

Corporate Governance & Accountability Compendium

FOR NSW HEALTH



Health

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Purpose of this Compendium

The Corporate Governance and Accountability Compendium (Compendium) outlines the governance requirements that apply to those organisations that form part of NSW Health and sets out the roles, relationships and responsibilities of those organisations.

The organisations comprising NSW Health include local health districts, statutory health corporations, affiliated health organisations and administrative units within the Health Administration Corporation, such as the NSW Ambulance Service, HealthShare NSW and the Ministry of Health.

The establishment and compliance with principles of sound corporate governance is essential in a diverse multi-agency system such as the NSW Public Health System. It is also a mandatory condition of subsidy imposed on public health organisations under section 127 of the *Health Services Act 1997*.

Information in this Compendium is sourced from legislation, whole of Government directives issued through the Department of Premier and Cabinet or NSW Treasury, NSW Health policy directives or guidelines and other best practice resources.

The resources and checklists included as weblinks (updated as required) within the Compendium are designed to assist with implementing best practice, monitoring standards and demonstrating achievements. Organisations may also wish to develop their own local resources.

Issuing and Updating the Compendium

The Compendium will be issued as current on and from 1 December 2012. It will however be regularly updated as relevant legislation, government policy and NSW Health Policy Directives are issued and revised and as the NSW Health Governance review progresses.

Amendments to the Compendium will be notified by way of Ministry Information Bulletins which will include a description of and a link to the amended content. Updates will also be included on the Board and Chair website. The e-version of the Compendium will also include an easy to reference record of amendments, so organisations can keep up to date.

A more comprehensive review and reissue of the Compendium will also be undertaken in 2017, in keeping with the 5 year review policy that applies to all NSW Health Policy Directives.

Issued by

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Foreword

The information in this Compendium has been developed to assist boards, chief executives, health executive service officers and staff understand the reporting structures and their accountabilities within NSW Health.

As well as setting out requirements in legislation and Government policy it provides a governance framework to underpin local decision making and the **CORE** values of the NSW Health:

Collaboration

Openness

Respect

Empowerment

Section 1 of the compendium provides background information about the NSW public health system. Section 2 identifies the basic corporate governance standards applying to organisations established as a part of NSW Health, which cover:

Standard 1: Establish robust governance and oversight frameworks

Standard 2: Ensure clinical responsibilities are clearly allocated and understood

Standard 3: Set the strategic direction for the organisation and its services

Standard 4: Monitor financial and service delivery performance

Standard 5: Maintain high standards of professional and ethical conduct

Standard 6: Involve stakeholders in decisions that affect them

Standard 7: Establish sound audit and risk management practices

The other sections of the compendium set out information about key areas of Local Health District, Specialty Network and other NSW Health organisations roles including clinical governance, finance and performance management, workforce and strategic and service planning.

The annual Corporate Governance Attestation Statement, which must be submitted to the Ministry as a part of the annual performance review process, will provide confirmation that each NSW Health organisation has sound governance systems and practices and attains the minimum expected standards.

I trust the Compendium will provide assistance to board chairpersons and members, chief executives and senior executive staff and a resource for key aspects affecting their work in and support best practice in health system governance.



Dr Mary Foley
Secretary, NSW Health
NSW Health



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1 About NSW Health

1.1 Governance and Management of the NSW Public Health System

1.1.1 Key Health Legislation

1.1.1.1 *The Health Services Act 1997* is the principal Act regulating the governance and management of the public health system in NSW. The Act establishes the NSW public health system as comprising:

- local health districts;
- statutory health corporations, including board, chief executive and network governed statutory health corporations;
- affiliated health organisations (with respect to their recognised services); and
- the Secretary, NSW Health with respect to ambulance services and other services to support the public health system.

The terms 'NSW public health system' and 'NSW Health' are used interchangeably throughout this compendium to refer to the NSW public health system as a whole.

Local health districts, statutory health corporations, and affiliated health organisations (with respect to their recognised services) are referred to collectively under the *Health Services Act 1997* as **public health organisations**.

1.1.1.2 *The Health Administration Act 1982* sets out the broad roles of the Minister and Secretary, NSW Health in relation to the health portfolio generally.

1.1.2 Role of the Minister for Health and the Minister for Medical Research

The Minister for Health and the Minister for Medical Research is the Health Cluster Minister (the Health Minister) and has powers and functions relating to the public health system under a number of Health acts, including the *Health Administration Act 1982*, *Health Services Act 1997* and the *Public Health Act 1991*.

Under the *Health Services Act 1997*, the Health Minister's role includes:

- appointing the chairs and members of local health district, specialty network and statutory health corporation boards;
- determining the amounts of monies to be paid from consolidated funds to public health organisations;
- fixing scales of fees for hospital services and other health services that are received from public health organisations; and
- determining additional functions for statutory health corporations.

The Health Minister also has powers and functions under the *Health Administration Act 1982*. These include:

- formulating general policies for the purpose of promoting, protecting, developing, maintaining and improving the health and well-being of the people of New South Wales;
- providing, operating and maintaining health services, as well as, where necessary, improving and extending services; and
- arranging for the construction of any buildings or works necessary for, or in connection with, health services.

Health Services Act 1997 and the Health Administration Act 1982 are the principal laws governing the NSW public health system

The Minister for Health powers and functions arise under several health laws including the Health Administration Act 1982

The Minister for Mental Health, Minister for Women and Minister for Ageing has joint responsibility with the Minister for Health for five Acts

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1.1.3 Role of the Minister for Mental Health

The Minister for Mental Health has functions relating to the public health system under a number of health acts and has responsibility for the NSW Mental Health Commission, which includes the state-wide policy for the mental health portfolio.

The Mental Health Care Reform aims to shift the focus of mental health care from hospitals to the community. The Minister is committed to delivering person-centred care and support for people in NSW living with mental illness, their families and carers.

The Minister for Health has joint administration of all Acts listed for the Minister for Mental Health.

1.1.4 Role of the Secretary, NSW Health

The Health Administration Act 1982 and the Health Services Act 1997 sets out the powers and functions of the Secretary of the Ministry of Health

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The Secretary, NSW Health has a range of powers and functions under the *Health Administration Act 1982*, the *Health Services Act 1997* and other legislation such as the *Public Health Act 1991* and the *Government Sector Employment Act 2013*.

Under the *Health Administration Act 1982*, the Secretary, NSW Health powers and functions include:

- to initiate, promote, commission and undertake surveys and investigations into the health needs of the people of New South Wales, the resources of the State available to meet those needs, and
- the methods by which those needs should be met,
- to inquire into the nature, extent and standards of the health services, facilities and personnel required to meet the health needs of the people of New South Wales and to determine the cost of meeting those needs,
- to plan the provision of comprehensive, balanced and co-ordinated health services throughout New South Wales,
- to formulate the programs and methods by which the health needs of the people of New South Wales may be met,
- to undertake, promote and encourage research in relation to any health service,
- to promote and facilitate the provision of the professional, technical or other education or training of any persons employed or to be employed in the provision of any health service.

Under the *Health Services Act 1997* the Secretary, NSW Health functions and powers include:

- facilitating the achievement and maintenance of adequate standards of care;
- facilitating the efficient and economic operation of the public health system;
- providing governance, oversight and control of the public health system;
- making recommendations to the Minister as to monies to be paid to public health organisations out of consolidated funds;
- entering into performance agreements with public health organisations and setting performance targets and reporting requirements;
- inquiring into the administration, management and services of public health organisations;
- providing services to support the public health system and enable co-ordinated provision of health services across the State;

- giving directions to local health districts and statutory health corporations to ensure that they meet their statutory and financial obligations; and
- being the employer of staff in the NSW Health Service and Health Executive Service.

1.1.4.1 The Ministry of Health

The NSW Ministry of Health supports the executive and statutory roles of the Health Cluster and Portfolio Ministers. It undertakes regulatory functions, public health functions (disease surveillance, control and prevention) and public health system manager functions in state-wide planning, purchasing and performance monitoring and support of health services.

The Ministry of Health also has the role of 'system manager' in relation to the NSW public health system, which operates more than 230 public hospitals, as well as providing community health and other public health services, for the NSW community through a network of local health districts, specialty networks and non-government affiliated health organisations, known collectively as NSW Health.

The Ministry consists of five divisions:

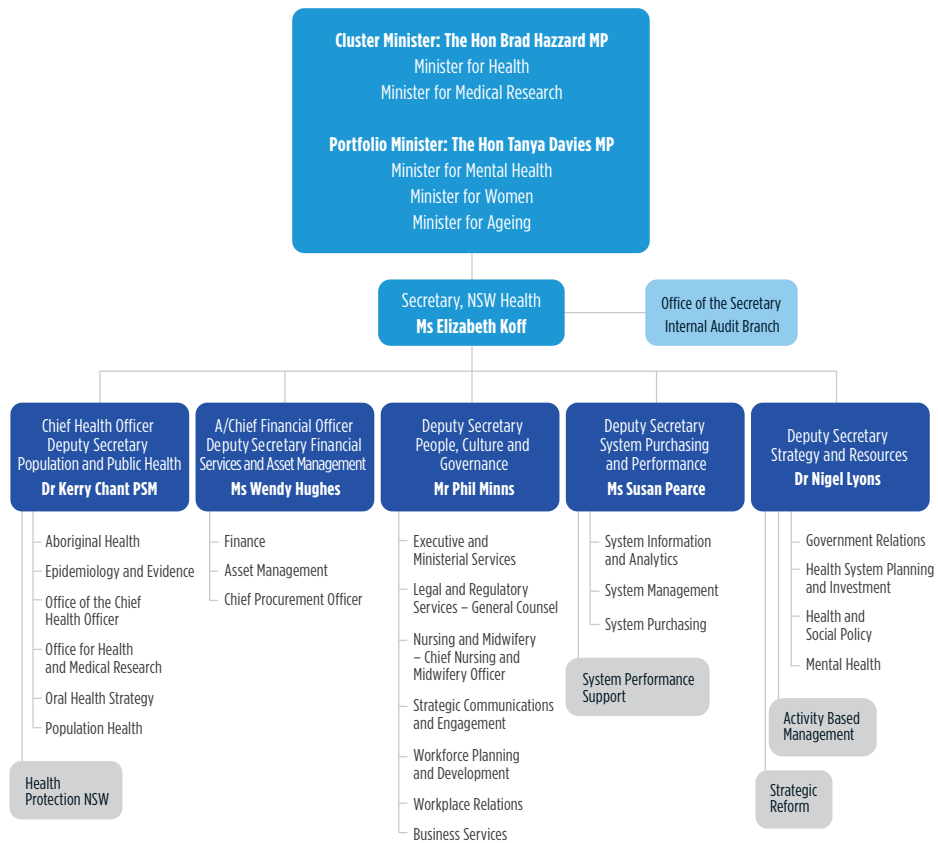
- Strategy and Resources;
- System Purchasing and Performance;
- Population and Public Health;
- People, Culture and Governance Corporate and
- Financial Services and Asset Management.

