$2,000	2.750%
	Total	$79,000	
	Weighted cost of funds		4.921%

3) Debt repayment profile

Year	Amount
2013/14	$10,500
2014/15	$4,000
2015/16	$14,450
2017/18	$19,000
2018/19	$20,950
2019/20	$5,000
2020/21	$5,100
Total	$79,000

4) Hedges

No hedging contracts have been entered into for the year to date.

5) Foreign exchange transactions for the month

No. of transactions involving foreign currency	8	
Total value of transactions	$528,634	NZD
Largest transaction	$437,515	NZD

	No. of	Equivalent	Exchange rates
AUD	5	$62,364	0.9430
USD	3	$466,270	0.8218
Total	**8**	**$528,634**	

Wairarapa and Hutt Valley DHB Emergency Management Work Plan April 2014 - Sept 2016
Executive Leadership Approval:

KEY
VERY HIGH
HIGH
MEDIUM
TASK COVERED ELSEWHERE

Section 1: District Health Boards (National Civil Defence Emergency Management Plan 2006) v1.0 070314

Ref	Description	Status Assessment	Actions	Deliverables	Lead	Risk Rating	Completion Date/Time	WDHB	HVDHB	CCDHB	Year
1	The DHB is required to develop and maintain a plan for significant incidents and emergencies	HVDHB Health Emergency Plan (HEP) (reviewed January 2012)	●Develop 2DHB HEP	●Fit for purpose 2DHB HEP	Emergency Management (SR) supported by ELT/DLT	Very High	2 months	X	X		1
2	DHB plans identify how services will be delivered in a civil defence or related emergency, and acknowledge the role of DHBs as both funders and providers of health services	Impossible to predict all emergency scenarios. Incident management team (IMT) are pivotal in developing and implementing response strategy	●IMT standard operating procedure developed ●Added as annex to HEP ●Include in CIMs training module	●IMT Standard Operating Policy sign off ●Potential IMT members and senior management on call members briefed on their role and responsibilites ●CIMs training module amended	Emergency Management (SR) supported by ELT/DLT	High	1 month	X	X		1
3a	DHBs must ensure that all their plans provide adequately for -										
(i)	public, primary, secondary, tertiary, mental, and disability health services	Existing plans focus on hospital rather than DHB wide	●Identify, assess and review plans ●Identify leads in all of these areas	●Leads identified **(Year 1)** ●Suite of SOPs, policies, plans and guidelines developed that take into consideration the needs of these sectors **(Year 2 or 3)**	**To be confirmed** supported by ELT/DLT	High	●1 Month ●9 months	X	X		1 2/3
(ii)	an integrated regional and national response	Central Regional DHB Emergency Plan (reviewed 2012) Whole of health sub regional co-ordination requires review to ensure alignment with WREMO Emergency Co-ordination Centre and lessons identified post storm/drought/EQs	●Review plan following regional lessons identified from 2013 incidents ●Review 'whole of health' sub regional incident co-ordination	●Fit for purpose Regional DHB Plan ●Agree and fit for purpose 'whole of health' sub-regional incident co-ordination	Emergency Management (SR) in consultation with DHBs and other health providers	High	●2 months ●1 month	X	X	X	1
(iii)	co-ordination with plans of other agencies e.g. Emergency Services, WREMO	Membership of: Chief Executive Group, Hutt Valley + Wairarapa Emergency Services Group Regional DHB Emergency Management group Recent changes to provision of Welfare responsibilities will impact on the DHBs	●WREMO inter-agency committee established Feb 2014 will increase multi agency co-ordination ●Identify DHB lead on Welfare work stream	●Nominated Welfare lead to assess DHB implication following changes to Welfare requirements and response ●Agreement on DHB attendance at WREMO Local Welfare meetings	Emergency Management (DM)	High	●2 weeks	X	X		1
(iv)	use of CIMs	On going CIMS training programme for staff	●Basic CIMs training to be delivered to administration staff to support their role in the EOC ●DLT training ●SIDU training	●Develop and roll out CIMs overview course to administration identified as having a n EOC role ●Develop and roll out DLT CIMs training ●Develop and roll out training to SIDU	Emergency Management (DM + SR)	High	●2 weeks	X	X		1
3b	contribute to the development, implementation, and revision of regional plans for health emergencies	2DHB emergency management work plan Strategic 3DHB emergency management work stream meeting to identify areas of collaboration Representation at Regional DHB Emergency Management group	●Review Central Region District Health Boards Health Emergency Plan	●Fit for purpose Regional DHB Plan	Emergency Management in consultation with DHBs and other health providers	High	see section 1: 3a (ii)	X	X	X	
3c	contribute to the development, implementation, and revision of Ministry of Health national plans	MoH Decontamination Guidelines in draft, expected release June 2014 National Health Emergency Plan under review	●Review guidelines to ascertain implications ●Identify leads to determine DHB implications (see MoH publications table)	●Decontamination Guidelines reviewed ●Recommendations implemented ●Leads identified	Emergency Management supported by ELT/DLT	Medium	see Section 2: 12	X	X		

