

GOVERNANCE GUIDE FOR PRIMARY HEALTH ORGANISATIONS

July 2007

Foreword

The launch of the Primary Health Care Strategy in 2001 signaled a significant change to, and investment in, the delivery of primary health care services. High-performing Primary Health Organisations (PHOs) are an integral component to achieving the Strategy in the long term. The governance arrangements of PHOs are a crucial factor to their robust management and stewardship.

PHO boards are made up of people from different stakeholder groups, including consumers, providers, communities and Māori. It is important to encourage positive contributions from these groups, and wider involvement of the community and other providers in delivering high quality, accessible primary health care services.

The PHO Service Agreement was amended to include a new purpose statement and corporate governance clauses. The amendments clarify and reinforce the principles of good governance and affirm the role of PHOs in implementing the Primary Health Care Strategy through improving the health of, and reducing inequalities among, their enrolled populations. Most importantly, the role of a board member is to pursue the collective interest of the PHO, not another group or individuals they may represent.

The contractual amendments on their own are only a small part of the solution – to improve the quality of governance, PHO boards need resources and training. The Ministry of Health with the assistance of a sector advisory group has developed this document as a resource for PHOs. It clarifies the purpose and expectations of PHOs, the principles of good governance and the roles and responsibilities of board members. In addition to this, a tailored governance training package is currently being developed for PHO board members and delivery of this will commence later in 2007. In addition a training programme, *Te Manu Whakahīato*, has also been developed for Māori PHO board members.

I trust that your board will find these resources useful in ensuring that your PHO has excellent governing processes.

Hon Pete Hodgson
Minister of Health

CONTENTS

PART 1: CONTEXT AND OVERVIEW

- 1.1 The Primary Health Care Strategy
 - 1.1.1 Achieving the vision through Primary Health Organisations
 - 1.1.2 Population Health
- 1.2 Governance and the Primary Health Care Environment
 - 1.2.1 Clinical Governance

PART 2: BOARD FUNCTIONING

- 2.1 Governance
 - 2.1.1 Policy Setting
 - 2.1.2 Responsibilities Specific to PHO Boards
- 2.2 Code of Ethics
- 2.3 Strategic Leadership
 - 2.3.1 Planning in the Primary Health Care Environment
 - 2.3.2 The Annual Work Plan
- 2.4 Roles and Responsibilities of Board Members
 - 2.4.1 Role of the Chair
 - 2.4.2 Role of PHO Board Members
- 2.5 Board Culture and Composition
 - 2.5.1 Composition of PHO Boards
- 2.6 Appointment of Board Members
 - 2.6.1 Induction of Board Members
 - 2.6.2 Training of Board Members
 - 2.6.3 Tenure
- 2.7 Interests and Managing Conflicts of Interest
- 2.8 Board Meetings
- 2.9 Risk Management
 - 2.9.1 Financial Management
- 2.10 PHO Accountability
- 2.11 Role of Committees
- 2.12 Reporting and Consultation

PART 3: RELATIONSHIPS

- 3.1 Board / Chief Executive Relationship
 - 3.1.1 Delegating to the Chief Executive
 - 3.1.2 Performance Monitoring
- 3.2 Relationship with the Community
- 3.3 PHO / DHB Relationship
- 3.4 Relationship with Providers

PART 4: MONITORING AND EVALUATING PERFORMANCE

- 4.1 Monitoring and Evaluation
- 4.2 Organisational Performance
- 4.3 Board Performance
 - 4.3.1 Methods for Assessing Performance

TEMPLATES AND RESOURCES

PART 1: CONTEXT AND OVERVIEW

1.1 The Primary Health Care Strategy

1.1.1 Achieving the vision through Primary Health Organisations

1.1.2 Population Health

1.2 Governance and the Primary Health Care Environment

1.2.1 Clinical Governance

1.1 The Primary Health Care Strategy

A strong primary health care system is essential to improve the health of New Zealanders. The launch of the Primary Health Care Strategy¹ in 2001 signaled a significant change to, and investment in, primary health care. One of the central aims of the Primary Health Care Strategy is reducing health inequalities between different groups of New Zealanders by improving access to primary health care services. The vision of the Primary Health Care Strategy is that:

- people will be part of local primary health care services that improve their health, keep them well, are easy to get to and coordinate their ongoing care
- primary health care services will focus on better health for a population, and will actively work to reduce health inequalities between different groups.

The vision will be achieved through six key directions:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people's health
- coordinate care across services areas
- develop the primary health care workforce
- continuously improve quality using good information

1.1.1 Achieving the vision through Primary Health Organisations

The New Zealand Public Health and Disability Act 2000 established 21 District Health Boards (DHBs) and gave them overall responsibility for assessing the health and disability needs of communities in their regions, and managing resources and service delivery to best meet those needs. The Primary Health Care Strategy directed DHBs to work with local communities and health care providers to establish Primary Health Organisations (PHOs) as the local structures for delivering and coordinating primary health care services. PHOs are responsible for implementing the Primary Health Care Strategy based on the six key directions described above.

PHOs are funded and monitored by DHBs. Positive relationships between DHBs and PHOs are crucial to the successful implementation of the Primary Health Care Strategy. The objective of the PHO Service Agreement is to enable a PHO to work in a collaborative and equal relationship with its DHB, to fulfil the responsibilities of a Primary Health Organisation to implement and deliver the Primary Health Care Strategy, through improving, maintaining and restoring the health of, and reducing inequalities among, its enrolled population and other eligible persons as appropriate, in support of He Korowai Oranga – Māori Health Strategy and the New Zealand Health Strategy.

1.1.2 Population Health

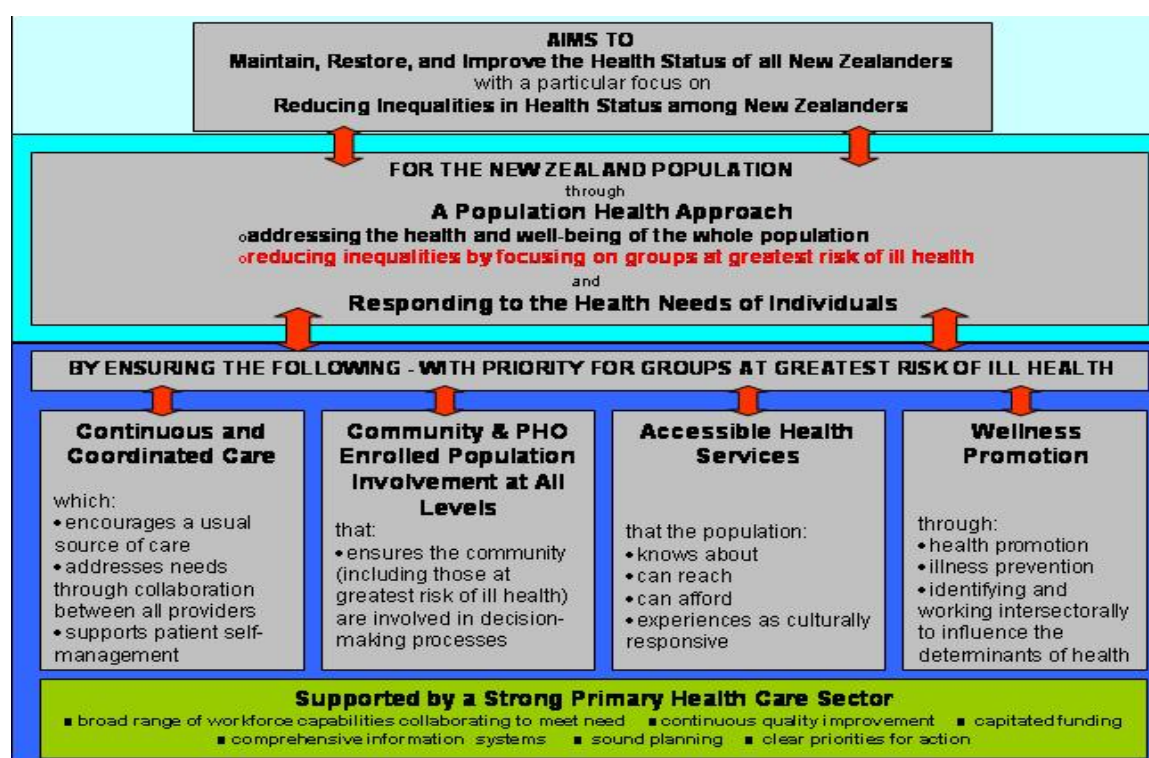
One of the key directions for PHOs is to provide services that will improve, maintain and restore the health of their populations. A focus on the well-being of whole populations rather than the individuals comprising them is the traditional domain of public health. Central, regional and, more recently, district and local approaches to health promotion and protection are ongoing and in development.