1.1.4.2 Services provided by the Health Administration Corporation

Under the *Health Administration Act 1982*, the Secretary is given corporate status as the Health Administration Corporation for the purpose of exercising certain statutory functions. The Health Administration Corporation is used as the statutory vehicle to provide ambulance services and support services to the public health system, public health organisations and the public hospitals they control. A number of entities have been established under the Health Administration Corporation to provide these functions including:

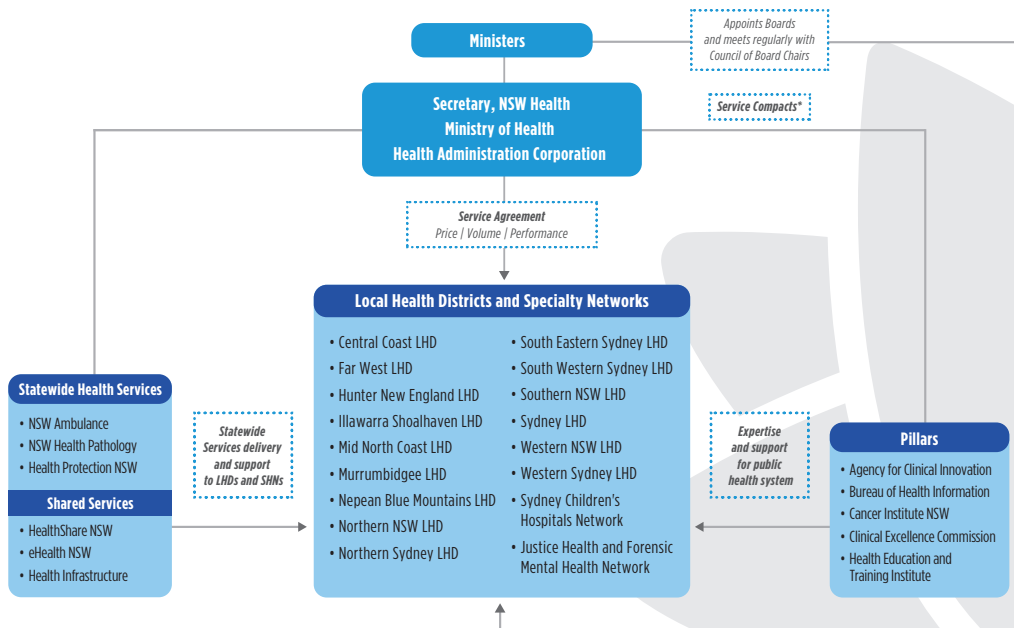
- **Ambulance Service of NSW** is responsible for the delivery of front line out-of-hospital care, medical retrieval and health related transport to people in NSW as set out in Chapter 5A of the Health Services Act 1997. Website: <http://www.ambulance.nsw.gov.au/>
- **HealthShare NSW** delivers efficient support services for NSW Health through the provision of food and linen services and the supply of disability services and equipment. Website: <http://www.healthshare.nsw.gov.au>
- **eHealth NSW** provides state-wide leadership on the shape, delivery and management of ICT-led healthcare introducing new ways of managing health information and the delivery of healthcare online, making it more accessible. Website: <http://www.ehealth.nsw.gov.au/>
- **Health Infrastructure** manages and coordinates approved major Health capital works projects, and provides capital project delivery support services to public health organisations. Website: <http://www.hinfra.health.nsw.gov.au/>
- **NSW Health Pathology** is a clinically integrated state-wide service that provides specialist diagnostic and disease monitoring pathology services, and forensic and analytical science services to the NSW health and justice systems. Website: <http://www.health.nsw.gov.au/pathology/Pages/our-services.aspx>

Please refer to the organisational diagram for the NSW Ministry of Health



Source: <http://www.health.nsw.gov.au/about/ministry/pages/chart.aspx>

Organisations in the NSW Public Health System



St Vincent's Health Network is an affiliated health organisation.
 *Service Compact – Instrument of engagement detailing service responsibilities and accountabilities.

Source: <http://www.health.nsw.gov.au/about/nswhealth/pages/chart.aspx>

1.2 Local Health Districts

1.2.1 Local Health Districts

Fifteen Local Health Districts are established as individual statutory corporations under section 17 of the *Health Services Act 1997*.

Local Health Districts are responsible for managing public hospitals and health institutions and for providing health services to defined geographical areas of the State and their primary purposes under section 9 of the *Health Services Act 1997*, are to:

- provide relief to sick and injured people through the provision of care and treatment; and
- promote, protect and maintain the health of the community.

1.2.2 Key Functions

The key functions of local health districts under the *Health Services Act 1997* reflect these responsibilities and primary purposes. They include:

- **to promote, protect and maintain** the health of residents of its area
- **to conduct and manage public hospitals**, health institutions, health services and health support services under its control
- **to achieve and maintain adequate standards** of patient care and services
- **to ensure the efficient and economic operation** of its health services and health support services and use of its resources
- **to cooperate** with other local health districts and the Secretary, NSW Health in relation to the provision of services
- **to make available to the public information** and advice concerning public health and health services available within its area

Key functions of local health districts under the Health Services Act 1997

1.2.3 Management and accountabilities

Under section 122 of the *Health Services Act*, the District is subject to the governance, oversight and control of the Secretary, NSW Health.

The Secretary, NSW Health may also determine the role, functions and activities of hospitals and services controlled by a local health district and, for that purpose, give any necessary directions to the local health district.

The Minister may direct a local health district to establish or close a hospital or other health service, or give directions as to the range of services to be provided.

The fifteen local health districts are:

- Central Coast
- Far West
- Hunter New England
- Illawarra Shoalhaven
- Mid North Coast
- Murrumbidgee
- Nepean Blue Mountains
- Northern NSW
- Northern Sydney
- South Eastern Sydney
- South Western Sydney
- Southern NSW
- Sydney
- Western NSW
- Western Sydney

1.2.4 Chief Executives

Each local health district has a chief executive employed by the NSW Government, being appointed by the local health district board in concurrence with the Secretary, NSW Health under section 23 of the *Health Services Act*.

The chief executive manages and controls the District in accordance with the relevant legislation, policies and procedures and with the district service performance agreement. The chief executive is accountable to the local health district board for the operations and performance of the local health district.

1.2.5 Further Governance Information

Section 3 of this Compendium sets out the governance relationships applying to local health districts in more detail.

A map of the Local Health Districts is available at: <http://www.health.nsw.gov.au/lhd/Documents/lhd-wall-map.pdf>

1.3 Statutory Health Corporations

Statutory health corporations (SHC) provide services across the whole State. These services are not limited to defined geographic areas, but are functionally defined through the services they provide. HETI is an accredited Higher Education Provider.

In 2017, the New South Wales Institute of Psychiatry (NSWIOP) became the newly established mental health portfolio of the Health Education and Training Institute (HETI). As a major provider of mental health education, NSWIOP has had a significant impact in shaping and equipping the mental health sector.

In relation to board-governed corporations, the Minister may determine the role, functions and activities of hospitals and services controlled by a statutory health corporation. The Secretary, NSW Health has been delegated this function, as well as having a similar function for chief executive governed corporations.

Under the section 41 of the *Health Services Act 1997*, statutory health corporations may be chief executive governed, board governed or specialty network governed.

- **Specialty Network governed statutory health corporations** have the same governance arrangements as Local Health Districts including a chief executive who manages and controls the corporation and is accountable to a board in carrying out these functions.
 - The Sydney Children's Hospitals Network and the Justice Health and Forensic Mental Health Network are specialty network governed statutory health corporations.
- **Board governed statutory health corporations** have a chief executive who manages the affairs of the corporation, subject to the direction and control of the board. The board is subject to the control and direction of the Minister, except in relation to the content of a recommendation or report to the Minister. This function has been delegated to the Secretary, NSW Health.
- **Chief executive governed statutory health corporations** are managed and controlled by a chief executive. The chief executive is subject to the control and direction of the Secretary, NSW Health.
 - The Health Education and Training Institute (HETI) is a chief executive governed statutory health corporation.

Statutory Health Corporations may be network governed statutory health corporations, or Board governed, or managed and controlled with a chief executive who manages the affairs of the corporation.

The following Statutory Health Corporations have been established:

Agency for Clinical Innovation

The Agency for Clinical Innovation (ACI) is a board governed statutory health corporation and works with clinicians, consumers and managers to design and promote better healthcare for NSW.

Clinical Excellence Commission

The Clinical Excellence Commission (CEC) is a board governed statutory health corporation and was established to promote and support improved clinical care, safety and quality across the NSW health system.

Bureau of Health Information

The Bureau of Health Information (BHI) is a board governed statutory health corporation and was established in 2010, to support transparency in health data and allow for greater local control of information analysis.

Health Education and Training Institute

The Health Education and Training Institute (HETI) is a Chief Executive-governed statutory health corporation which coordinates education and training for NSW Health staff. The Institute works closely with local health districts, specialty health networks, other public health organisations and health education and training providers to ensure that world-class education and training resources are available to support the full range of roles across the public health system including patient care, administration and support services. HETI is an accredited Higher Education Provider.

In 2017, the New South Wales Institute of Psychiatry (NSWIOP) became the newly established mental health portfolio of the Health Education and Training Institute (HETI). As a major provider of mental health education, NSWIOP has had a significant impact in shaping and equipping the mental health sector.

Cancer Institute NSW

Established under the *Cancer Institute (NSW) Act 2003* to lessen the impact of cancer across the State, the Cancer Institute NSW is Australia's first state-wide government cancer agency. Its statutory objectives are to reduce the incidence of cancer in the community; increase survival from cancer; improve the quality of life for people with cancer and their carers; and provide a source of expertise on cancer control for the government, health service providers, medical researchers and the general community.

The Cancer Institute NSW leads the development and delivery of the state-wide NSW Cancer Plan, which sets out a coordinated and collaborative approach to cancer control, involving people affected by cancer, government and non-government organisations, health professionals and researchers.

The Cancer Institute drives initiatives to reduce unwarranted variations in outcomes across diverse cultural and geographic communities; report on the performance of cancer services; and enhance cancer research capabilities across NSW.

1.4 **Affiliated Health Organisations**

Affiliated health organisations are not-for-profit religious, charitable or other non-government organisations which provide health services and are recognised as part of the public health system under the *Health Services Act 1997*.

Under section 65 of the *Health Services Act*, the Minister may determine the role, functions and activities of the recognised establishments and services of affiliated health organisations following consultation with the relevant organisation. This has been delegated to the Secretary, NSW Health.

Not all facilities or services provided by an affiliated health organisation are recognised as part of the public health system. For example, the NSW Benevolent Society conducts some recognised services but also conducts a range of other activities unrelated to the public health system which are not regulated by the *Health Services Act 1997*.

Where an affiliated health organisation has more than one recognised establishment or service, or provides state-wide or significant services, the Minister may declare them to be treated as a network for the purposes of receiving funding under the now National Health Reform Agreement (NHRA), with the consent of the organisation concerned.

The St Vincent's Health Network, comprising St Vincent's Hospital and Sacred Heart Health Service in Darlinghurst and St Joseph's Hospital at Auburn is the first affiliated health organisation that is recognised as a network under these provisions.



Table of Affiliated Health Organisations

| Affiliated Health Organisation | Recognised service |
|--|---|
| Benevolent Society of New South Wales | Central Sydney Scarba Services, Early Intervention Program, Eastern Sydney Scarba Services and South West Sydney Scarba Services |
| Calvary Health Care (Newcastle) Limited | Calvary Mater Newcastle |
| Calvary Health Care Sydney Limited | Calvary Health Care Sydney |
| Catholic Healthcare Limited | St Vincent's Health Service, Bathurst. Lourdes Hospital and Community Health Service (other than Holy Spirit Dubbo) |
| Hammondcare Health and Hospitals Limited | Braeside Hospital, Prairiewood; Greenwich Hospital, Greenwich; Neringah Hospital, Wahroonga; and Northern Beaches Palliative Care Service |
| Karitane | Child and Family health services at Carramar, Fairfield, Liverpool and Randwick |
| Mercy Care Centre, Young | Mercy Care Centre: Young, excluding Mount St Joseph's Nursing Home |
| Mercy Health Service Albury Limited | Mercy Health: Albury |
| NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) | NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) |
| Royal Rehab (formerly Royal Rehabilitation Centre Sydney) | General rehabilitation services, Brain injury rehabilitation services, spinal injury rehabilitation services, extended care services. |
| Royal Society for the Welfare of Mothers and Babies | Tresillian Family Care Centres at Belmore, Lismore, Penrith, Willoughby and Wollstonecraft |
| St Vincent's Hospital Sydney Ltd | Sacred Heart Health Service*, St Joseph's Hospital (Auburn)*, St Vincent's Hospital Darlinghurst* |
| Stewart House | Child health screening services at Stewart House Preventorium, Curl Curl |
| The College of Nursing | Nursing Education Programs conducted under agreement with the NSW Ministry of Health |
| Uniting Church in Australia | War Memorial Hospital (Waverley) |

*Recognised collectively as St Vincent's Health Network for the purposes of the National Health Reform Agreement 2011.