Ref	Description	Status Assessment	Actions	Deliverables	Lead	Risk Rating	Completion Date/Time	WDHB	HVDHB	CCDHB	Year
3d	respond to a regional or national health emergency, or to the threat of one	MoH Alert Cascade reviewed and ready for implementation Mass Casualties, Pandemic Influenza and Decontamination Plans require review	●Develop 2DHB Health Emergency Plan ●Review following plans: Pandemic Influenza Decontamination Mass Casualties ●Emergency Management Information System Training delivered to (1) IMT (2) DNM/Admin (3) Super Users	●Fit for purpose 2DHB HEP ●Plans reviewed ●Recommendations implemented ●A cadre of staff trained at all levels of HealthEMIS **(Year 1)**	Emergency Management (DM) supported by ELT/DLT	●Assessed in other sections ●Assessed in other sections ●Assessed in other sections ●High	● 2 weeks	X	X		1
3e	when necessary make, with the CDEM Group(s), a local EoC or a significant change to one	Operational/emergency comms equipment Monthly testing of regional and national communications equipment Live testing during polar Storm EQ and drought response 2013	●2DHB HEP to include stakeholder activation/deactivation and SITREP template	●Fit for purpose 2DHB HEP	Emergency Management supported by ELT/DLT	High	See section 1.3a (i)	X	X		
3f	ensure that new service agreements contain contractual commitments from providers for an appropriate plan in relation to the services they provide	Provide back to back contracts state 'required to have emergency plans' Business Continuity/Emergency plans should be a requirement fo all DHB contracts	DHB to assess whether this is required	●Develop FRAC paper post detailing findings and recommendations	SIDU supported by Emergency Management	High	**To be confirmed**	X	X		1+2
3g	require health providers to have plans and resources in place to ensure they can respond to emergencies in an integrated and effective manner	Te Awakairangi EOC exercise 2014 will allow us the opportunity to assess this Review their Emergency Plan and EOC Activation documentaion Compass exercise, 2014 demonstrated their capabilites	●Participate in Te Awakairangi EOC exercise ●Review Emergency Plan and EOC Activation documentation	●Assurance from exercise that organisation can co-ordinate and response to an incident ●Assurance that Emergency Plan and EOC Activation documentation is fit for purpose	Emergency Management (SR)	Medium	2 months		X		1
3h	ready to function to the fullest possible extent during and after an emergency by ensuring -										
(i)	the provision of continuity of care for existing patients, the management of increased demand for services, and assistance with the recovery of services	DHB Business Continuity Plan requires streamlining. Reviewed January 2012. Strategic BC Policy required.	●EOC location/systems review ●Develop 2 DHB Strategic BC Policy ●Develop 2DHB template ●Assess requirement for Business Continuity Group	●Completion of EOC project as per Statement of Objectives (including shared systems/processes across 2DHB ●2DHB Strategic BC Policy developed + approved ●Organisation agreement on departments prioritised for Stage 1 completion of Business Impact Analysis ●2DHB BC/BIA templates developed	●Emergency Mgmt (SR) ●Emergency Mgmt (SR) ●ELT/DLT ●BC Lead (TBC)	●Very High ●High ●High ●High	●2 months ●2 weeks ●2 weeks ●6 weeks	X	X		1 1 1 2
(ii)	the preparation of an incident and emergency management plan that is integrated locally and coordinated and compliant with the plans of the other emergency services and the regional group	Joint 2DHB emergency management framework planned Strategic DHB emergency management framework presented to Quality Improvement Committee Regional DHB Emergency Management group facilitator in place	●Develop 2DHB Health Emergency Plan ●Review Central Regional DHB Emergency Plan ●Review following plans: Pandemic Influenza Decontamination Mass Casualties	●Fit for purpose 2DHB HEP ●Fit for purpose Regional DHB Plan ●National plans, policies and guidelines reviewed ●Recommendations implemented	Emergency Management supported by ELT/DLT	●Very High ●High ●Assessed in other sections		X	X		
(iii)	their own planning and responses are integrated with public health planning and responses	HVDHB/RPH monthly emergency management meetings established to enable alignment of emergency management planning and response phase	●Develop 2DHB/Regional Public Health exercise ●Configure CIMs training package	●2DHB/RPH Exercise delivered ●1 x joint CIMs training delivered	Emergency Management (DM +SR) /RPH	Medium	●6 weeks	X	X		2
(iv)	ensure evacuation plans are prepared for health care facilties	Phase 1 Heretaunga Evacuation Workshop November 2013 Evacuation Equipment installed/training delivered February 2014	●Phase 2 Heretaunga Evacuation Workshop ●Emergo Train Exercise	● Phase 2 Heretaunga Evacuation Workshop ●Heretunga Evacuation Plan developed + resources shared across 2DHBs ●Exercise designed to test element (s) of Evacuation Plan	Emergency Management (SR + DM) supported by ELT/DLT	High	●2 weeks ●6 weeks ●4 months	X	X		●1 ●1 ●2