¹ The Primary Health Care Strategy, Hon Annette King Minister of Health, February 2001

However, our ability to focus on the health of at-risk sub-groups within enrolled populations is a product of developments in database technology and medical information systems. These have enabled closer attention to individual risk factors within the context of a wider population, be that a practice population or the enrolled population of a PHO.

By successfully encouraging a population health approach in primary health care settings, the system changes needed to support it become very apparent. These include for example, increased involvement by primary health care nurses, dieticians, health promoters and smoking cessation facilitators. In this sense population health is a key element in shifting the way we think about and deliver primary health care.

THE PRIMARY HEALTH CARE STRATEGY



1.2 Governance and the Primary Health Care Environment

Following the launch of the Primary Health Care Strategy, two documents were released to guide the establishment of PHOs – the *Minimum Requirements for Primary Health Organisations*², and *A Guide for Establishing Primary Health Organisations*³. Both documents were largely non-prescriptive in terms of how PHO boards should be formed and structured. PHOs were established from very different starting points – some were established from existing Independent Practitioner Associations (IPAs), and the establishment of others was driven more by communities in response to identified needs. As a result, PHO boards vary widely in terms of their size and structure; they take different legal forms and have different governing processes.

² Minimum Requirements for Primary Health Organisations, Hon Annette King Minister of Health, November 2001

³ A Guide for Establishing Primary Health Organisations, Ministry of Health, April 2002

A Guide for Establishing Primary Health Organisations outlined three legal forms that are consistent with the Primary Health Care Strategy. These are:

- Non-profit Companies – under this arrangement, the organisation registers as a company under the Companies Act 1993, and is governed by a board of directors
- Incorporated Societies – under this arrangement, the organisation registers under the Incorporated Societies Act 1908, and is governed by officers elected by its members
- Trusts – under this arrangement, the organisation registers under the Charitable Trusts Act 1957, and is governed by trustees.

A few PHOs have been established as Incorporated Societies, but the majority of PHOs have been established as Charitable Trusts and Non-profit Companies. The constitutional and legal frameworks that PHOs operate within will differ according to their legal form. This Guide does not focus on any particular legal form; instead it focuses on the principles of good governance and is intended to provide general advice to PHO boards.

1.2.1 Clinical Governance

Clinical governance is about ensuring safe, high quality care from all involved in the patient's journey and to ensure patients are the main focus and priority. It is fundamental to a PHO in delivering on its contracted services and in particular, improving health outcomes for, and reducing inequalities among, its enrolled population. Clinical governance can be defined as “a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

Care providers are expected to take responsibility for providing the best care possible and for surveying for failures or gaps. Clinical governance means different things to different stakeholder groups and interpretation varies accordingly. Clinical governance goes beyond what is purely 'clinical' and covers the work of anyone involved in the treatment and care of patients. Several components make up good clinical governance, including:

- clinical audit – the review of clinical performance
- clinical risk management – minimising risks to patients, practitioners and provider organisations
- clinical effectiveness – measuring how well a particular intervention works
- professional education and development
- whole systems approaches to quality improvement.

Clinical governance committees are advisory committees to PHO boards, and may be established regionally and span more than one PHO. All PHOs should have clinical governance structures in place – it is a prerequisite for participating in the PHO Performance Programme.

PART 2: BOARD FUNCTIONING

2.1 Governance

2.1.1 Policy Setting

2.1.2 Responsibilities Specific to PHO Boards

2.2 Code of Ethics

2.3 Strategic Leadership

2.3.1 Planning in the Primary Health Care Environment

2.3.2 The Annual Work Plan

2.4 Roles and Responsibilities of Board Members

2.4.1 Role of the Chair

2.4.2 Role of PHO Board Members

2.5 Board Culture and Composition

2.5.1 Composition of PHO Boards

2.6 Appointment of Board Members

2.6.1 Induction of Board Members

2.6.2 Training of Board Members

2.6.3 Tenure

2.7 Interests and Managing Conflicts of Interest

2.8 Board Meetings

2.9 Risk Management

2.9.1 Financial Management

2.10 PHO Accountability

2.11 Role of Committees

2.12 Reporting and Consultation

2.1 Governance

The role of the board is to provide leadership, set the organisation's strategic direction and vision, set policies and organisational / financial performance measures, appoint, delegate authority to and monitor the chief executive, ensure the organisation has the resources to run efficiently and monitor and evaluate performance.

The board is required to act within the boundaries of its own constitution, and other relevant legislation and regulations. The board is responsible for:

- setting the organisation's strategic direction, vision, purpose and priorities, within its legal and constitutional framework, and ensuring that these are upheld
- setting the policies and plans to guide operational activities to support the organisation to achieve its objectives ensuring that it complies with its own direction, policies and constitutional framework
- appointing, supporting and monitoring the performance of the chief executive
- succession planning for the chief executive
- succession planning for board members
- establishing processes for identifying and managing risks
- regularly scanning the environment in which the organisation operates, to ensure that goals and objectives remain relevant and achievable
- setting the standards for, and evaluating its own performance
- ensuring that key stakeholders have input into planning and decision-making of the organisation
- communicating and being accountable to key stakeholders through reporting and the production of annual reports.

The board should 'lead without managing'. The board is responsible for governing – providing direction and control, for setting objectives, monitoring chief executive performance and for leading the organisation as a whole.

The chief executive is responsible to the board for the day to day management of the organisation and for achieving the objectives, expectations and key performance indicators set out by the board. While separating governance and management is a key component of good governance practice, it can be an issue for small organisations with limited financial resources. If boards become involved in operational issues, and responding to immediate ad hoc issues, there is a risk that strategic issues go unresolved, accountability is unclear and monitoring performance is less effective. Where the board decides to contract out part or all of its management functions, robust processes are needed for selecting the management services provider, and for ensuring appropriate accountability.