Affiliated health organisations are recognised under the *Health Services Act 1997*

1.5 Summary of Organisations in the NSW Public Health System

The table below provides a summary and lists examples of the organisations within the NSW public health system: local health districts; statutory health corporations (chief executive, board, or specialty network governed) and affiliated health organisations.

The NSW Public Health System

Local Health Districts

- Central Coast
- Far West
- Hunter New England
- Illawarra Shoalhaven
- Mid North Coast
- Murrumbidgee
- Nepean Blue Mountains
- Northern NSW
- Northern Sydney
- South Eastern Sydney
- South Western Sydney
- Southern NSW
- Sydney
- Western NSW
- Western Sydney

Statutory health corporations – network governed (Specialty Health Networks)

- Sydney Children’s Hospitals Network
- Justice Health and Forensic Mental Health Network

Statutory health corporations – chief executive governed

- Health Education and Training Institute

Statutory health corporations – board governed

- Bureau of Health Information
- Clinical Excellence Commission
- Agency for Clinical Innovation
- Cancer Institute NSW

Affiliated health organisations

Secretary, NSW Health

- Ambulance Service of NSW
- NSW Health Pathology
- Health Protection NSW
- HealthShare NSW
- Health Infrastructure
- eHealth NSW

1.6 Other NSW Government Entities in the Health Portfolio

1.6.1 Health Care Complaints Commission

The NSW Health Care Complaints Commission (HCCC) is established under the *Health Care Complaints Act 1993*. The HCCC is an independent statutory body headed by a Commissioner that:

- receives and deals with complaints concerning the care and treatment provided by health practitioners and health services;
- investigates complaints and takes appropriate action including making recommendations to NSW Health;
- prosecutes cases before disciplinary bodies;
- advises the Minister for Health and others on trends in complaints;
- resolves complaints with parties and provides opportunities and support for people to resolve their complaints and concerns locally; and
- consults with consumers and other key stakeholders.

The Health Care Complaints Commission is subject to the control and direction of the Minister, except in respect of the assessment, investigation and prosecution of a complaint or the terms of any recommendation or report of the Commission including the annual report. Website: www.hccc.nsw.gov.au

Government entities that oversight public health system under legislative powers

1.6.2 Mental Health Review Tribunal

The Mental Health Review Tribunal is a specialist quasi-judicial body established under the *Mental Health Act 2007*. It has a wide range of powers that enable it to make and review orders and to hear some appeals, about the treatment and care of people with a mental illness. Website: www.mhrt.nsw.gov.au

1.6.3 Health Professional Councils

Since 1 July 2010, health professional registration and accreditation has been undertaken at a national level under the National Registration and Accreditation Scheme, through national health professional boards under the *Health Practitioner Regulation National Law*.

The National Law covers ten health professions, namely chiropractic, dental, medical, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology, with four additional professions, Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy were established in July 2012.

New South Wales applies the National Law differently from other states as complaints, performance and disciplinary processes continue to be managed at the State level. This means the existing "co-regulatory model", where complaints are dealt with through a health professional body and an independent complaints body (the HCCC), is retained.

Co-regulatory model for complaints

As a result, complaints about health professionals who reside in NSW, or have their primary place of practice in NSW, must be referred to the relevant NSW professional council and the HCCC, rather than the national boards. The NSW law establishes the following NSW Health Professional Councils to administer NSW specific complaints and make determinations on performance for the respective professions:

- Aboriginal and Torres Strait Islander Health Practice Council of New South Wales
- Chinese Medicine Council of New South Wales
- Chiropractic Council of New South Wales
- Dental Council of New South Wales
- Medical Council of New South Wales
- Medical Radiation Practice Council of New South Wales
- Nursing and Midwifery Council of New South Wales
- Occupational Therapy Council of New South Wales
- Optometry Council of New South Wales
- Osteopathy Council of New South Wales
- Paramedicine Council of New South Wales*
- Pharmacy Council of New South Wales
- Physiotherapy Council of New South Wales
- Podiatry Council of New South Wales
- Psychology Council of New South Wales

*Not operational until 2018.

These Councils are supported to perform their regulatory and legislative functions under the National Registration and Accreditation Scheme by the Health Professional Councils Authority, an administrative unit of the Health Administration Corporation. Website: www.hpca.nsw.gov.au

1.6.4 **NSW Mental Health Commission**

The NSW Mental Health Commission was established in July 2012 under the *Mental Health Commission Act 2012*. The Commission is charged with preparing a draft strategic plan for the mental health system in New South Wales for submission to the Minister for approval. The Commission will also monitor and report on the implementation of the strategic plan and also has a broader role in promoting and facilitating the sharing of knowledge and ideas about mental health issues, undertaking research and advocating for and promoting the prevention of mental illness and early intervention strategies for mental health.

The Mental Health Commission is headed by a Commissioner who is appointed by the Governor. The Commission is subject to the control and direction of the Minister responsible for the Act, being the Minister for Health and the Minister for Mental Health. The Act also makes provision for the appointment of Deputy Commissioners, one of whom must be a person who has or has had a mental illness.

Staff of the Commission are employed under the *Government Sector Employment Act 2013* in the Mental Health Commission Division of the Government Service. The Secretary, NSW Health is the Division Head for the Mental Health Division and exercises on behalf of the Government of NSW the employer functions in relation to the members of the staff of the Commission. The terms and conditions of the Mental Health Commission Division are similar to those of the NSW Public Service. Website: nswmentalhealthcommission.com.au

1.7 History of the NSW public health system

- 1788 The Colonial Medical Services established, essentially as a hospital medical service for convicts.
- 1841 Convict transportation to NSW ceased and convict hospitals progressively handed over to civilian control. Government exercised little control over the operations, but did provide some financial assistance.
- 1850s Public health administration commenced, concerned with sanitation and infectious diseases.
- 1881 The first Board of Health established in response to the smallpox epidemic.
- 1896 The first *Public Health Act* introduced.
- 1901 Establishment of the Commonwealth of Australia, with State Governments responsible for providing health services.
- 1946 A referendum gives the Commonwealth power to operate a national health scheme for pharmaceutical, sickness and hospital benefits and establish medical and dental services.
- 1949 The Australian Government begins to provide funds for health to the states through special purpose grants.
- 1970s The level of Commonwealth financial support increases with arrangements for sharing operating costs of some hospitals and the commencement of the community health program and the school dental scheme.
- 1972 The NSW Health Commission established, bringing together state psychiatric hospitals, community health services and public health services under the same body responsible for public hospitals. Decentralisation of the administration commences with the creation of regional Commission offices.
- 1981 General purpose funds for health replace the specific purpose assistance the Commonwealth previously provided.
- 1982 The NSW Department of Health established under the *Health Administration Act*.
- 1984 Medicare introduced, providing insurance against the cost of most private medical services and some optometry and dental services as well as care for patients in public hospitals.
- 1986 Board governed area health services established in the Sydney, Newcastle and Wollongong areas to administer individual hospitals and health services in their geographic area.
- 1997 The *Health Services Act* established the area health services model across all of NSW, and gives statutory recognition to health promotion and education, community health and environmental health services.
- 2003 Independent Pricing and Regulatory Tribunal (IPART) review of health administration in NSW lead to amalgamation of 17 area health services into 8 and removal of area health boards. Chief executives were made directly accountable to the Secretary, NSW Health for the management of hospitals and health institutions within their areas.
- 2010 In April, the Council of Australian Governments (COAG) concludes the National Health and Hospitals Network Agreement (NHHNA), which requires establishment of small, locally-based hospital networks to provide public health services in local areas with local governing councils.

- 2011 In January a new structure of local health networks and governing councils is established to implement the national Agreement.
- In July, a revised structure of local health districts and district boards comes into effect. This approach is aimed at improving patient-centred care and better integration with primary care services, and to enhance the role for local decision making and clinician engagement. Under this structure NSW Health now operates with 15 local health districts, 2 specialty networks, and recognises the St Vincent's Health Network as a AHO-based network for the purposes of federal reforms.
- In August, the Council of Australian Governments finalises the National Health Reform Agreement (NHRA), which secured arrangements for funding public hospitals and includes provision for introduction of activity based funding (ABF) from 1 July 2012, as well as arrangements for efficient growth funding for public hospitals from 2014-2015, the administration of the national funding pool and the national performance and accountability framework. The NHRA provides for the Commonwealth to share the funding risk of the demand pressures on public hospitals and provides guaranteed growth funds for public hospitals.
- In November, a Governance Review of NSW Health results in further structural reforms with the Department of Health becoming the Ministry of Health, and a range of functions, some previously undertaken by the Department, identified for consolidation into the four pillar organisations (Clinical Excellence Commission, the Agency for Clinical Innovation, the Bureau of Health Information and the Health Education and Training Institute).
- 2012 Activity Based Funding commenced from 1 July 2012 with Local Health Districts allocated funding using a combination of block funding grants and funding based on patient activity.
- In July, the NSW Mental Health Commission was established under the Mental Health Commission Act as an independent body which helps drive reform that benefits people who experience mental illness and their families and carers.
- In November, NSW Health Pathology was established as an integrated state-wide service to coordinate and deliver safe, technologically advanced and reliable services across our communities.
- 2013 From 1 July 2013 the proportion of funding to Local Health Districts for Activity Based Funding (ABF) services increased to include sub and non-acute patient (SNAP) services and mental health services.
- 2014 eHealth NSW was been established as a distinct organisation within the NSW Ministry of Health to provide state-wide leadership on the shape, delivery and management of ICT-led healthcare. It is responsible for setting eHealth strategy, policy and standards, and works with Local Health Districts (LHDs) and Health Agencies to implement state-wide core systems and ensure compliance with state-wide standards.

About NSW Health – Resources & References

NSW Health

Ministry of Health website:

<http://www.health.nsw.gov.au/>

Information about the Ministry of Health, including its structure and roles of each Division:

<http://www.health.nsw.gov.au/about/ministry/Pages/Structure.aspx>

Ministerial and Ministry of Health media releases:

<http://www.health.nsw.gov.au/news/pages/default.aspx>

Directory of NSW Health services and links to health organisation websites:

<http://www.health.nsw.gov.au/hospitals/pages/default.aspx>

Commonwealth/State Agreements

Establishment of a National Health and Hospitals Network (April 2010) for Reform

www.coag.gov.au/meeting-outcomes/coag-meeting-communic%C3%A9-19-20-april-2010

National Health Funding Agreements

www.aph.gov.au/about-parliament/parliamentary-departments/parliamentary-library/pubs/rp/budgetreview201415/healthfunding

Intergovernmental Agreement on Federal Financial Relations

www.federalfinancialrelations.gov.au/content/intergovernmental_agreements.aspx

NSW Government

Department of Premier and Cabinet

Department of Premier and Cabinet NSW Government Boards and Committees Guidelines:

<http://www.boards.dpc.nsw.gov.au/publications-for-agencies>

Public Service Commission

<http://www.psc.nsw.gov.au>



2 Governance Framework

Good Governance

The NSW Health System is committed to the principles and practice of good governance, across all public health organisations, in a way that involves stakeholder and community participation.

As stated by the Audit Office of NSW¹ “Good governance is those high-level processes and behaviours that ensure an agency **performs** by achieving its intended purpose and **conforms** by complying with all relevant laws, codes and directions and meets community expectations of probity, accountability and transparency. Governance should be enduring, not just something done from time to time”.