Section 2: Ministry of Health Plans, Policies and Guidelines

Ref	Ministry Of Health Publications	Publication Date	HVDHB/ WDHB Status	Deliverables	Lead	Risk Rating	Completion Date/Time	WDHB	HVDHB	CCDHB	Year
4)	National Health Emergency Plan: Multiple Complex Burn Action Plan	Sep-11	●No official documentation ●No official documentation	●National documentation reviewed ●Recommendations implemented	Emergency Management (SR), Plastics and Emergency Departments	Very High - Regional Burn Unit and sub region natural hazardscape	2 months	X	X		1
5)	National Health Emergency Plan: Mass casualty action plan	Sep-11	●Reviewed Jan 2012 version 1.1 ●2008	●National documentation reviewed ●Recommendations implemented	Emergency Department and Emergency Management (DM + SR)	Very High - sub region natural hazardscape	9 months	X	X		1+2
6)	New Zealand Influenza Pandemic Plan: A framework for action	Apr-10	●Reviewed 1/11/2008 ●Reviewed 2008	●National documentation reviewed ●Lessons identified from H1N1 reviewed ●Recommendations implemented	**To be confirmed** Read IP docs and discuss with CT/DM then RPH	Very High - reasonably quiet seasonal flu post H1N1, have not incorporated H1N1 lessons identified or reviewed plan to incorporate latest national guidance	4 months	X	X		1
7)	National Health Emergency Plan; National Reserve Supplies Management and Usage Policies: 3rd edition	Dec-13	●No official documentation ●No official documentation	●National documentation reviewed ●Recommendations implemented	Procurement/ Supply, Emergency Management (SR), Infection Control and Pharmacy	High	1 month	X	X		1
8)	National Health Emergency Plan: H5N1 Pre-Pandemic Vaccine Usage Policy	Dec-13	●No official documentation ●No official documentation	●National documentation reviewed ●Recommendations implemented	OH+Safety, Emergency Management (SR), Infection Control and Pharmacy	Very High - DHB needs to meet MoH expectations aas set out in this document	1 month	X	X		1
9)	National Health Emergency Plan	Dec-08	●Reviewed January 2012 ●Reviewed 2008	●Recommendations implemented	Emergency Management Supported by EM DCT	High	As per section 1.3a (ii)	X	X		
10)	National Health Emergency Plan: Hazardous Substances Incident Hospital Guidelines	Dec-05	●Reviewed January 2012 ●Reviewed 2008	●National documentation reviewed ●Recommendations implemented	Emergency Management (SR + DM), Emergency Department + Health and Safety	Medium	4 months	X	X		2
11)	National Health Emergency Plan: Decontamination Guidelines for the Health Sector (still draft)	expected. 1/06/2014	N/A	●Recommendations implemented	Emergency Management (SR + DM), Emergency Department + Health and Safety	Medium	4 months	X	X		2
12)	National Health Emergency Plan: concerning access to the national stockpile or organophosphate and cyanide poisoning antidotes	Mar-10	No official documentation	●National documentation reviewed ●Recommendations implemented	Pharmacy Manager + Emergency Management (SR)	Medium	1 month	X	X		2

a) Quarterly Report to FRAC
b) Monthly EM meeting CT/DM + SR
c) 2DHB Risk Register Monthly Updating (sharepoint)
d) Intranet EM link to support Senior Mgmt on call and Response
e) EM Sharepoint
f) 3DHB led monthly Health EM mtg
g) Gantt Chart
h) Annual Planning Meeting 2DHB + 3DHB March 2015