2.1.1 Policy Setting

The chief function of a board is to set policies. The policies should provide a framework for how the organisation should be run and differentiate between the responsibilities and functions of the board and the chief executive and staff. Once a policy is adopted, the board should speak with one voice around the policy – even if board members are not unanimous and the policy was agreed by majority vote.

A number of boards have developed governance policy frameworks based on the work of international governance expert John Carver. The four policy areas that constitute Carver's framework are: strategic ends policies; process policies; board / chief executive linkage policies; and executive limitation (or delegation) policies.

1. Strategic ends policies set out the organisation's vision, priorities, fundamental reason for existence and the outcomes to be achieved. Setting the organisation's strategic direction, vision and purpose is a key role for the board, and forms the basis of the strategic plan and setting of the strategic goals.

2. Process policies define the board's scope and set out the framework that the board operates within. The process policies may include the following topics (which are detailed further in this part of the Guide):

- code of ethics
- roles and responsibilities of board members, and the chair
- induction of new board members
- processes for identifying and managing conflicts of interest
- meeting processes and protocols
- the role of board committees.

3. Board / chief executive linkage policies define the relationship between the board and the chief executive and the extent of the board's delegation to the chief executive. The board / chief executive relationship is covered in Part 3 of this Guide.

4. Executive limitations (or delegation) policies describe the restraints or limits that the board places on the chief executive. There are different approaches that the board can use to delegate authority to the chief executive. The executive limitations or proscriptive approach defines what must be achieved and then sets *limits* on the chief executive. By contrast, the prescriptive approach tells the chief executive what they *can* or *should* do – this is the most commonly used approach to policy. Delegation policies may include the following topics:

- budgeting, financial management and planning
- reporting to the board
- relationships with staff, volunteers and consumers
- remuneration and benefits
- compliance with legislation (e.g. OSH and EEO)
- protection of assets
- programmes and services.

The board will usually retain decision-making authority for some items – for example, capital expenditure over a certain value. Such reserved powers should be clearly specified in the delegation policies.

2.1.2 Responsibilities Specific to PHO Boards

PHOs are required to work with local communities to provide services that will improve, maintain and restore health – with a particular focus on reducing inequalities among groups

that are known to have poor health status. To achieve the goals of the Primary Health Care Strategy, and improve the health of their populations, PHO boards are responsible for:

- supporting a population health approach and reducing health inequalities by balancing responsibilities between different groups and focusing on groups at risk of poor health outcomes
- working with local communities, and those groups in their populations (including Māori, Pacific and lower income groups) that have poorer health outcomes or are missing out on services
- including their communities, iwi, providers and consumers in their governing processes
- ensuring that the PHO engages and consults with its community and demonstrates that it is responsive to the community's identified needs
- ensuring the primary health workforce has the capability and capacity to provide services the PHO is contracted to deliver
- developing effective relationships with their populations, providers and funders (DHBs)
- being financially accountable and delivering services within resources
- fostering, implementing and evaluating innovation to improve the quality of services
- coordinating provision of care within their population, and advocating for patients / consumers.

2.2 Code of Ethics

The board is required to act ethically in all areas of its responsibility and authority.

Individual board members should:

- act with honesty and integrity at all times
- when acting in the capacity as a PHO board member, act in good faith and in the interests of the PHO, and not pursue their own interests or the interests of another organisation
- disclose any actual or potential conflicts of interest as soon as they arise
- exercise care and diligence, attend board meetings and devote sufficient time to preparation for board meetings to allow for full and appropriate participation in the board's decision making
- not disclose any confidential information to any person other than as agreed by the board or required under law
- abide by the board's decisions once reached, and endeavour to be supportive of both the board and the chief executive
- act in accordance with their fiduciary duties, complying with the spirit and letter of the law, recognising the legal and moral duties of the role.

2.3 Strategic Leadership

The most important role of the board is providing strategic leadership, setting the strategic direction and the long-term focus – activities fundamental to the future of the organisation.

The board, supported by the management team should regularly assess the main strategic challenges facing the organisation, and continually review the organisation's vision, purpose and strategic goals to ensure they remain relevant.

To build commitment and a sense of common purpose, it is important that the vision is shared by the board, management and staff, and that all staff members have the opportunity to contribute to strategic planning. The following are important to consider as part of the strategic planning process:

- the vision, purpose and long-term focus of the organisation
- the environment in which the organisation operates, and the legislation and regulations that bind the organisation
- the current and future expectations and requirements of key stakeholders
- ensuring adequate resources are available to deliver on agreed outcomes and key results
- any potential risks to the organisation.

Strategic work happens on two levels – the board sets the strategic direction and goals, creating a framework for the chief executive and the management team to develop operational strategies (within allocated financial parameters) to support the overall direction of the organisation and deliver on strategic goals. The strategic framework should be kept simple:

- the board first needs to decide and agree on strategic goals that are measurable, achievable and reflect the vision and purpose of the organisation
- the strategic goals then need to be translated into more specific outcomes and key results (the organisation's short-term goals / objectives)
- the board can then allocate resources and set performance measures to ensure that the organisation is achieving its key results.

For more details on the points that should be considered as part of the strategic planning process see the Resources section.

2.3.1 Planning in the Primary Health Care Environment

DHBs have a statutory duty to assess the health and disability needs of their population, and to manage resources and service delivery to best meet those needs. DHBs have an ongoing role to monitor and fund PHOs to deliver essential primary health care services organised to meet the needs of their enrolled populations.

DHBs are required to produce District Annual Plans and District Strategic Plans. All PHOs should develop strategic plans, as well as annual work plans outlining key results areas – these plans should be determined in partnership with the DHB. There should be alignment in the relevant planning activities of DHBs and PHOs.

PHO strategic plans should:

- be consistent with the vision, purpose and goals of the Primary Health Care Strategy, and:
 - adopt a population health approach, by addressing the health of the whole population and reducing health inequalities by focusing on groups at risk of poor health outcomes

- ensure provision of continuous and coordinated care
- engage the community at all levels
- provide accessible health services
- coordinate health promotion activities
- engage a wide range of health providers to deliver appropriate services that meet the population's health needs
- be aligned with relevant DHB plans.

2.3.2 The Annual Work Plan

The board needs to develop an annual work plan that is consistent with its strategic direction and goals. In developing its annual work plan, the board should consider and allocate dates for all significant events and meetings including, for example:

- board meetings (and the type of meeting – e.g. administration or strategic planning)
- board committee meeting and reporting dates
- other external meetings (e.g. DHB/PHO planning meetings and meetings with providers)
- community engagement / consultation with external stakeholders
- the Annual General Meeting
- strategic planning and review of organisational strategies
- financial planning and reporting
- completing the annual report
- the chief executive's performance assessment cycle
- retirement / selection dates of new board members.

The annual work plan should incorporate the organisation's short-term goals and objectives and specific key results areas. The board can then check that the organisation has the resources required to achieve the objectives. An effective annual work plan should keep the work of the board focused.