2.1 Governance Framework

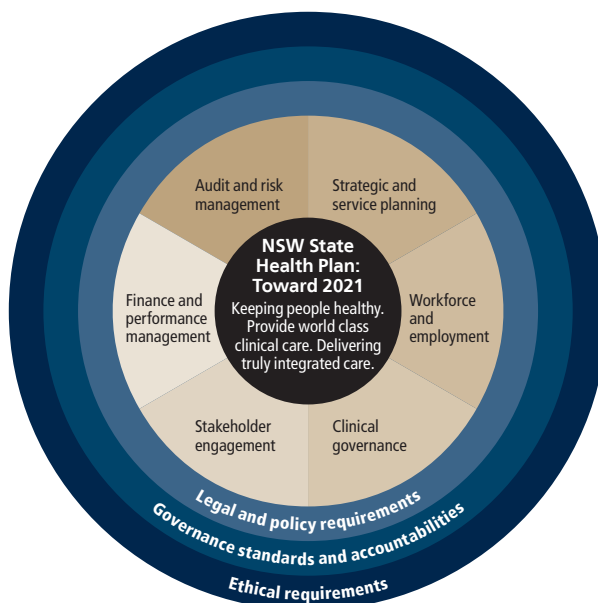
This Compendium sets out the key elements of a robust governance framework for organisations within the Health portfolio.

The **governance framework** recognises the organisation’s purpose, its legislative, policy and ethical obligations, as well as its workforce and employment responsibilities. The framework is supported by the organisation’s CORE values (collaboration, openness, respect and empowerment) and structures and is underpinned by the seven governance standards.

- 1 Establish robust governance and oversight frameworks
- 2 Ensure clinical responsibilities are clearly allocated and understood
- 3 Set the strategic direction for the organisation and its services
- 4 Monitor financial and service delivery performance
- 5 Maintain high standards of professional and ethical conduct
- 6 Involve stakeholders in decisions that affect them
- 7 Establish sound audit and risk management practices

1 NSW Auditor-General’s Report Volume Two 2011
CORPORATE GOVERNANCE – STRATEGIC EARLY WARNING SYSTEM p12

The **governance framework** is summarised in the following diagram. At the centre depicts the key elements of effective governance which public health organisations are responsible for managing and in the outer circles are the key external governance requirements that apply to these organisations across all their activities.



2.2 Corporate Governance Standards

The key components of the governance framework are the seven governance standards for organisations in the Health portfolio. The Standards apply to public health organisations, with those agencies required to publish an Annual Corporate Governance Attestation Statement outlining their governance arrangements and providing key information relating to their operation.

These seven standards are detailed in sections 2.2.1 to 2.2.7.

2.2.1 Standard 1: Establish robust governance and oversight frameworks

Every organisation in the Health portfolio (health organisation) should ensure that the authority, roles and responsibilities of its governance, management and operating structures are clearly defined, documented and understood.

Health organisations should ensure that:

- The authority, roles and responsibilities of its governing, management and operating structures, including reporting relationships of the board, chief executive and senior management, are documented clearly and understood.
- The legal and policy obligations of the organisation are identified and understood; and responsibilities for compliance are allocated.
- Financial and administrative authorities are approved by the chief executive and/or board and are published in a delegations manual for the organisation which is readily accessible.
- A system is in place to ensure that the policies and procedures of the organisation are documented, endorsed by the board and/or chief executive and are readily accessible to staff.
- Leadership and accountability responsibilities for Aboriginal health are built into the roles of executives and managers at all levels of the system.

2.2.2 **Standard 2: Ensure clinical responsibilities are clearly allocated and understood**

Public health organisations that deliver clinical services must ensure that clinical management and consultative structures within the organisation are appropriate to the needs of the organisation and its clients. The role and authority of clinical directors and general managers should be clearly defined, documented and understood.

Local health districts and statutory health corporations that deliver clinical services should ensure that:

- clear lines of accountability for clinical care are established and are communicated to clinical staff and staff who provide direct support to them.
- the authority of facility/network general managers is clearly understood.
- a Medical and Dental Appointments Advisory Committee (MADAAC) is established to review and make recommendations about the appointment of medical staff and visiting practitioners
- a Credentials Subcommittee is established to make recommendations to the Medical and Dental Appointment Advisory Committee on all matters concerning the scope of practice and clinical privileges of visiting practitioners or staff specialists; and to advise on changes to a practitioner's scope of practice.
- an Aboriginal Health Advisory Committee is established, or clear lines of accountability are in place for clinical services delivered to Aboriginal people.
- a systematic process for the identification, and management of clinical incidents and minimisation of risks to the organisation is established.
- an effective complaint management system for the organisation is developed and in place.
- effective forums are in place to facilitate the involvement of clinicians and other health staff in decision making at all levels of the organisation.
- appropriate accreditation of healthcare facilities and their services is achieved.
- licensing and registration requirements are checked and maintained.
- the Decision Making Framework for Aboriginal Health Workers to Undertake Clinical Activities is adopted to ensure that Aboriginal Health Workers are trained, competent, ready and supported to undertake clinical activities.

2.2.3 **Standard 3: Set the strategic direction for the organisation and its services**

It is important that all health organisations have clear, articulated and relevant plans for meeting their statutory or other purposes and objectives. Strategic plans provide a mechanism for the progressive achievement of the long term vision of an organisation. As such, they are a mechanism to link the aspirations of the future with the reality of the present.

Health organisations should ensure that:

- The strategic goals of the organisation are documented within a **Strategic Plan** approved by the chief executive and where appropriate by the board with a 3-5 year horizon.
- Detailed plans for asset management, information management and technology, research and teaching and workforce management are linked to the **Strategic Plan**.
- A **Local Healthcare Services Plan** and appropriate supporting plans including operations/business plans at all management levels.
- A **Corporate Governance Plan**.

- An **Annual Asset Strategic Plan**.
- An **Aboriginal Health Action Plan** is developed that aligns with the *NSW Aboriginal Health Plan 2013-2023*. The action plan must help:
 - Ensure that all relevant NSW Health policies, programs and services consider Aboriginal people as a priority population and reflect the needs of Aboriginal communities.
 - Recognise and strengthen the ongoing role NSW Health has in contributing to the social determinants of health for Aboriginal people through activities such as employment, resource distribution, and education/training.

2.2.4 **Standard 4: Monitor financial and service delivery performance**

Boards and chief executives are responsible for ensuring appropriate arrangements are in place to secure the efficiency and effectiveness of resource utilisation by their organisation; and for regularly reviewing the financial and service delivery performance of the organisation.

Health organisations should ensure that:

- A committee is established for the organisation and that finance matters and performance and its meeting frequency complements the board meeting cycle.
- The organisation complies with critical government policy directives and policies, including the Accounts and Audit Determination for Public Health Organisations, annual budget allocation advice, the Fees Procedure Manual, Goods and Services Procurement Policy, and the Accounting Manual.
- Local Health District and Network Service Agreements with the Secretary, NSW Health are signed and in place.
- Performance agreements are in place with the chief executive and health executive service staff and performance is assessed on an annual basis.
- Budgets and associated activity/performance targets are issued to relevant managers no later than four weeks after the delivery of the NSW State budget.
- Systems are in place for liquidity management and to monitor the financial and activity / performance of the organisation as a whole, and its facilities.
- Financial reports submitted to the Ministry of Health and the Finance and Performance Committee represent a true and fair view, in all material aspects, of the financial condition and the operational results for the organisation.
- Specific grants or allocation of monies for specific purposes are spent in accordance with the allocation or terms of the grant.
- Aboriginal health performance, service access, service utilisation and quality measures are included in all relevant service agreements.

2.2.5 **Standard 5: Maintain high standards of professional and ethical conduct**

Health organisations must have systems and processes in place to ensure that staff and contractors are aware of and abide by the NSW Health Code of Conduct and relevant professional registration and licensing requirements. Public health organisations must also have policies, procedures and systems in place to ensure that any alleged breaches of recognised standards of conduct or alleged breaches of legislation are managed efficiently and appropriately.

Health organisations should ensure that:

- Boards and chief executives lead by example in order to ensure an ethical and professional culture is embedded within their organisations, which reflects the CORE values of the NSW Health system.

- Staff and contractors are aware of their responsibilities under the NSW Health Code of Conduct and that obligations are periodically reinforced.
- All disciplinary action is managed in accordance with relevant NSW Health policies, industrial instruments, legislative, contractual and common law requirements.
- Suspected corrupt conduct, indecent acts, sexual or physical violence or the threat of sexual or physical violence by a staff member against another person (adult or child) is reported to the appropriate agency; and is assessed and managed by an appropriate senior officer within the local health district and/or facility.
- There are systems and processes in place and staff are aware of their obligations to protect vulnerable patients / clients – for example, children and those with a mental illness.
- Suspected professional misconduct or unsatisfactory professional conduct by staff and visiting practitioners is reported to the relevant healthcare professional council and any other relevant agencies, with appropriate action to be taken by the local health district and/or facility to protect staff, patients and visitors.
- The organisation is responsive to external oversight and review agencies such as the Health Care Complaints Commission, NSW Coroner, NSW Ombudsman, the Commission for Children and Young People, NSW Privacy, Independent Commission Against Corruption and the Audit Office of NSW.
- Cultural competence is embedded as a core feature of recruitment, induction, professional development and other education and training strategies.
- Models of good practice are implemented that provide culturally safe work environments and health services through a continuous quality improvement model.

2.2.6 **Standard 6: Involve stakeholders in decisions that affect them**

Health organisations must have systems and processes in place to ensure the rights and interests of key stakeholders are incorporated into the plans of the organisation and that they are provided access to balanced and understandable information about the organisation and its proposals.

All public health organisations should ensure that:

- Appropriate consultative and communication strategies are in place to facilitate the input of consumers of health services, and other members of the community, into the key policies, plans and initiatives of the organisation.
- Appropriate consultative strategies are in place to involve staff in decisions that affect them and to communicate the strategies, values and priorities of the organisation to staff.
- A Local Partnership Agreement is in place with Aboriginal Community Controlled Health Services and Aboriginal community services within their boundaries, which include involvement in decision-making regarding service provision to local Aboriginal communities.
- Appropriate information on key policies, plans and initiatives of the organisation is made available to the public.
- Policies, plans and initiatives of the organisation are updated regularly and readily accessible to the staff.
- The performance of the organisation in delivering key plans, targets and initiatives is reported to the public at least annually.

2.2.7 **Standard 7: Establish sound audit and risk management practices**

Each public health organisation must establish and maintain an effective internal audit function that is responsible for overseeing the adequacy and effectiveness of the organisation's system of internal control, risk management and governance.

The audit and risk management structures of the organisation should provide an assurance to the board and chief executive that the authorities and roles allocated to management effectively support the achievement of the goals of the organisation.

All public health organisations should ensure that:

- An Audit and Risk Management committee for the organisation is established.
- An internal audit function for the organisation is established.
- Risk management is embedded in the culture of the organisation. The risk management framework (enterprise wide) should encompass the identification, elimination, minimisation and management of both clinical and non-clinical risks.

2.3 **Reporting on Governance Standards**

2.3.1 **Corporate Governance Attestation Statements**

Corporate Governance Attestation Statements must be completed for the financial year by 31 August each year

.....

Public health organisations must publish an annual **Corporate Governance Attestation Statement** that outlines their governance arrangements and includes key information on their operations.

Compliance with the actions in the governance statements does not ensure the quality of governance for the organisation, rather it provides the minimum structural elements for good governance which is necessary to support the organisation to meet its objectives and obligations as a public sector entity.

Where an organisation has not met one of the governance standards, the statement should include a qualification as to whether the organisation is intending to meet the standard but is still working towards implementation of the minimum actions required, or the reasons the standard is not applicable.

The **Corporate Governance Attestation Statement** is available in a template format for completion and should be:

- certified by the chief executive and board chair (where applicable) as accurately reflecting the corporate governance arrangements for the preceding financial year;
- **submitted to the Ministry of Health by 31 August** each year to ensure the information is available during the organisation's annual performance review;
- published (whole statement) on the organisation's Internet site.

A **Governance Standards Checklist** has been developed as a guide for boards and chief executives in undertaking corporate governance assessments. A checklist template is available on the next page. The checklist highlights a number of actions that public health organisations can and should take in order to meet each governance standard.

Implementation of these actions does not automatically ensure the quality of governance and compliance with standards for the organisation. However, the checklist provides key structural elements which are considered to provide a basis within a good governance framework, that will when effectively implemented, support the organisation in meeting its objectives and obligations as a public sector entity.