The Ministry provides funding to all DHBs to support and enhance emergency management preparedness and response. Funding for an emergency shall be used for an emergency shall be used for the following: to provide for the development and maintenance of emergency plans, to ensure planning reached beyond the hospital environment to encompass a health sector-wide response, to ensure the response links robustly with local services, to provide sustained and effective emergency management education and training, to ensure the capacity of DHBs and the primary health sector can be fully utilised in an emergency response and to develop and maintain effective means of emergency communication with identified stakeholders

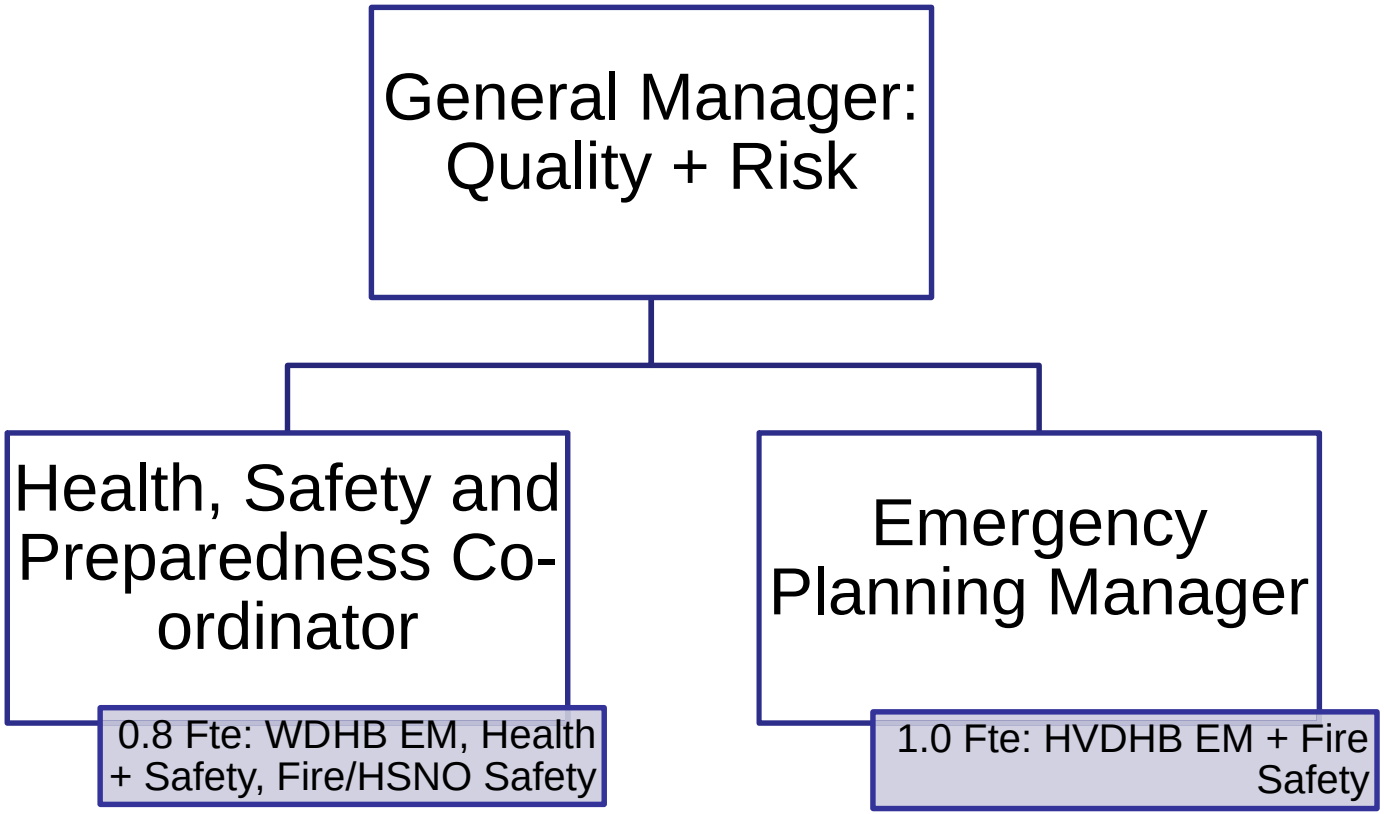
Emergency Management Update

Emergency Planning Manager
07 March 2014

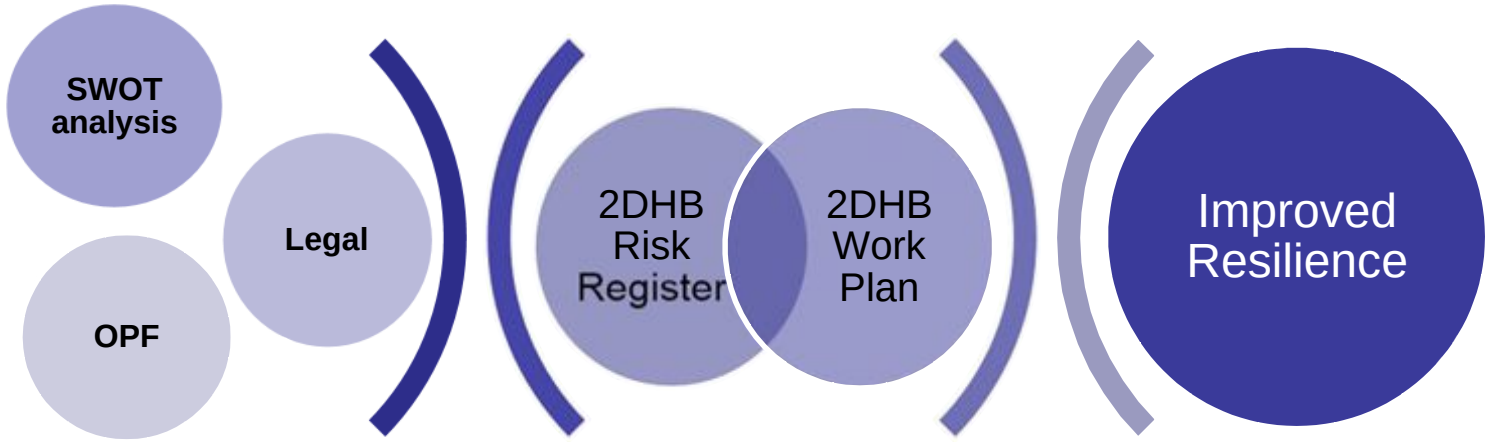
Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