2.4 Roles and Responsibilities of Board Members

Board members have both collective and individual responsibilities. Details of board member responsibilities are often specified in the organisation's constitution, code of ethics, governance policies and other legislation and regulations. Board members share common fiduciary responsibilities – in that they hold a position of trust to act in the best interests of the organisation. This requires individual board members to:

- exercise a duty of care
- act with honesty and integrity
- avoid using their position for personal advantage
- act within the legal and constitutional framework of the organisation.

Board members are jointly liable for actions and decisions made by the board, and are bound by decisions of the board. It is important that the board speaks with one voice, and

any member speaking on behalf of the board is required to express and support the view of the board.

Board members should have a clear understanding of their duties and responsibilities and the principles of good governance. In order to be effective, board members need to be provided with the relevant information to actively contribute to meetings and decision making. All papers need to be circulated well in advance of meetings (e.g. one week before), and make clear recommendations to the board.

2.4.1 Role of the Chair

The chair has an important role, and the time and commitment required is often greater than that of other board members. The chair provides a link between the board and the chief executive, and is responsible for:

- ensuring that the board acts with integrity and within the boundaries of its own constitution, and other legislation and regulations relating to the environment in which it operates
- acting consistently with the board's governance policies and processes
- chairing the meeting with the commonly accepted responsibilities of the position
- monitoring the agenda to ensure that meetings are productive
- ensuring board discussion is orderly and efficient, that discussion points are not constantly reiterated, and that discussion on general business items is kept brief
- ensuring the board is made up of members with a cross section of appropriate skills
- focusing board discussion on issues that are clearly the role of the board, and avoid making operational decisions that are the responsibility of the chief executive and management team.

To provide effective leadership, the chair should:

- be familiar with the board's policies and delegations to the chief executive
- fully understand and practice effective governance or undertake relevant governance training
- know the strengths and limitations of all board members, and how to get the best out of the board
- know what is on the agenda and what outcomes are sought from each item
- know how to deal with conflicting views and perspectives of board members
- know when a discussion has run its course, and should be drawn to a close
- know the strengths and weaknesses of the chief executive
- meet regularly with the chief executive and provide supportive leadership.

A few PHO constitutions provide for an independent chairperson.

2.4.2 Role of PHO Board Members

To be effective in their roles, PHO board members should:

- be committed to supporting the PHO to achieve the goals and objectives of the Primary Health Care Strategy
- develop knowledge and understanding of the primary health care environment and a population health approach
- devote sufficient time to become familiar with the demographics and issues facing the PHO's population
- regularly communicate with their community contacts
- devote sufficient time to become familiar with the PHO's policies, programmes and priorities, to actively contribute to discussion and for full and appropriate participation in the board's decision-making
- undertake relevant governance training.

2.5 Board Culture and Composition

The culture of the board is important – it determines the overall culture of the organisation and in turn how it is perceived by the public. 'Good' culture can be achieved through board members having a strong common sense of purpose, mutual respect, trust and effective working relationships and clear distinction between the responsibilities of the board and management. Conflicts that arise between board members need to be resolved quickly as these can seriously impact on the work and effectiveness of the board.

The organisation's constitution generally determines the size and composition of the board, and how it is formed. Board members should collectively have the right mix of skills, experience and expertise to effectively govern the organisation. The board should not be comprised of totally like-minded individuals – diversity is vital, and board members should come from different backgrounds and bring different perspectives.

2.5.1 Composition of PHO Boards

This Guide is not intended to prescribe the composition of PHO boards. Rather it focuses on the mechanisms and processes that the board adopts to ensure good governance.

As described in Part 1 of this Guide, the two documents released to guide the establishment of PHOs were largely non-prescriptive in terms of how PHO boards should be formed and structured. As a result, PHO boards vary widely in terms of their size and structure; they take different legal forms and have different governing processes. *A Guide for Establishing Primary Health Organisations* outlined three legal forms that are consistent with the Primary Health Care Strategy. These are Non-profit Companies, Incorporated Societies and Trusts. Most PHOs have been established as Charitable Trusts and Non-profit Companies.

PHO boards are made up of people from different stakeholder groups including providers, communities, Māori and consumers. The *Minimum Requirements for Primary Health Organisations* did not specify how the community voice should be heard at the governing level, but did state that there must be processes in place for genuine community participation and that this should include communities, iwi and consumers. Nor did they specify how providers would be represented at the governing level, but stated that there must be sufficient processes in place to ensure that decisions take account of the range of views. Provider representation on PHO boards varies, but generally includes GPs and nurses. With

an increased focus on multi-disciplinary primary health care teams, PHOs boards should consider the roles of other health professionals (including, but not limited to pharmacists, midwives, physiotherapists, allied health professionals, population health specialists and Māori health workers) in their governing processes. Having a person with financial and accounting expertise on the board that has the ability to understand and interpret financial statements is also valuable.

2.6 Appointment of Board Members

The board's constitution usually sets out the process for appointing board members. Boards should have succession plans and when a vacancy arises, the board should consider the skills and attributes needed in the new member that will complement the rest of the board. Appointment of board members should be open and transparent and focus on creating a diverse and effective board.

Board member appointment processes vary widely between PHOs, and this largely depends on the legal and constitutional arrangements of the PHO.

2.6.1 Induction of Board Members

All new board members should receive comprehensive induction. New members need to be familiar with the board's governance role, the work of the organisation, and the environment in which it operates, to enable them to be effective in their role and to contribute to the board's work. Before their first meeting, new board members should meet with the Chair and the chief executive to discuss board protocols and current issues. Induction material should consist of:

- the constitution
- information on the composition of the board, including brief biographical material of the members
- information about the organisation, including an organisational chart and information on key staff members
- current and recent board meeting papers, including minutes and financial statements
- the board's policies
- key documents, such as the strategic plan, the board's annual work plan and other relevant background material.

New PHO board members should be provided with a copy of the Primary Health Care Strategy and all other resources relevant to the work of the PHO.

2.6.2 Training of Board Members

Board members should be provided with the opportunity to undertake relevant training and receive ongoing professional development to be effective in their roles. Board members should accept responsibility for keeping themselves informed of developments relevant to the organisation they govern. Regular evaluation of the board's performance will help to identify areas where the board as a whole and individuals need development.

PHO board members need to receive ongoing training relevant to the primary health care environment.

2.6.3 Tenure

Most constitutions will specify the term of office for appointments to the board (usually up to three years), and processes around reappointment. The constitution may also specify the total (maximum) term for each board member, including the chair. Retirement and appointment of board members should be staggered to prevent loss of institutional knowledge and to ensure there is support to bring new members up to speed.

2.7 Interests and Managing Conflicts of Interest

PHOs should have an Interests Register for board members to record any interests they have that are, or could have the potential to be, in conflict with their position as a board member. Potential conflicts of interest could arise in a PHO setting when a board member provides professional services to the PHO, or stands to gain financially from any business dealings with the PHO.

All boards should have a policy and process in place for managing conflicts of interest when they do arise. Board members hold a position of trust to act in the best interests of the organisation (fiduciary responsibilities) that requires them to exercise a duty of care, act with honesty and integrity, and avoid using their position for personal advantage. The actions of the board sets the standards for the organisation, and all board members should declare any potential conflicts of interest as soon as they arise.