Governance Standards – Checklist

The following table summarises a number of recommended actions that public health organisations should take in order to meet each governance standard. Implementation of these recommended actions does not ensure the quality of governance for the organisation, but provides structural elements required as a basis for good governance to support the organisation in meeting its objectives and obligations as a public sector entity.

| Activity | Requirements |
|---|---|
| Set the strategic direction for the organisation and its services | <ul style="list-style-type: none"> ✓ Have a 3-5 year strategic plan in place to identify the strategic priorities for the district and its key services. ✓ Have an Asset Strategic Plan with a four and 10-year horizon, which is aligned to the strategic priorities of the district and is reviewed annually and revised to reflect achievements. ✓ The District Service Agreement, identifying the annual operating targets and funding allocations for the district, should be publicly available. ✓ Annual operating plans for each of the facilities/wards/units within the district must be in place and clearly identify budgets and performance targets across all operational units of the district. |
| Set clear accountabilities for management and service delivery | <ul style="list-style-type: none"> ✓ Members of the board, the chief executive and the senior management of the district must be aware of the role of the district, the role of national governance authorities, the Minister for Health and the Ministry of Health. ✓ Governing structures required by model by-laws must be established to provide effective oversight of clinical and corporate responsibilities. ✓ Accountabilities for health service delivery and for the provision of health support services within the district must be clearly established. ✓ The authorities reserved for the board and those delegated to the management and councils within the district must be clearly documented. ✓ The board and chief executive must be able to demonstrate compliance with the 7 corporate governance standards |
| Promote professional and ethical decision making and conduct | <ul style="list-style-type: none"> ✓ Members of the board must be aware of their roles and responsibilities and lead by example (eg. fiduciary duties, duty of care and diligence). ✓ Staff and contractors of the district must be made aware of the NSW Health Code of Conduct when appointed and obligations must be periodically reinforced. ✓ A fraud and corruption prevention program must be in place. ✓ All instances of improper conduct must be managed appropriately and reported to the relevant statutory authority. ✓ All facilities demonstrate action towards becoming more culturally competent. |
| Review the financial and service delivery performance of the network | <ul style="list-style-type: none"> ✓ All national and state reporting obligations with respect to financial management and service delivery must be fulfilled. ✓ A system must be in place to monitor the performance of all hospitals/wards/units. ✓ Funding specifically allocated for Aboriginal health programs and services is accounted for separately and protected. |

| Activity | Requirements |
|---|--|
| Recognise and manage risk | <ul style="list-style-type: none"> ✓ A compliance program must be in place to ensure the legal and policy obligations of the district are identified, understood and are eliminated, minimised, managed and monitored. ✓ A risk management plan is established which identifies the responsibilities of managers and staff in responding to/and escalating risks and opportunities. ✓ An effective incident management system must be in place to record and review corporate and clinical incidents and to action recommendations. ✓ An internal audit function for the district must be established. ✓ The internal auditor must review the financial and accounting practices and associated internal controls of the district to ensure they meet relevant government and accounting standards. ✓ An external auditor for the district must be appointed. |
| Respect the rights of stakeholders | <ul style="list-style-type: none"> ✓ Information on the policies, publications and performance must be published on the internet. ✓ A consumer and community engagement plan should be in place to facilitate broad input into the strategic policies and plans of the district. ✓ A patient service charter must be established to identify the commitment of the district to protecting the rights of patients in the health system. ✓ A Local Partnership Agreement is in place with Aboriginal Community Controlled Health Services and Aboriginal community services within their boundaries. ✓ Mechanisms must be in place to ensure the district respects the privacy of personal and health information that it holds. ✓ An effective complaint management system must be developed and in place for the district. ✓ The district must be responsive to reports of statutory agencies such as the Coroner, Health Care Complaints Commission, Commission for Children and Young People and Ombudsman. |



Governance Framework – Resources & References

Corporate Governance

Australian

The corporate governance standards set out in this section have been developed with reference to the following:

- Australian Standard, AS8000-2003, Good Governance Principles, November 2004, Standards Australia International, Sydney. <http://www.standards.org.au/>
- Australian Standard, AS3806-2006, Compliance Programs, March 2006, Standards Australia International, Sydney. <http://standards.org.au/>
- Australian Securities Exchange, Corporate Governance Council website: <http://www.asxgroup.com.au/regulation/corporate-governance-council.htm>

NSW Legislation

- The legislative framework that underpins the NSW Health system can be found at: www.health.nsw.gov.au/legislation/pages/default.aspx

NSW Government

- NSW Audit Office, Better Practice Guides for Public Sector Governing and Advisory boards: <http://www.audit.nsw.gov.au/publications/better-practice-guides>

NSW Department of Premier and Cabinet

- Department of Premier and Cabinet - Guides and Publications for Agencies: <http://www.boards.dpc.nsw.gov.au/publications-for-agencies>
- Department of Premier and Cabinet - Public Service Commissioner's Appointment Standards: Boards and Committees in the NSW Public Sector
<http://www.boards.dpc.nsw.gov.au/publications-for-agencies>

NSW Health

- Annual Corporate Governance Attestation Statement template: http://internal.health.nsw.gov.au/cgrm/cger/governance_statement.html
- Policy Directive Internal Audit PD2010_039
- Policy Directive Risk Management Enterprise wide PD2015_043
- Decision making framework for Aboriginal Health Workers: <http://www.health.nsw.gov.au/workforce/aboriginal/pages/decision-making-framework.aspx>

Local Documentation

Approved By-Laws

Approved Delegations Manual

Approved enterprise-wide risk management framework and plans

Approved service delivery plans

Approved financial management plans

Approved Audit Plan

Consultation framework to facilitate local and clinician engagement

Annual Governance Attestation Statement to confirm compliance with the approved governance framework and minimum governance standards.



3 Roles of Boards & Chief Executives

There are several types of public health organisations within the New South Wales public health system. These are:

- Local health districts.
- Statutory health corporations, being either network governed (specialty networks), board governed or chief executive governed.
- Affiliated Health Organisations, in relation to establishments or services recognised under the *Health Services Act*.

3.1 Local Health District and Specialty Networks

This section outlines the roles and accountabilities for the Local Health Districts and Specialty Networks (being the Sydney Children's Hospitals Network and the Justice and Forensic Mental Health Network), their boards and the chief executives and their key governance relationships.

3.1.1 Role of boards

The role of the board is focused on leading, directing and monitoring the activities of the local health district and specialty network and driving overall performance.

The Board has specific statutory functions, outlined in section 28 of the *Health Services Act 1997*. Those functions are:

- to ensure effective clinical and corporate governance frameworks are established to support the maintenance and improvement of standards of patient care and services by the local health district and to approve those frameworks,
- to approve systems:
 - to support the efficient and economic operation of the local health district, and
 - to ensure the district manages its budget to ensure performance targets are met, and
 - to ensure that district resources are applied equitably to meet the needs of the community served by the district,
- to ensure strategic plans to guide the delivery of services are developed for the local health district and to approve those plans,
- to provide strategic oversight of and monitor the local health district's financial and operational performance in accordance with the State-wide performance framework against the performance measures in the service agreement for the district,
- to make recommendations for the appointment of the chief executive of the local health district and, where it considers it appropriate to do so, to make recommendations concerning the removal of the chief executive,
- to confer with the chief executive of the local health district in connection with the operational performance targets and performance measures to be negotiated in the service agreement for the district under the National Health Reform Agreement (NHRA)²,
- to approve the service agreement for the local health district under the NHRA,

² Under the *Health Services Act*, the National Health and Hospitals Network Agreement (NHHN) 2010 is a defined term that also means any agreement that replaces or supersedes that agreement. This would include the National Health Reform Agreement (NHRA).

- to seek the views of providers and consumers of health services and of other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services, and to confer with the chief executive of the district on how to support, encourage and facilitate community and clinician involvement in the planning of district services,
- to advise providers and consumers of health services and other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services,
- to endorse the local health district's annual report,
- to liaise with the boards of other local health districts and specialty network governed health corporations in relation to both local and State-wide initiatives for the provision of health services,
- such other functions as are conferred or imposed on it by the regulations.

These functions are in the nature of governance oversight, not a day to day management and operational role. The Board chair also has an oversight role in respect of the Chief Executive. In addition to making recommendations as to appointment of the Chief Executive, the Board chair also enters into the annual performance agreement with the chief executive and undertakes their annual performance review as provided for under the Health Executive Service Framework.

3.1.2 **Role of the Chief Executive**

Chief executives of Local Health Districts (and SHNs) are employed in the Health Executive Service (part of the NSW Health Service) by the Director-General under s116 of the *Health Services Act* on behalf of the NSW Government.

The role of the chief executive is set out in section 24 of the *Health Services Act*. The Chief Executive *manages* and *controls* the affairs of the Local Health District. The Chief Executive can commit the District contractually and legally and is the employer delegate for all staff working in the organisation. Chief Executives are, in the exercise of their functions, accountable to their Board.

3.1.3 **Board appointments and procedure**

3.1.3.1 **Appointments**

Boards consist of 6 to 13 members appointed by the Minister. The selection criteria for board members in the Act aim to ensure an appropriate mix of skills and expertise to oversee and provide guidance to large, complex organisations. These include:

- expertise and experience in matters such as health, financial or business management;
- expertise and experience in the provision of clinical and other health services;
- representatives of universities, clinical schools or research centres; and
- knowledge and understanding of the community.
- other background, skill, expertise, knowledge or expertise appropriate to the organisation;
- at least one member must have expertise, knowledge or experience in relation to Aboriginal health.

The Model By-Laws for LHDs also establish processes for medical, nursing and midwifery and allied health staff to nominate short lists of interested clinicians for the Minister to consider when making appointments to the board, providing for local clinical input on the Board.

Terms of Office

Board members are appointed for a specific term with a maximum term of up to four years. The position of a board member is vacated if the member resigns, dies, becomes bankrupt or mentally incapacitated, is convicted of certain criminal offences, or if the member or board is removed by the Minister.

Duties as a board member

Board members are appointed for the good of the organisation and are not there to represent the group or interest that nominated them. The role of the board member is not one of direct representation of any particular sectional interest, rather they must carry out their role and functions in the interests of the organisation and the community it represents as a whole. For a comprehensive list of Board member duties, see the table at section 3.4.

Deputy Chair

In addition to the Chairperson appointed by the Minister, the board may nominate a Deputy Chairperson. The Deputy Chairperson may act and exercise all the functions of the office of the Chairperson during the Chairperson's absence.

Attendance of Chief Executive at board meetings

The Chief Executive is not a member of the board, but under the *Health Services Regulation 2008* is entitled to attend board meetings *ex officio*.

Other Invitees

The regulation also provides for the Chair of the Medical Staff Executive Council to attend board meetings and also provides guidance on board meeting procedures.

3.1.3.2 Meeting Times and Procedures

At least six ordinary meetings of the board must be held at regular intervals and an annual public meeting must be held between 1 July and 31 December each year.

Each local health district should establish procedures for the board and each of the board approved committees, in accordance with the Act, Regulation and by-laws. The procedures should be documented and readily accessible and cover matters such as (but not limited to):

- distribution of minutes, reports to be received (and frequency), types of matters that must be approved; types of matters that should be noted,
- declarations of conflicts of interest
- matters to be dealt with in confidence
- media spokespersons
- training and development; attendance at conferences specific to board roles and responsibilities
- remuneration and petty cash reimbursements
- fundraising activities

More detail on Board procedures can be found in the Model-By Laws and Schedule 1 to the *Health Services Regulation 2008*.

3.1.3.3 Confidentiality

The maintenance of confidentiality at board meetings is an essential aspect of good governance. It ensures trust and supports open and honest discussion of matters so that those in attendance can frankly express their views. Information discussed in board meetings will often also be information that is not otherwise in the public domain, or which is subject to protections or restrictions such as legal privilege, commercial in confidence obligations, or privacy rules.