2 DHB EM Structure



2 DHB Needs Assessment

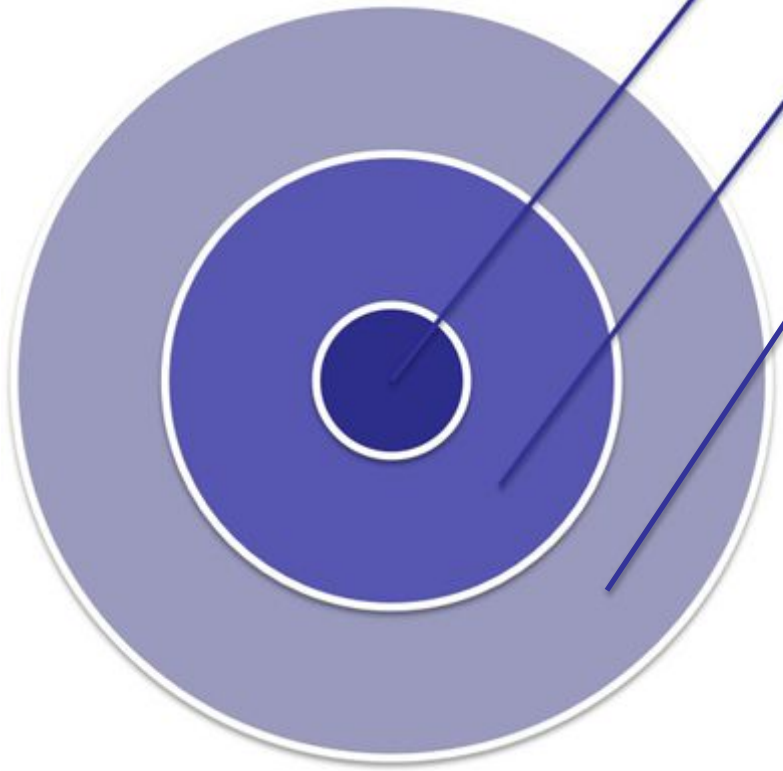


2DHB Work plan

- Robust approach to increased resilience
- Prioritisation
- Timeframes*

*Based on successful application for 3DHB Fire Safety/HSNO post

Sub Regional Resilience



2DHB

- Work Plan
- Risk Register

3DHB

- Work Plan
- Risk register

<u>Underpinned by</u>

- Joint Operating Measures
- Impact Measures
- Outputs

COMMUNITY PUBLIC HEALTH & DISABILITY SUPPORT ADVISORY COMMITTEES

Information Paper

To	Community & Public Health and Disability Support Advisory Committees
From	Dr Ashley Bloomfield – **Director, Service Integration & Development**
Date	14 February 2014
Subject	**Quarterly Equity Monitoring Report, February 2014**
Status	Decision ☐ Information ☑
Prepared by	Rebecca Rippon **– Principal Analyst, SIDU**

1. RECOMMENDATIONS

It is **recommended** that the Committees:

Note the most recent performance against equity monitoring indicators. Updated data for headline measures shows:

- Although there have been small incremental improvements in dental service enrolment for pre-schoolers in Capital & Coast and Hutt Valley DHBs, more work is required to accelerate the improvement for Maori and Pacific children;
- Completion rates for cardiovascular risk assessments in primary care have been reasonably equitable; however, the significant gains recently have been larger for non-Maori, non-Pacific in Capital & Coast in particular and it will be important to maintain equity in the push to reach the 90% target;
- Maori and Pacific attendance at specialist assessment appointments has improved at Capital & Coast and Wairarapa hospitals, whereas the initial improvement achieved at Hutt following the implementation of U-Book has not been sustained and rates have increased slightly. Hutt Valley DHB has commenced work to improve clinic attendance with a consultation process which involved patients, clinicians and administrative staff.

Note the report on activity previously undertaken and currently planned or underway to improve performance against equity measures.

2. PURPOSE

The purpose of this paper is to provide updated data (where available) for the equity monitoring indicators and an update on sub-regional activity to improve performance.

3. BACKGROUND

A request was made by the three Boards for the development of a small set of core indicators that they could monitor to assess the impact of the DHBs' planning, funding and service delivery on equity within its population. The set of equity indicators were selected based on the following criteria:

- Priority area – for both the Government and Boards;
- Coverage across the life-course;
- Ready availability of data;
- Measures of both the process of health care delivery and health outcomes;
- Consistency with the existing Maori Health indicators set.

It was further proposed that a small number of 'headline indicators' be selected, for which aspirational targets could be set to drive improvement in equity in these key areas. The headline indicators are:

i) Pre-school enrolment in dental services;
ii) Cardiovascular disease (**CVD**) risk assessment in primary care;
iii) Did Not Attend (**DNA**) rates for hospital outpatient appointments.

The headline indicator areas represent some of the major contributors to avoidable morbidity in both children and adults. They have been chosen because there are documented disparities relating to either the indicator itself or downstream outcomes (*e.g.* with respect to CVD inequities in cardiac surgical interventions and mortality rates). They are key measures of effective access to community-based primary and secondary healthcare services and are amenable to intervention by District Health Boards (**DHBs**) and Primary Health Organisations (**PHOs**).

4. HIGHLIGHTS FOR THIS PERIOD

Results and key initiatives to improve performance against headline indicators include:

- **Pre-School Enrolment in Dental Services**

  Although there have been small incremental improvements in dental service enrolment for pre-schoolers in Capital & Coast and Hutt Valley DHBs, more work is required to accelerate the improvement for Maori and Pacific children.

  The newborn enrolment project has been resourced with a project manager and is now making progress. The purpose is to develop a single system in each of the three DHBs that enables enrolment of newborns with primary care, oral health and Well Child /Tamariki Ora services. The project will also include the development of information for parents and providers about the importance of newborn enrolment and the process for enrolling.

  The project plan and terms of reference (**ToR**) have been developed and approved. The working group to advise the project is currently being finalised; it is planned that the

design of the newborn enrolment system and an implementation plan will be developed by June 2014.