When the chair is aware of any actual or potential conflict of interest, they must take the steps necessary to ensure that it is managed appropriately. When an individual board member is aware of any actual or potential conflict of interest, they have a responsibility to bring it to the attention of the board.

When a conflict of interest is identified and declared, any action taken should be noted in the board minutes, and officially documented in the board's Interests Disclosure Register. The board needs to decide how serious the conflict of interest is, and this process will determine how it is dealt with. Depending on the seriousness of the conflict, the board may decide:

- to note that the conflict is minor, and allow the board member to continue to participate in the discussion, and if appropriate in the decision
- that the board member should not participate in discussions on the issue
- that the board member should not vote on the issue
- that the board member should not receive any papers or information relating to the issue.

Dealing with conflicts of interest can sometimes be difficult, particularly when a number of board members have identified a conflict of interest in relation to the same issue. This may make it impossible for the board to form a quorum. If this does happen the board may decide to form an independent committee to deal with the issue.

2.8 Board Meetings

The board should organise its work in a way that makes the most effective use of the time, skills and knowledge of its members. Developing an annual work plan which includes the dates of all significant events and meeting dates (as outlined above in Part 2.3.2) will help keep the board focused. The time available for boards to meet is often scarce, and meetings will be more effective when:

- meetings are well planned and chaired
- board members are prepared, and have the opportunity to read papers in advance
- board members work well together, different points of view are respected and everyone is given the opportunity to participate.

The chair has an important role in keeping discussions on topic and to time, and in encouraging all members to participate and express their views.

The board should have a policy that sets out its meeting processes and protocols, including:

- **meeting frequency** – the board should meet as often, and for as long as is required to carry out its work
- **meeting agendas** – the structure and sequence of agenda items is important; it can be beneficial to discuss strategic issues at the start of the meeting and leave other general business items to the end
- **focus** – the board should avoid getting involved in operational and management issues, and ensure that its work stays focused on strategic issues
- **board papers** – board members need to receive board papers and information well in advance of meetings to enable them to participate effectively and make good decisions
- **minutes** – records of all meetings and decisions made should be completed
- **quorum** – the organisation’s constitution will generally state the number of board members required for a board meeting to proceed (usually 50 percent or greater).

2.9 Risk Management

Risks are unavoidable future events that could impact on the organisation’s ability to achieve its objectives. The operating environment of all organisations is subject to some change – which can bring risk or alter the organisation’s focus. Risk management is the process by which the board and the chief executive ensures the organisation is equipped to deal with risk, and using the uncertainty brought about by risk to its best advantage.

The board should accept a certain level of risk, and needs to have effective systems in place for identifying, evaluating and managing risk. The board should be aware of and regularly review any strategic and operational risks that the organisation faces. Having strategies in place for managing risk and being prepared for a range of potential outcomes in the future will reduce uncertainty and allow the board to respond appropriately. Developing a policy detailing the respective responsibilities of both the board and management around risk is important.

As part of its risk management responsibility the board should:

- be aware of any key risks facing the organisation and have an understanding of their potential impact
- set the tone around risk management for the organisation as a whole – this will depend on whether the organisation is more risk averse, or willing to take some risk
- avoid undertaking any activities that put the reputation of the organisation, or its staff or service users, at risk
- exercise care when investing the organisation’s funds, or borrowing funds, and ensure this complies with the organisation’s constitution and any other legal requirements

- have procedures accessible to all staff, board members and others associated with the organisation to allow for confidential reporting of any matters of concern, including risks to the organisation, misconduct or the misuse of funds.

In some circumstances board members can be deemed liable for the organisation's financial failure or its failure to meet certain legal requirements. Having a liability insurance policy can protect the personal liability of board members.

2.9.1 Financial Management

The board is responsible for protecting the financial integrity of the organisation and ensuring that it has the resources to run effectively. The board should have a financial policy that clearly delineates the respective financial management responsibilities of the board, and the chief executive. As part of their reporting requirements, the chief executive should provide regular financial statements to the board – and all board members should be able to understand and interpret these.

2.10 PHO Accountability

The PHO Service Agreement between the PHO and the DHB sets out the services the PHO has to provide to its enrolled population, as well as other requirements including reporting. As stated under the PHO Service Agreement, all PHOs are required to make their annual reports and annual financial statements available to the public. Annual reports are a report back to the community, DHBs and the Ministry on how the PHO is performing and achieving the goals of the Primary Health Care Strategy.

PHOs receive a significant amount of public funding (via DHBs) and must be accountable for its use. In funding the PHO, the DHB must be satisfied that the PHO can provide accountability for its use of public money, and that it is used appropriately and effectively.

An up-to-date informative website can also enhance PHO accountability. Board minutes, reports, GP practice fees, specific project outcomes and general news should be a feature of a PHO's website.

2.11 Role of Committees

The board should have the authority to establish committees to address specific issues. The committees may be standing (permanent) committees or ad hoc committees created to help the board with specific tasks. Board committees can improve effectiveness, particularly in large organizations, and often allow for better utilisation of the skills of individual board members. Committees should only be established where they will add value and improve the effectiveness of the board by assisting with its work. Boards are ultimately accountable and must decide if they accept the work and recommendations made by committees.

Committees may be comprised wholly of board members and make recommendations to the board on certain issues. Examples of such boards are:

- Strategy Committee
- Finance and Audit Committee
- Chief Executive Appointment / Review Committee

Alternatively, committees may be established in an advisory capacity and may be comprised of board members, as well as other individuals with an interest or expertise in the area. Examples of such committees are:

- Clinical Governance Committee
- Community Advisory Committee
- Population Health Committee

All committees should have a Terms of Reference that sets out the committee's membership, role, functions, boundaries and reporting requirements. Standing committees should review their Terms of Reference regularly. For a sample Terms of Reference see the Resources section.

2.12 Reporting and Consultation

PHOs are responsible for improving the health of their populations and reducing inequalities through the delivery of appropriate and accessible primary health care services. To achieve this objective, PHOs need to have effective relationships with different groups across the community, with a range of providers and NGOs, and with DHBs. Community engagement must be genuine and give the community a meaningful voice.

The board should be open, accountable and responsive to its key stakeholders. The board needs to identify the key stakeholders and those interested in its work and ensure there is a regular forum for communicating and reporting information about the organisation's achievements and work.

The board should have consultation processes that enable key stakeholders and service users to:

- provide feedback on the organisation's achievements, services, and planning processes
- be involved in the organisation's planning and decision making processes.

PART 3: RELATIONSHIPS

3.1 Board / Chief Executive Relationship

3.1.1 Delegating to the Chief Executive

3.1.2 Performance Monitoring

3.2 Relationship with the Community

3.3 PHO / DHB Relationship

3.4 Relationship with Providers

3.1 Board / Chief Executive Relationship

The chief executive is accountable to the board. The relationship between the board and the chief executive should be a partnering approach that recognises the respective roles and responsibilities. As outlined in Part 2 of this Guide, the role of the board is to set the strategic direction and to provide overall leadership of the organisation.

The chief executive is responsible for the day to day management of the organisation within the direction set out by the board. Board members should avoid getting involved in operational matters that are the responsibility of the chief executive. If board members are required to undertake executive or management functions, these should be clearly defined and minuted by the board. It is more common in small organisations where resources are limited, for the chief executive to request help from a board member outside the board setting. In these situations the board member is accountable to the chief executive, not the board.