At an operational level, it is the responsibility of the Board to ensure minutes of the meeting are publicly available and there is proper level of transparency with their community and clinicians, while also observing an appropriate level of confidentiality in respect of their internal discussions on board business and confidential or sensitive information provided to them to assist in the conduct of their business. For these reasons, it is appropriate for a board to determine the extent of release of information discussed at, and provided to, the board, either on a case by case basis, or through guidelines tailored to the business of a particular board.

For further information see: <http://www.health.nsw.gov.au/LHDBoards>.

Publication of Board Minutes

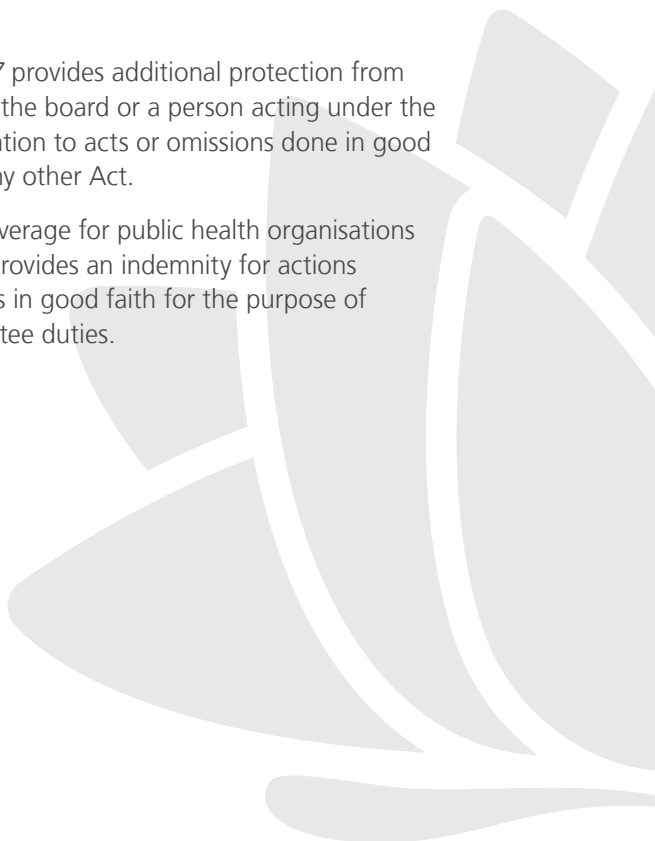
The Minutes of Board Meetings are required to be publicly available. NSW Health policy on board minutes however, also makes it clear that where there are substantial and genuine reasons for maintaining confidentiality such as commercial sensitivity, adverse effect on law enforcement, prejudice to current litigation or negotiations or interference with the right to privacy of third parties, it would be appropriate to excise the confidential information.

3.1.3.4 Legal Protections

The Corporations Law does not apply to local health districts and specialty networks. As such, board members are not subject to the criminal and civil penalty regimes under that legislation.

Section 133B of the *Health Services Act 1997* provides additional protection from personal liability for the board, a member of the board or a person acting under the direction of the board or organisation, in relation to acts or omissions done in good faith for the purposes of executing that or any other Act.

The Treasury Managed Fund Contract for Coverage for public health organisations includes directors and officers cover, which provides an indemnity for actions committed by board members or committees in good faith for the purpose of discharging their governing board or committee duties.



3.1.4 Key Governance Relationships

3.1.4.1 Minister for Health and Director-General

The Minister and Director-General each have important governance roles in relation to the local health districts and specialty networks.

Minister

The Minister is responsible for the appointment and dismissal of individual board members. The Minister may also remove the entire board and appoint an administrator in their place. Where an administrator is appointed, the Minister is required to make a statement to Parliament that sets out the basis for that decision. These provisions are required to enable action to be taken where a local health district is failing and urgent intervention is required.

The Chairs of Local Health District Boards and Specialty Networks come together on a regular basis as the Council of Board Chairs to confer with the Minister for Health and the Director-General. The Council provides a key leadership group for NSW Health.

The Director-General

The Director-General is responsible for the overall governance, oversight and control of the NSW public health system and public health organisations, including public health system performance.

In this capacity, the Director-General has the function of giving directions to local health districts, to ensure that they fulfill their statutory and financial obligations and to assist the State meet its own obligations as system manager.

The Director-General is also responsible for entering into performance and Service Agreements with local health districts and employing staff of local health districts on behalf of the State.

3.2 Board Governed Statutory Health Corporations

This section outlines the roles and accountabilities for board governed statutory health corporations, recognising that the governance structure applying to these organisations (such as the ACI, CEC) is different from those applying to the local health districts and specialty networks.

3.2.1 Role of the Board

Under section 47 of the *Health Services Act*, the affairs of a board governed health corporation are controlled by the board, which is in turn subject to the direction and control of the Minister and Director-General (by delegation).

The *Health Services Act 1997* does not set out a specific list of functions for a statutory health corporation board, but their broad role is to guide and direct the operation of the organisation through establishing operating policies and charting the course of each organisation. This will include setting directions for the organisation and within the bounds of statutory, Government and Ministry of Health requirements and available resources;

- ensuring the effective and efficient management of the organisation;
- ensuring that the community is well informed about the organisation, its goals and performance;
- being accountable to the Director-General for the organisation's output;

- having a leadership role, with and through the chief executive, in motivating staff and creating the culture of the organisation;
- being responsible for safeguarding assets and ensuring the financial viability of the organisation;
- establishing monitoring and management reporting mechanisms to fulfil its accountability for governing the organisation;
- ensuring proper working relationships exist with government, other agencies, unions and the community in general.
- ensuring business continuity planning is undertaken to sustain service delivery during emergencies;

The Board has also been delegated with the responsibility of entering the annual performance agreement with the chief executive and undertaking their annual performance review.

3.2.2 **Role of the Chief Executive**

Under section 51 of the *Health Services Act*, the chief executive manages the affairs of a board governed statutory health corporation, and is, in the exercise of his or her functions, subject to the direction and control of the organisation's board. As with Local Health Districts and Specialty Networks, the Chief Executive is also the employer delegate for staff working at the organisation.

3.2.3 **Statutory Health Corporation Board appointments and procedure**

3.2.3.1 **Appointments**

Statutory Health Corporation Boards consist of 5 to 11 members appointed by the Minister, plus the chief executive officer, who is an *ex officio* a member of the board.

The only statutory requirement in relation to appointees is that organisations with more than 50 staff include a board member employed in the NSW Health Service. More generally, members will be appointed having regard to the knowledge or experience necessary to support the board, which may be in business, law or health administration, or other background, skills, expertise or knowledge that may be appropriate or relevant to the particular to role of the organisation.

Terms of Office

Board members are appointed for a period of up to four years, and may be reappointed. The position of a board member is vacated if the member resigns, dies, becomes bankrupt or mentally incapacitated, is convicted of certain criminal offences, or if the member or board is removed by the Governor.

3.2.3.2 **Duties as a board member**

Board members are appointed for the good of the organisation and are not there to represent the group or interest that nominated them. The role of the board member is not one of direct representation of any particular sectional interest, rather they must carry out their role and functions in the interests of the organisation and the community it represents as a whole. For a comprehensive list of Board member duties, see the table at section 3.4.

3.2.3.3 Meeting times and procedures

Board governed statutory health corporations should establish procedures for the board and each of the board approved committees, in accordance with the by-laws. The procedures should be documented and readily accessible and cover matters such as (but not limited to):

- frequency of meetings, distribution of minutes, reports to be received (and frequency), types of matters that must be approved; types of matters that should be noted,
- declarations of conflicts of interest
- matters to be dealt with in confidence
- media spokespersons
- training and development; attendance at conferences specific to board roles and responsibilities
- remuneration and petty cash reimbursements
- fundraising activities

More detail on Board procedures can be found in the Model-By Laws and Schedule 5 to the *Health Services Act 1997*.

Attendance at meetings

The chief executive is ex officio a member of the board, and attends as such. The Board may also invite such other persons as it chooses to attend from time to time.

3.2.3.4 Confidentiality

The maintenance of confidentiality at board meetings is an essential aspect of good governance. It ensures trust and supports open and honest discussion of matters so that those in attendance can frankly express their views. Information discussed in board meetings will often also be information that is not otherwise in the public domain, or which is subject to protections or restrictions such as legal privilege, commercial in confidence obligations, or privacy rules.

At an operational level, it is the responsibility of the Board to ensure minutes of the meeting are publicly available and there is proper level of transparency with their community and clinicians, while also observing an appropriate level of confidentiality in respect of their internal discussions on board business and confidential or sensitive information provided to them to assist in the conduct of their business. For these reasons, it is appropriate for a board to determine the extent of release of information discussed at, and provided to, the board, either on a case by case basis, or through guidelines tailored to the business of a particular board.

3.2.3.5 Publication of Board Minutes

The Minutes of Board Meetings are required to be publicly available. NSW Health policy on board minutes however, also makes it clear that where there are substantial and genuine reasons for maintaining confidentiality such as commercial sensitivity, adverse effect on law enforcement, prejudice to current litigation or negotiations or interference with the right to privacy of third parties, it would be appropriate to excise the confidential information.

3.2.3.6 **Legal Protections**

The Corporations Law does not apply to local health districts and specialty networks. As such, board members are not subject to the criminal and civil penalty regimes under that legislation.

Section 133B of the *Health Services Act 1997* also provides additional protection from personal liability for the board, a member of the board or a person acting under the direction of the board or organisation, in relation to acts or omissions done in good faith for the purposes of executing that or any other Act.

The Treasury Managed Fund Coverage for public health organisations includes directors and officers cover, which provides an indemnity for actions committed by board members or committees in good faith for the purpose of discharging their governing board or committee duties.

3.2.4 **Key Governance Relationships**

3.2.4.1 **Minister for Health and Director-General**

The Minister and Director-General each have important governance roles in relation to board governed statutory health corporations.

Minister

Under section 48 of the *Health Services Act 1997*, statutory health corporation boards are subject to the control and direction of the Minister except in relation to the content of a report or recommendation or report made by the board to the Minister. The Minister is also responsible for the appointment and dismissal of individual board members.

The Minister may also remove the entire board and appoint an administrator in their place. These provisions are required to enable action to be taken where a board governed statutory health corporation is failing and urgent intervention is required.

The Director-General

The Director-General is responsible for the overall governance, oversight and control of the NSW public health system and public health organisations, including public health system performance.

In this capacity, the Director-General has the function of giving directions to statutory health corporation or local health districts, both to ensure that they fulfill their statutory and financial obligations and to assist the State meet its own obligations as system manager.

The Director-General has also been delegated the control and direction functions of the Minister under section 48.

The Director-General is responsible for entering into performance and Service Agreements with local health districts and employing staff of local health districts on behalf of the State.

3.3 Chief Executive Governed Statutory Health Corporations

This section outlines the roles and accountabilities for chief executive governed statutory health corporations, recognizing that the governance structure applying to these organisations (such as HETI) is different from those applying to the local health districts, specialty networks and board governed statutory health corporations.

Under section 52B of the *Health Services Act*, the chief executive manages and controls the affairs of a CE governed statutory health corporation. As with districts specialty networks and board governed statutory health corporations, the CE is also the employer delegate for staff working at the organization.

The Director-General is responsible for the overall governance, oversight and control of the NSW public health system and public health organisations, including chief executive governed statutory health corporations.

In this capacity, the Director-General has the function of giving directions to both to ensure the organization fulfils their statutory and financial obligations and to assist the State meet its own obligations as system manager.

3.4 Duties of NSW Health Board Members

The following table sets out the key duties applying to board members as they undertake their role.



General legal duties applicable to board members

Compliance with laws and policy directives

- Requirement to comply with relevant legislation including regulations (refer to section 4 for details).
- Requirement to comply with the Department of Premier and Cabinet Conduct Guidelines for Members of NSW Government Boards and Committees, and the NSW Health Code of Conduct.