- **Cardiovascular Disease (CVD) Risk Assessment in Primary Care**

  Completion rates for cardiovascular risk assessments in primary care had been increasing and reasonably equitable to date. However, the significant gains recently have been larger for non-Maori, non-Pacific in Capital & Coast in particular and it will be important to maintain equity in the push to reach the 90% target.

  Primary care practices across the sub-region are using a patient dashboard to identify eligible people for CVD risk assessment and ensure they are recorded correctly. SIDU has discussed the application of new Ministry of Health (**MoH**) funding with PHOs and is in the process of finalising the agreements with the PHOs. We will report further on the planned activities to achieve the target (for all groups) once we have received all their service delivery plans.

  Te Awakairangi Health Network, which currently has the lowest rates in the sub-region, has completed a number of activities recently to promote awareness of CVD risk assessment. It has also developed and conducted both basic and advanced training for nurses on CVD risk assessment, in conjunction with the Heart Foundation,. A voucher created for eligible patients has helped reach significant numbers of high needs patients and raised awareness in the Hutt Valley.

- **Did Not Attend (DNA) Rates for Hospital Outpatient Appointments**

  Maori and Pacific attendance at specialist assessment appointments has improved at Capital & Coast and Wairarapa hospitals, whereas the initial improvement achieved at Hutt following the implementation of U-Book has not been sustained and rates have increased slightly.

  Hutt Valley DHB has commenced work in improving clinic attendance with a consultation process that involved patients, clinicians and administrative staff. Maori and Pacific teams are using a range of culturally specific approaches including engaging with patients and whanau prior to appointments, co-ordinating appointments, providing assistance to attend or linking with community services and responding to referrals from clinics following DNA. A trial completed in December with the Maori Health Unit has improved the current process for both Maori and Pacific patients and families. The teams have prioritised four services to improve attendance and have commenced work with these teams and patients.

  Capital & Coast has developed an implementation plan to reduce DNAs by Maori and Pacific patients. Both cultural care units meet with leaders of identified services to inform them of activities that are taking place and engage with patients prior to their appointment to assist them to attend. Whanau Care Services and the Pacific Health Unit will engage with the primary care practices that have over 1000 outpatient appointments per year as well as high DNA rates to refer patients for assistance from cultural care services.

Changes in other equity monitoring indicators include:

- Dental examination arrears have worsened across the sub-region. Arrears are being addressed through a variety of strategies including prioritising those children that are farthest behind, providing block appointments each day for pre-schoolers and progressing the oral health business case build project to increase clinic capacity;
- While targets have not been achieved for the average number of decayed, missing or filled teeth in Maori and Pacific children as yet, there have been improvements for Maori in Capital & Coast DHB and Pacific in both Hutt Valley and Capital & Coast DHBs;
- Ambulatory sensitive hospitalisation (**ASH**) rates for Maori children in Wairarapa declined from 2011/12 to 2012/13 and again in the most recent period. Rates for all children in Hutt Valley have decreased in the most recent period, however they are still higher than the national average. ASH rates for all children in CCDHB have increased slightly in the most recent period. A number of strategies to reduce ASH rates are in place or planned, including newborn enrolment in dental services, access to free primary care for under sixes, DHB funded housing initiatives, Regional Public Health healthy skin initiatives and the gastroenteritis project in Hutt Valley;
- The Ministry of Health (**MOH**) has provided additional funding for diabetes care improvement plan (**DCIP**) services. For 2013/14 this has been allocated to supporting practice plans and insulin starts in CCDHB, workforce development across Hutt Valley and CCDHB and self-management programmes across the sub-region, with a focus on Maori and Pacific;
- ASH rates for adults 45-64 years in Wairarapa have reduced from their 2010/11 level, however have remained relatively static since then. In Hutt Valley there has been a modest but steady decline for Pacific adults whereas the rate for Maori has fluctuated. In Capital & Coast the Pacific rate has dropped slightly from a peak in 2012/13, however the Maori rate has been increasing over the last couple of years. CCDHB is undertaking work on a series of clinical pathways to help reduce ASH rates. These pathways will be rolled out in the 2014 year. The three areas initially focussed on are for adults presenting with deep vein thrombosis (**DVT**), cellulitis and gastroenteritis/dehydration.

A full report against all indicators in the equity monitoring framework is included in **Appendix 1**.