A successful relationship between the board and the chief executive is built on:

- a clear division of roles and responsibilities
- mutual expectations that are clear and realistic
- clear reporting and information requirements – the board should be clear about the information they require, in what form and in what timeframe
- fair processes for chief executive performance management.

The relationship between the chair and the chief executive is important, and they should meet regularly outside the board setting. The chief executive is accountable to the board as a whole, however it is more practical for the chair to manage day to day relationships with the chief executive. The chair provides and facilitates the connection between the chief executive and the whole board.

Where the board decides to contract out part or all of its management functions, robust processes are needed for selecting the management services provider, and for ensuring appropriate accountability.

3.1.1 Delegating to the Chief Executive

The board needs to be clear about the extent of its delegation to the chief executive – if it is not clear it can confuse respective roles, responsibilities and accountabilities. The delegation policy may cover the following:

- financial delegation – including expenditure limits, financial reporting requirements, use of the organisation's funds, budgeting processes
- personnel management – including staff relationships, compliance with legislation (such as OSH and EEO), recruitment, performance management, remuneration
- management of assets – including buildings and vehicles, intellectual property
- supporting the board – including reporting requirements and frequency, alerting the board to potential risks, contributing to strategic planning processes
- management of contracts – with all providers including Management Services Organisations
- public relations – including protocols around media enquiries and representing the organisation in public.

For examples of what to include in a delegation policy see the Resources section.

3.1.2 Performance Monitoring

One of the responsibilities of the board is setting and monitoring the chief executive's performance. This involves agreeing and establishing realistic and measurable performance objectives. These should be aligned to the overall strategic goals the organisation sets out to achieve.

The chief executive's performance should be reviewed annually, and the board needs to decide on how the process will be carried out. The process needs to be fair and constructive and aim to build relationships between the chief executive and the board. The chief executive is employed by and is accountable to the whole board; therefore all board members should have the opportunity to provide feedback on the chief executive's performance as part of the review process. However it may not be fair or practical for the whole board to be involved in the performance review process. The chair (or where appropriate a board committee) should complete the performance review with the chief executive on behalf of the whole board.

Where a PHO has all of its management services provided by an MSO, the MSO is accountable to the board in the same way a chief executive would be, and will be assessed on achieving the objectives as set out by the board.

3.2 Relationship with the Community

The board is ultimately accountable for ensuring that the PHO is effectively engaging its community and is responsive to its needs. Community participation is a key component of the Primary Health Care Strategy. The concept of consumer and community participation in planning and governing is not new, and some health organisations were actively involving their communities in their governing processes prior to the establishment of PHOs. The *Minimum Requirements for Primary Health Organisations* did not specify how the community voice should be heard at the governance level but did specify that PHOs must be responsive to their communities and have genuine processes for including community, iwi and consumers in their governing processes.

The 'communities' served by PHOs are diverse and are represented by smaller community groups. The PHO's patient register is a natural starting point for identifying the different community groups with whom key relationships need to be developed. Building active and effective relationships and undertaking meaningful community participation will help to build trust and understanding, and result in services that reflect the needs and priorities of people in the community.

Community participation capacity varies widely among PHOs. The PHO board, management and providers should all be familiar with the health issues facing its population. The board should work in partnership with PHO management to develop a framework that supports effective community engagement that allows the community to identify and prioritise its health needs.

Community participation in decision making happens at different levels. The ladder of participation originally published by Sherry R Arnstein in 1969, is often adapted and used by different organisations to describe the degrees of participation the community has in the decision making process:

- At one end of the spectrum, communities are not consulted and are simply provided with information once decisions have been made or new policies announced
- The next level of consultation is presenting a plan to the community for information and feedback – compliance is expected and any suggestions made will not generally influence final decision making
- The next level involves the community in more collaborative decision making, where the community is presented with a tentative plan and encouraged to contribute and be involved in final decision making
- At the other end of the spectrum, communities have a high degree of participation in that the community is asked to identify the problem and make the key decisions on goals and means for addressing the problem. A PHO that is actively involving its community and consumers in the planning and delivery of health services will be operating at this end of the spectrum.

One of the key directions of the Primary Health Care Strategy is identifying and removing health inequalities that exist between different groups of New Zealanders. High needs groups, currently defined as Māori, Pacific and those living in areas of high deprivation (deciles 9 and 10 of the New Zealand deprivation index) are known to have poorer health outcomes and more barriers to accessing primary health care services. PHOs play a crucial role in developing strategies to identify and provide appropriate services for disadvantaged and hard to reach groups. Most PHOs that have significant numbers of Māori and Pacific enrollees have developed services specifically for these people – for example, delivering health services in different settings such as marae, in the home and in churches.

The New Zealand Public Health and Disability Act 2000 provides mechanisms to enable Māori to be involved in decision-making on, and participation in the delivery of, health and disability services to improve health outcomes for Māori. Supporting Māori participation at all levels of the health and disability sector in decision-making, planning, developing and delivering health and disability services is the second pathway of *He Korowai Oranga – Māori Health Strategy*. This is aimed at achieving whānau ora (Māori families supported to achieve their maximum health and well-being). Active participation by Māori in PHOs in the planning, development and delivery of primary health care services will help to ensure that services are appropriate and effective for Māori.

The Resources section of this Guide contains website links on community development and participation. Pat Neuwelt's book *Community Participation Toolkit – a resource for primary health organisations*, provides PHOs with a framework for community engagement and responsiveness. It is based on the principle that community involvement in planning and delivering services will lead to better health outcomes for the community.

3.3 PHO / DHB Relationship

DHBs have statutory obligations to improve and protect the health of communities by reducing health inequalities between different groups of New Zealanders. The Primary Health Care Strategy gave DHBs the direction to establish PHOs to deliver primary health care services to reduce inequalities between different groups of New Zealanders.

Relationships between PHOs and DHBs are critical as they share a common interest in improving health outcomes for their populations. PHOs and DHBs are jointly responsible for developing effective working relationships, and should focus on moving forward together. Examples of good relationships between DHBs and PHOs exist where:

- there is mutual respect and an agreed common sense of purpose in improving health outcomes for populations
- PHOs are involved in relevant DHB planning processes
- relationships are built on a partnering approach, and DHBs provide PHOs with support where necessary
- DHBs facilitate opportunities between their PHOs for sharing information and knowledge
- contracts are well managed and contracting processes are fair and transparent
- expectations relating to primary health care in the Minister's annual letters to DHB Chairs setting out expectation for the DHB are shared with the PHO Chairs.

3.4 Relationship with Providers

PHOs need to work with a range of providers to develop services to meet the needs of their population, including Māori and Pacific providers, to improve health outcomes for these groups.

The Primary Health Care Strategy requires PHOs to:

- offer access to comprehensive services to improve, maintain and restore people's health
- coordinate care across service areas

To achieve these objectives, the PHO's enrolled population needs to have access to a range of health providers and services. Coordination between services will ensure the best possible care for patients and avoid unnecessary duplication of services. Therefore, positive relationships between PHOs and their providers are crucial.