Fiduciary duties of good faith

- Duty to act honestly and properly for the benefit of the organisation.
- Duty to disclose interests in matters before the board, including potential conflicts of interest.
- Duty not to divert (without properly delegated authority) the organisation's property, information and opportunities.

Duty to act honestly and properly for the benefit of the organisation

- A board member must not act in self-interest and must at all times avoid any conflict between their duty to the board and the health organisation, and their own or third party interests.
- A board member has an overriding and predominant duty to serve the interests of the board and the health organisation, in preference, wherever conflict arises, to any group of which he or she is a member or which elected him or her.
- A board member has a duty to demonstrate leadership and stewardship of public resources.

Duty to disclose interest

- A board member must disclose to the board any direct or indirect interest the member has in a matter before them.
- A statutory form of this duty is set out in the *Health Services Act 1997*. It requires a board member to remove themselves from deliberation and voting on a matter in which they have a direct or indirect pecuniary interest.

Duty not to misuse the organisation's property, information or opportunities

- Duty of confidentiality of information about the affairs of the board or its organisation obtained as a board member.
- Release of information by a board member must be both lawful and either required by law or authorised by the board.
- The use of the organisation's property, information or opportunities must be authorised by the board and be for the benefit of the organisation.

Duty of care and diligence

- Board members are required to exercise care and diligence in the exercise of their powers.
- A board member need show no greater skill than may reasonably be expected from a person of his/her knowledge and experience.
- A board member is not required to give continuous attention to the organisation's affairs – the duties are intermittent to be performed at and in preparation for board meetings.
- Where duties may properly be left to an officer of the organisation, a board member is justified in trusting the officer to perform the duties honestly.

The Roles of Boards and Chief Executives – Resources & References

Legal

- Relevant legislation: <http://www.legislation.nsw.gov.au/>
- The legislative framework that underpins the NSW Health system can be found at: www.health.nsw.gov.au/aboutus/legal/legal.asp

NSW Health

- NSW Health policy directives and guidelines: <http://www.health.nsw.gov.au/policies/pages/default.aspx>
- NSW Health Performance Framework: <http://www.health.nsw.gov.au/performance/pages/frameworks.aspx>

NSW Government

- Department of Premier and Cabinet Conduct Guidelines for Members of NSW Government Boards and Committees: <http://www.boards.dpc.nsw.gov.au/publications-for-agencies>
- Department of Premier and Cabinet An Introduction to Board & Committee Membership Version 2 April 2008 <http://www.boards.dpc.nsw.gov.au/publications-for-agencies>

Local Documentation

- Board procedures
- Guidelines for Board members, for example training and development, declaration of potential conflicts of interest; media management, fundraising
- By-Laws for the public health organisation
- Approved Delegations Manual
- Terms of reference/purpose of committees established by the board (other than those listed in the by-laws)



4 Legal & Policy Requirements

4.1 Legal Obligations for Health Organisations

All organisations involved in the delivery or support of public health services are required to comply with the general law including obligations of duty of care to patients, as well as specific State and Commonwealth requirements designed to regulate the functioning of public sector or health related bodies.

A guide to key legal obligations of public health organisations is available on the NSW Health website at: www.health.nsw.gov.au/aboutus/legal/legal.asp

All persons employed by, or providing a service to, a public health organisation have legislative obligations, whether they are clinicians caring for patients / clients, contractors, administrative or support staff, senior managers or board members.

Local health district management has a role in ensuring and monitoring compliance with applicable legislation, the general law and NSW Health policy.

Clinical staff have a duty of care to their patient/clients; and these staff should be familiar with relevant legislation, professional standards of practice, and NSW Health policy directives and guidelines. Information is readily accessible from professional associations (such as Colleges, Guilds and registration and professional authorities); training bodies (such as universities) and NSW Health.

Chief executives have an obligation to ensure that all equipment is properly licensed and that all personnel are appropriately qualified, licensed and registered.

A brief outline of the key legislative obligations, from a management 'governance' perspective is provided in the following pages.

Compliance with legislation, general law and NSW Health Policy

Key health laws Health Services Act & Health Administration Act

4.1.1 Health Services Act and Health Administration Act

The chief executive and the board must be mindful of the legislation under which the organisation is established and operates. For public health organisations the relevant Act is the *Health Services Act 1997*.

Extracts of sections of the *Health Services Act 1997* relevant to the structure and functions of public health organisations are provided at the end of this compendium.

The *Health Administration Act 1982* sets out the roles of the Minister and the Secretary in general terms in relation to the provision, conduct and operation of health services.

4.1.2 Work Health and Safety

The *Work Health and Safety Act 2011* substantially amended the previous *Occupational Health and Safety Act 2000*. The *Work Health and Safety Act 2011* (the Act) places obligations on "persons who conduct a business or undertaking" (PCBU) to ensure, as far as is reasonably practicable, the health and safety of workers³ and others who may be put at risk from work carried out as part of the conduct of the business or undertaking such as visitors to that workplace.

³ Workers under the Work Health and Safety Act 2011 include a range of parties including employees, volunteers and visitors.

Chief executives and boards are responsible for public health organisations having health and safety systems implemented across the public health organisation to eliminate/minimise workplace injuries; as well as injury management plans in returning injured employees to work (including external employment).

Under the Act these persons must discharge their duties to the extent that they have the capacity to influence or control the matter.

Other persons, such as visitors have a legal duty under the Act to take 'reasonable care' to ensure that their acts do not adversely affect the health and safety of themselves and others.

Mitigating violent behaviour in the workplace

An important workplace health and safety issue is having effective policies and procedures that are supported by risk management programs that address potential risks of violent behaviour occurring in the public health sector workplace.

The primary responsibility for achieving a violence-free workplace for staff, patients and the public rests ultimately with the chief executive and the board of the public health organisation. The organisation should consider the following strategies in mitigating risks of violent behaviour occurring within their organisation:

- giving emphasis to occupational health and safety in the design of new facilities, refurbishments and upgrades to facilitate risk reduction;
- conducting risk assessments to minimise, and where possible eliminate, risks – for example, identification of high risk environments (e.g. emergency departments, isolated sites, high dependence and critical care wards, mental health and dementia services); improved facility design; provision of specific training and development for frontline staff; development of safe work practice policies and procedures
- installation of appropriate communication systems, monitoring and duress alarm systems and protocols, particularly for staff working in the community or at isolated sites, or high risk facilities such as emergency departments and drug and alcohol clinics;
- restricting patient access through the use of key access, for example, to areas that hold cash, drugs or potentially dangerous equipment.

4.1.3 Industrial relations

Chief executives are required to ensure that employment arrangements comply with NSW Ministry of Health policy and instructions and that employment related delegations from the Secretary are exercised in an appropriate and lawful manner.

The public health organisation is responsible for customary employer responsibilities such as hiring, managing, reviewing performance and taking disciplinary action, terminations, work health and safety, and ensuring that staff receive the appropriate remuneration, conditions and other entitlements.

The Human Resources E-Compendium has been developed for the benefit of chief executives and human resource practitioners across the NSW Health public health system. The E-Compendium contains direct access to current human resource policies, guidelines, and information bulletins. It is updated and expanded as new policies are developed. The Human Resources E-Compendium can be accessed at <http://www.health.nsw.gov.au/careers/hrcompendium/pages/default.asp>.

Another useful reference is the employment, industrial relations, work health and safety, anti-discrimination and workers compensation section of the legal compendium accessible at <http://www.health.nsw.gov.au/legislation/Pages/Legal-Compendium.asp>.

Further information on workforce and development is provided in section 8 of the compendium.

4.1.4 **Independent Commission Against Corruption**

The *Independent Commission Against Corruption Act 1988* imposes obligations on principal officers of public authorities to notify the Independent Commission Against Corruption (ICAC) of any matter where the officer suspects, on reasonable grounds, that corrupt conduct has occurred.

An effective internal reporting system must be established in each NSW Health organisation to facilitate the flow of corruption reports to the chief executive: Further information is provided in PD2011_070, *Corrupt Conduct – Reporting to the Independent Commission Against Corruption (ICAC)* available at: http://www.health.nsw.gov.au/policies/pd/2011/PD2011_070.html and Policy Directive PD2015_027 *Public Interest Disclosures*. Further information is also provided in section 9 of the Compendium.

4.1.5 **State Records Act**

The *State Records Act 1998* applies to public health organisations. It provides for:

- protecting records in the custody of a public office;
- making and keeping full and accurate records of its activities;
- establishing and maintaining a records management program in conformity with standards and codes of best practice;
- making arrangements for monitoring and reporting on the records management program; and
- keeping technology-dependent records accessible.

All papers maintained by the public health organisation are considered to be state records and subject to the *State Records Act*. Organisations should be aware of the provisions as to retention, disposal and maintenance. Records can include work papers, electronic records, diaries, minutes of meetings etc.

Information on records management, including record retention, maintenance and disposal requirements is available on the internet via the State Records website. Health organisations are subject to specific records management requirements and should refer to the public health sector section of the State Records website.

4.1.6 **Privacy obligations**

Public health organisations have a legal obligation to comply with privacy law. Chief executives have ultimate responsibility for ensuring privacy obligations are met within the organisation.

Public health organisations in NSW are bound by the *Health Records and Information Privacy Act 2002 (HRIP Act)* which regulates the collection and use of personal health information and the *Privacy and Personal Information Protection Act 1988 (PPIP Act)* which regulates the collection and use of other personal information.

The obligations of public health organisations are addressed in the NSW Health Privacy Manual for Health Information (2015) and the Privacy Management Plan, and can be accessed by going to:

<http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-health-information.pdf> and
http://www.health.nsw.gov.au/policies/pd/2005/PD2005_554.html.

Information about the privacy governance framework and the online privacy tool for NSW public sector agencies is available on the NSW Privacy website.

Chief executives must ensure that the public health organisation has in place processes to comply with these legislative requirements including:

- the notification to patients on the collection of their personal information and outlining their rights under privacy law;
- the establishment of internal review processes where patients wish to lodge a complaint where they believe their privacy has been breached;
- the establishment of internal processes for patients / others who wish to access records under privacy legislation
- training for staff on their privacy obligations and support for staff through local health information management processes; and
- the provision of a dedicated Privacy Contact Officer (PCO) in all health districts to coordinate privacy implementation and oversee internal reviews.

4.1.7 **Government Information (Public Access) Act (GIPA Act)**

On 1 July 2010, the *Government Information (Public Access) Act 2009 (GIPA Act)* came into effect, replacing the former *Freedom of Information Act 1989 (FOI)*.

The *GIPA Act* provides a framework for accessing information from New South Wales Government agencies, and seeks to promote a more proactive and transparent approach towards accessing and releasing government information.

The *GIPA Act* is predicated on government agencies practising proactive disclosure by creating a presumption in favour of disclosure of information unless there is an overriding public interest against disclosure. As a result, New South Wales Government agencies are expected to release a wider range of information either free of charge or at a reasonable cost.

- Information about i) an organisation's obligations to publicly disclose certain information and ii) its processes for granting access to information are available at: <http://www.oic.nsw.gov.au/oic>
- Each organisation should have a nominated Right to Information Officer to co-ordinate and process applications for information submitted under GIPA.

Under the *GIPA Act* any person may complain about an agency's conduct in relation to its functions under the *GIPA Act* to the Office of the Information Commissioner. A complaint cannot be made in relation to an agency decision that is reviewable under the *GIPA Act*. If the Information Commissioner decides to deal with the complaint, the aim will be to help the parties resolve the complaint using any measures considered appropriate including bringing the parties together for conciliation. The Commissioner may also conduct investigations into a complaint and, in certain circumstances, report the matter to the Minister responsible for the agency.

4.1.8 Public Interest Disclosures

The *Public Interest Disclosures Act 1994* (the *PID Act* – formerly the *Protected Disclosures Act 1994*) offers protection for public officials who, in the public interest, disclose information on:

- Corrupt conduct;
- Maladministration;
- Serious and substantial waste;
- Government information access contravention.