The majority of first-level services will generally be provided by GPs and practice nurses. The Primary Health Care Strategy recognises that no single practitioner can meet an individual's needs completely – it therefore places a greater emphasis on developing broader, multi-disciplinary primary health care teams involving a wide range of providers.

PART 4: MONITORING AND EVALUATING PERFORMANCE

4.1 Monitoring and Evaluation

4.2 Organisational Performance

4.3 Board Performance

4.3.1 Methods for Assessing Performance

4.1 Monitoring and Evaluation

As part of the strategic planning process, the board will set measurable and achievable goals that support the overall vision and direction of the organisation. An important part of the board's governance role is monitoring the organisation against its strategic goals. It is important to distinguish between monitoring and evaluation.

- Monitoring is retrospective and involves observing, recording and reporting information.
- Evaluation focuses on improving future performance. It looks at whether the organisation has achieved its objectives and any issues relating to performance that need to be addressed.

4.2 Organisational Performance

The board has overall responsibility for the performance of the organisation as a whole. The board needs to clearly set performance *expectations* before setting specific performance *measures*. Performance expectations are usually based on the agreed outcomes and key results identified as part of the strategic planning process. Organisational performance includes:

- monitoring the performance of the chief executive (covered in Part 3 of this Guide)
- monitoring the organisation against its agreed outcomes and key results areas, and achievements against its work plan.

The six key directions of the Primary Health Care Strategy provide a useful basis for measuring the effectiveness of a PHO and determining how a PHO is meeting the needs of its population.

4.3 Board Performance

The board should have good processes in place for measuring its own performance. All boards should regularly review their own performance and the performance of individual members as a way of improving the governance of the organisation. Evaluating the board's performance is a useful tool for:

- assessing how the board is functioning as a team
- identifying areas for improvement for the board as a whole
- assessing the performance of individual board members and the chair, and identifying areas where individuals can improve and enhance their personal contributions
- dealing with board conflict
- assessing the performance of board committees.

Evaluating board performance should be viewed as a positive team building process for continually improving governance; it is not a report card. Performance targets should be based on the board's agreed processes and achieving the objectives it sets itself.

4.3.1 Methods for Assessing Performance

There are many different ways of assessing board performance; one common approach is for board members to complete a self-assessment – which usually takes the form of a

questionnaire. Self-assessments generally require individual board members to complete an evaluation of their own performance as well as the performance and functioning of the board as a whole. For a sample set of self-assessment questions see the Resources section.

After the self-assessments have been completed, the collated and analysed results will help to identify areas where improvements need to be made, and facilitate discussion for processes for making improvements.

When there are problems or conflicts within the board, it may decide to use someone independent of the board to:

- complete the assessment process and to help facilitate discussion on where strengths and weaknesses lie
- to help develop a programme to improve effectiveness and performance.

It may be useful to occasionally complete an extended evaluation of the organisation to gain a better understanding of how the organisation is performing and how it is perceived by the wider public and its stakeholders. Completing an extended evaluation may be desirable for a PHO to measure, in particular, the effectiveness and appropriateness of its services and how well the PHO is engaging with its community. A 360 degree assessment can be a useful tool for receiving feedback from communities, providers and other stakeholders.

TEMPLATES AND RESOURCES

Strategic Planning Processes

Board Committee Terms of Reference

Chief Executive Delegation Policies

Board Self-Assessment

Resources

Strategic Planning Processes

As described in Part 2.3: Strategic Leadership, the most important role of the board is setting the strategic direction, vision and objectives for the organisation. The board should regularly review the organisation's vision and strategic goals to ensure they remain relevant to the environment in which it operates. It is important that the vision is shared by the board, management and staff. The following are useful points to consider as part of the strategic planning process.

Constitutional and legislative frameworks
The board is required to act within the boundaries of its own constitution and other relevant legislative frameworks. Strategic planning activities, including setting the vision, purpose, objectives and strategic direction must be set within these boundaries. For example, for PHOs this requires a commitment to achieving the goals and objectives of the Primary Health Care Strategy.
External environment
It is important to consider external factors such as the environment in which the organisation operates as part of the strategic planning process. For example, PHO boards need to be aware of primary health issues and where the linkages are with other areas of health.
Strengths and weaknesses
The organisation should assess where its strengths and weaknesses lie, and any potential threats and risks.
Purpose
It is important to define the organisation's purpose and reason for being, and the long-term focus of the organisation. For example, PHOs were established to provide essential primary health care services organised around the needs of their enrolled populations.
Key stakeholders
The organisation's key stakeholders and their expectations need to be identified. For example, a PHO's key stakeholders are its enrolled population and the wider community it serves, and its service providers.
Resources
The board should consider the resources available to the organisation when setting strategic goals and more specific outcome areas.

Considering these points as the first stage in the strategic planning process will ensure that strategic goals and more specific outcomes and key results areas are realistic and achievable and consistent with the organisation's strategic direction and long-term vision.

Board Committee Terms of Reference

Below is a sample template for a Board Committee Terms of Reference. For more information – refer Part 2.11: Role of Committees.

COMMITTEE NAME
Constitution
The <i>[Name]</i> Committee was established as a committee of the Board / as an advisory committee to the Board.
Objectives
The Committee was established to assist the Board: <ul style="list-style-type: none"> • <i>[state the key objectives of the Committee]</i>
Responsibilities
The responsibilities of the Committee are: <ul style="list-style-type: none"> • <i>[state the agreed responsibilities of the Committee]</i>
Authority
<i>[Specify the level of authority the Board has delegated to the Committee, for example, authority to obtain information from the organisation, authority to seek advice from outside parties with relevant expertise]</i>
Membership
The Committee shall comprise <i>[X members / not less than X members]</i> , appointed by the Board. <i>[specify any other requirements relating to membership of the Committee, including whether a Chair will be appointed and who will appoint them]</i>
Meetings
<i>[Specify details of meetings, for example, the number of members required to form a quorum, minutes of meetings, other people that are able to attend, etc]</i>
Reporting
<i>[Specify the agreed reporting requirements, for example, who the Committee will report to, how often, and in what form]</i>
Review of Committee and Terms of Reference
The Committee's Terms of Reference will be approved by the Board. The Committee will review its Terms of Reference, objectives and responsibilities regularly <i>[specify the review period]</i> .
Payment
<i>[Specify details of any payment to Committee members]</i>

Chief Executive Delegation Policies

As described in Part 3.1: Board / Chief Executive Relationship, it is important that the board clearly defines the roles and responsibilities of the chief executive, and the extent of its delegation. The headings in the template below may be useful in developing delegation policies for the chief executive.

<p>Responsibilities of the Chief Executive</p> <p>The role of the chief executive is to manage the [Organisation]. The chief executive shall <i>[state the requirements of the chief executive, for example]</i>:</p> <ul style="list-style-type: none"> • act within the organisation's legal and constitutional framework • develop operational strategies (within allocated financial parameters) to support the overall direction of the organisation as agreed and set out by the board • keep the board informed of the position of the organisation, including the financial position, potential risks, and outcomes of programmes and services
<p>Financial Delegation / Budget Planning</p> <p>The chief executive is responsible for the day-to-day financial management of the organisation. <i>[Specify details such as expenditure limitations, financial reporting requirements, use of the organisation's funds and responsibilities related to annual budget planning]</i></p>
<p>Personnel Management</p> <p>The chief executive is responsible for day-to-day management of staff, and should provide a safe environment and manage staff in a fair and respectful manner. <i>[Specify requirements relating to responsibilities to staff, processes for disputes and grievances, informing the board of potential disputes, recruitment and performance management processes, compliance with legislation such as EEO and OSH]</i></p>
<p>Management / Protection of Assets</p> <p>The chief executive is responsible for the management and protection of the organisation's assets, and ensuring that assets are not misused. <i>[Specify details such as responsibilities for cash handling, maintenance and use of assets including vehicles and property, protection of intellectual property, insurances and liability]</i></p>
<p>Supporting the Board</p> <p>The chief executive is accountable to the board, and is responsible for regular reporting and keeping the board informed of the organisation's position. <i>[Specify details such as regular reporting requirements and frequency, processes for alerting the board to potential risks and other important issues]</i></p>
<p>Management of Contracts</p> <p>The chief executive has responsibility for the day-to-day management of contracts with providers. <i>[Specify details of contracts the chief executive is responsible for]</i></p>
<p>Public Relations</p> <p>The chief executive has a responsibility for ensuring that public affairs are not conducted in a way that brings the organisation into disrepute. <i>[Specify protocols around media enquiries and public affairs, including situations when the board should be notified regarding media issues]</i></p>

Board Self-Assessment

As described in Part 4: Monitoring and Evaluating Performance, using a questionnaire is the most common process for completing a self-assessment. As well as assessing the performance of the board as a whole, many self-assessments include an evaluation of individual board members. Individuals are asked to give a rating for each question, which could be set up as follows:

- 1 – Strongly Agree
- 2 – Agree
- 3 – Disagree
- 4 – Strongly Disagree
- N/A – Not Applicable

Evaluating Individual Board Members

Below is a set of sample questions that could be included in individual board member evaluations.

Individual Board Member Evaluation	Rating
1. I understand and support the vision, direction and objectives of the organisation	
2. I am committed to the work of the organisation	
3. I understand my roles and responsibilities as a board member	
4. I regularly attend meetings and prepare for meetings by reading background material provided	
5. I actively participate in discussions at board meetings	
6. I promptly declare any potential conflicts of interest	
7. I carry out my other board responsibilities effectively and efficiently (for example, duties as a sub-committee member)	
8. I am willing to undertake further development and training opportunities, and to take on new roles	

Evaluating the Board's Performance

Below is a set of sample questions that could be included in the evaluation of the full board's performance.

Strategic Planning	Rating
1. The organisation's vision, direction and objectives are understood and supported by all board members	
2. The board is clear on the direction the organisation should be taking and regularly reviews the vision and strategic goals to ensure they remain relevant	
3. The board collectively reviews the organisation's strategic plan at least every 2-3 years	
4. The board develops and completes an annual work plan that is consistent with the organisation's strategic plan	
5. The roles and responsibilities of the board and the management team are clearly defined and separated	

Board Practices	
1. The composition of the board is good, and board members work well together	
2. The board has open and transparent processes for appointing new members	
3. Board members collectively have the right skill mix to effectively govern the organisation	
4. The training and induction of new board members helps to quickly bring them up to speed with the work of the organisation	
5. The board has a process for recording and managing conflicts of interest	
6. The board has a process in place for identifying, evaluating and managing risk	
Board Meetings	
1. The board meets regularly and as agreed in the annual work plan	
2. The agenda and supporting papers are distributed in advance of the meetings, and members are well prepared	
3. Board meetings are run effectively and make good use of member's time	
4. All board members are given the opportunity to participate and different points of view are respected	
5. Minutes of all board meetings and major decisions are recorded	
Board Committees	
1. The board's committees help to add value and improve the effectiveness of the full board	
2. The board's committees complete the tasks assigned to them effectively, and report regularly to the board	
3. Each committee reviews its objectives, responsibilities and Terms of Reference annually	
Accountability	
1. The board is accountable to its key stakeholders, and regularly communicates relevant information	
2. The board is accountable for the use of any public funding it receives	
3. Annual reports are made available to the public	
Financial Management	
1. The financial reports and financial status of the organisation are understood by all board members	
2. Accurate financial reports are completed by a suitably qualified person on a regular basis	
Comments	

Resources

Governance Guides and Tools

Nine Steps to Effective Governance – Sport and Recreation New Zealand (SPARC)
<http://www.sparc.org.nz/filedownload?id=03ab2975-e294-4f6c-8ff9-6b210df80b21>

Getting on Board: A governance resource guide for arts organisations – Creative New Zealand
<http://www.creativenz.govt.nz/files/resources/getting-on-board.pdf>

Board Works International <http://www.boardworksinternational.com/>

Community Resource Kit: Governance – CommunityNet Aotearoa
<http://www.community.net.nz/how-toguides/crk/governance/>

Integrated Governance Handbook: A handbook for executives and non-executives in health care organisations – Department of Health, United Kingdom
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4128739

Good Governance: A Guide for the Community and Voluntary Sector – The National Hub of Expertise in Governance, United Kingdom.
<http://www.governancehub.org.uk/GovHub/Content/Documents/Gd-Gov-FINAL.pdf>

Clinical Governance Guidelines

What is Clinical Governance – NHS Clinical Governance Support Team, United Kingdom
http://www.cgsupport.nhs.uk/about_cg/

Community Development and Participation

Good Practice Participate – Office for the Community and Voluntary Sector
<http://www.goodpracticeparticipate.govt.nz>

Community participation and empowerment: putting theory into practice – Joseph Rowntree Foundation
<http://www.jrf.org.uk/knowledge/findings/housing/h4.asp>

The benefits of community participation: A review of the evidence – Home Office, United Kingdom
http://www.togetherwecan.info/acc/the_benefits_of_community_engagement.html

Community Development – What is it? <http://www.maaori.com/develop/commwhat.html>

Community Participation Toolkit: a resource for primary health organisations – Pat Neuwelt

Self Assessment Tools

The Corporate Fund: Nonprofit Board Self-Assessment Kit
http://www.thecorporatefund.org/board_self_assessment_kit.asp

Cause and Effect: Quick Board Self-Assessment Survey
http://www.ceffect.com/resources/self_assesment_suvey.pdf

Sector Advisory Group

The Ministry of Health acknowledges the valuable contribution of the following people in the development of this Guide:

Doug Matheson – Best Practice Governance Expert
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Hamish Kynoch – Chair, Hawkes Bay PHO / Chair PHO Alliance
Toby Regan – Chair, South East and City PHO (SECPHO)
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Sandra Cook – PHO Community Council / Board Member, Takatimu PHO
Carol Ryan – PHO Community Council / Board Member, Harbour PHO
Elaine Tapsell – Chief Executive, Nga Mataapuna Oranga PHO
Peter Cooke – PHO Taskforce / Board Member, Partnership Health Canterbury

Sector Feedback

Primary Health Organisations, District Health Boards and a range of key stakeholder groups, including the following, were invited to provide submissions and had the opportunity to inform the Guide before publication of the final version:

- Independent Practitioners Association Council
- Royal New Zealand College of General Practitioners
- New Zealand Medical Association

The draft document was also available on the Ministry's website.