Policy Directive PD2015_027 Public Interest Disclosures provides the framework for management of public interest disclosures within NSW Health.

Under the *PID Act*, Principal Officers of Agencies are responsible for ensuring that:

- their organisation has an internal reporting policy;
- their staff are aware of the policy and the protections of the *PID Act*;
- their organisation complies with the policy and its obligations under the *PID Act*;
- at least one officer is responsible for receiving public interest disclosures for their organisation.

Under the Act, organisations are required to:

- manage public interest disclosures in accordance with legislative and policy requirements;
- establish appropriate systems in order to minimise the risk of reprisal following a PID, and deal appropriately with any reprisal which occurs;
- maintain confidential records of public interest disclosures received;
- report information on public interest disclosures received in the Annual Report;
- report information on public interest disclosures as specified in the regulations to the NSW Ombudsman twice annually (30 January and 30 July each year);
- ensure that a person who has made a written disclosure is provided with a copy of the policy and a written acknowledgement of the disclosure within 45 days;
- ensure that a person who has made a disclosure is provided with appropriate information about the outcome of their disclosure within 6 months.

4.1.9 Notification of legal matters to the Ministry of Health

Public health organisations are required to notify the Corporate Governance and Risk Management Unit, Legal and Regulatory Services Branch, of the NSW Ministry of Health of certain legal matters in accordance with Policy Directive PD2014_011.

Legal matters which have implications beyond the local affairs of the public health organisation must be reported to the Ministry. These are legal matters which:

- raise issues which are fundamental to the responsibilities of the Minister or NSW Ministry of Health;
- involve significant medico-legal, ethical or health policy issues;
- concern legal proceedings to which a public health organisation or any of its officers are a party which raise a significant question of interpretation of Ministry policy or legislation administered by the Minister for Health; and
- concern legal proceedings involving more than one public health organisation.

Legal matters requiring notification by the Minister to the Attorney General under Department of Premier and Cabinet's Memorandum 1995-39 must also be reported to the Ministry. These are matters which:

- have implications for Government beyond the NSW Health Minister's portfolio; and
- involve the constitutional powers and privileges of the State and/or the Commonwealth.

Public health organisations must also carry out compliance and enforcement of health legislation in accordance with NSW Health's prosecution policy and guidelines (Policy Directive PD2014_021).

The NSW Ministry of Health provides guidance to the NSW Health Service and Ministry staff on how to conduct investigations in relation to suspected breaches of health legislation.

4.2 Government Policy Requirements

4.2.1 NSW Government policy

Whole of government policies are issued from time to time by central agencies including the Department of Premier and Cabinet, NSW Treasury or the Department of Finance & Services (DF&S)⁴. These policies can include mandatory requirements across the whole government sector in relation to financial accountability and reporting, procurement or other issues.

The content of these policies and any mandatory requirements will generally be notified to public health organisations through the NSW Health Policy Directive system.

4.2.2 NSW Health Policy Directives

The NSW Health Accounts and Audit Determination (Determination) requires all public health organisations to comply with policy directives issued by the Secretary and the Ministry of Health. Compliance with the Determination is a condition of subsidy received under s127 (4) of the *Health Services Act 1997*.

NSW Health Policy Directives

A Ministry of Health *policy* directive is any document that contains material that must be understood by, complied with and implemented across NSW Health as a part of ongoing operations. Policy directives include a policy statement outlining the purpose, mandatory requirements and implementation responsibilities associated with the policy position taken by the Ministry of Health.

Direction of mandatory requirements applicable broadly to the system are notified by way of these policy directives, in addition to any other means for particular requirements and advice.

Policy directives may include:

- *strategic policy* that articulates a direction that NSW Health may be taking with respect to a certain policy area or
- *operating policy* which establishes practices (including protocols, standards or procedures) that must be followed by all organisations delivering public health services.

4 Note: the Department of Finance & Services (DF&S) was formally i) the Department of Services, Technology and Administration (DSTA) and ii) the Department of Commerce (DoC)

NSW Health Guidelines

Guidelines issued by the Ministry of Health establish best practice for NSW Health organisations. Whilst not requiring mandatory compliance, NSW Health organisations must have sound reasons for not implementing standards or practices set out within guidelines issued by the Ministry of Health. Guidelines are issued with a guideline summary outlining the purpose, key principles and the application of the guideline.

Guidelines may also be issued to provide details as to how a policy directive or requirements under legislation should be implemented, or to assist NSW Health organisations implement practices considered best practice by external authorities such as Standards Australia or the Australian Council on Healthcare Standards (ACHS). The key factor that differentiates a guideline from a policy directive is that the actions articulated by the document are recommended rather than mandatory.

NSW Health organisations must have sound reasons for not implementing the recommended standards established within Ministry for Health guidelines.

NSW Health Policy on the web

To ensure a central repository for policy documents issued by the Ministry of Health and that all policy is approved by the appropriate authority, policy directives and guidelines are reviewed by the Strategic Relations and Communications Branch of the NSW Ministry of Health and issued through the policy distribution system also managed by that branch.

All NSW Health policy directives and guidelines, as well as information bulletins issued by the Ministry, can be accessed at <http://www.health.nsw.gov.au/policies/Pages/default.aspx>

4.2.3 Local procedures

Local operating procedures may be developed by public health organisations to document a process or standard required in that area of responsibility. These procedures must be consistent with statute and common law, and with Government policy.

These documents must also be consistent with NSW Health policy directives and guidelines; and should generally only be developed to clarify local implementation issues where there is no other instruction, or there is a gap in instruction.

Ministry of Health policy directives or guidelines must not be redrafted or re-badged to incorporate local operating procedures. When developed and circulated, local procedures should reference Ministry of Health policies or guidelines, with appropriate links to facilitate access.

Local procedures must be properly identified, appropriately retained and readily accessible to all personal (as needed) and must remain compliant with Ministry of Health policies and guidelines, and should be reviewed at least every 5 years.

4.2.4 Policy and procedure manuals

A range of policy and procedure manuals for NSW Health are published on the Ministry of Health internet and are updated continually to incorporate the latest policies issued by the Ministry. These are summarised below.

Accounting Manual for Ministry of Health

The Accounting Manual for Ministry of Health is a resource for staff involved with accounting functions within the Ministry of Health and the Ambulance Service.

Accounting Manual for Public Health Organisations

This manual contains the financial, accounting and audit policy and procedures applicable to public health organisations.

Accounts & Audit Determination for Public Health Organisations

Identifies responsibilities of NSW Health organisations in respect to accounting procedures; the accuracy of accounting, financial and other records; the proper compilation and accuracy of statistical records; and, observance of the directions and requirements issued by the Minister, Secretary, NSW Health and the Ministry.

Fees Procedures Manual for Public Health Organisations

The Fees Manual contains policy and procedures relating to revenue and charging for services and accommodation provided to inpatients and non-inpatients of hospitals, nursing homes and multi-purpose services.

Leave/Salaries Manual – Public Service

The Leave/Salaries Manual contains policy and procedures for Public Service staff in relation to leave and salaries, complementing the Public Service Personnel Handbook.

Patient Matters Manual for Public Health Organisations

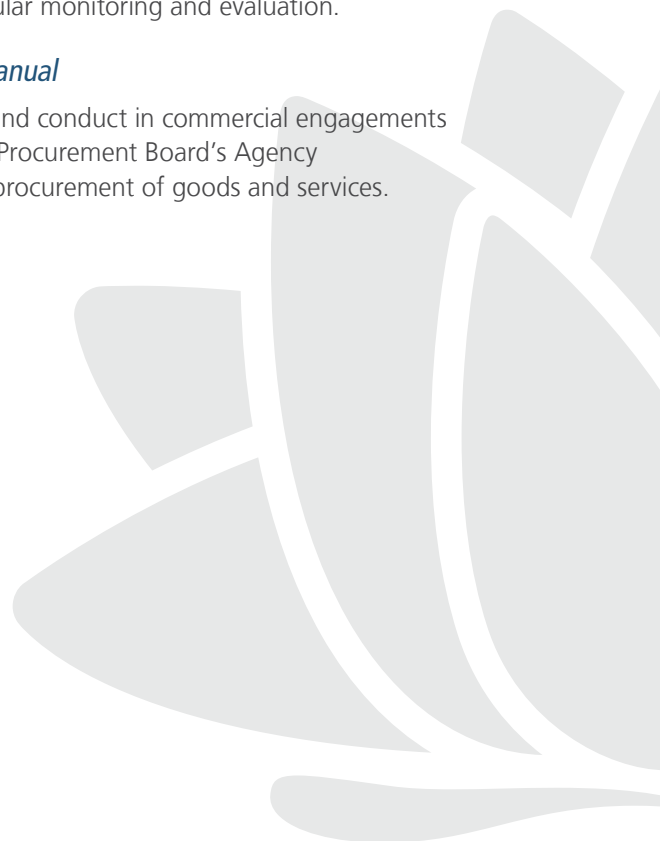
The Patient Matters Manual is a compilation of NSW Health policies and procedures relating to the care and treatment of clients of the health system and includes health record and privacy policies.

Protecting People & Property: NSW Health Policy & Standards for Security Risk Management in NSW Health Agencies

Outlines NSW Health policy on key aspects of personal and property security that assist local health districts to maintain an effective security program that is based on a structured, on-going risk management process, consultation, appropriate documentation and record keeping and regular monitoring and evaluation.

Goods and Services Procurement Policy Manual

This manual ensures high ethical standards and conduct in commercial engagements in NSW Health that complies with the NSW Procurement Board's Agency Accreditation Scheme requirements for the procurement of goods and services.



4.3 Delegations of Authority

4.3.1 Delegating statutory powers

The Minister, Secretary and the Health Administration Corporation may delegate their statutory functions under section 21 of the *Health Administration Act 1982*. There are also specific provisions for financial delegations under the *Public Finance and Audit Act 1983* and specific provisions for public service staff-related delegations under the *Government Sector Employment Act 2013*.

Public Health Organisations may also delegate powers they have under statute. Consistent with section 40 and section 61 of the *Health Services Act 1997* a chief executive can delegate to any of the officers or employees of the organisation the exercise of any functions other than:

- the power of delegation itself;
- the exercise of its functions to close or restrict health services;
- the authority to offer displaced staff members' voluntary redundancy or terminate staff of the NSW Health Service; and
- the power to make by-laws.

Although chief executives and boards can delegate their authority, they remain accountable to the Minister or Secretary for the performance of the organisation and for the implementation of any directions from the Secretary and the Minister for Health.

When an officer delegates functions or authority to another person, that person becomes accountable to the officer for the delivery of that function or the exercise of the authority. However, the officer who delegates a function or authority remains responsible for ensuring the delegate effectively exercises the delegated functions or authority.

The Delegations Manual for the Organisation

The chief executive must ensure that a written manual of delegations is maintained to record details of delegations of authority. A formal written instrument of delegation is to be signed and be available for audit. The written manual of delegations must set out what function of authority has been delegated, to whom, when, and any conditions or limits to the delegation.

In deciding what to delegate, chief executives and boards should consider:

- the structure of the organisation and the appropriate level to hold the delegation;
- an assessment of the risk of delegating the authority;
- an assessment of the knowledge and skill of the person to whom they plan to delegate; and
- processes needed to regularly monitor and review the exercise of delegation of authority.

4.3.2 **NSW Ministry of Health Delegation Manuals**

Manuals outlining the delegations of the Minister, the Secretary and the Health Administration Corporation are published at: <http://www.health.nsw.gov.au/policies/manuals/Pages/default.aspx>

Combined Delegations

The Combined Delegations Manual contains administrative, financial and staff type delegations of powers and functions that have been delegated by the Minister for Health, the Secretary and the Health Administration Corporation for the Ministry of Health.

Public Health Delegations

The Public Health Delegations Manual incorporates delegations derived from powers and functions specified in public health type Acts and Regulations including Poisons, Public Health and Mental Health Acts and Regulations.

HealthShare NSW Delegations

HealthShare NSW is an administration unit within the Public Health System Support Division of the Health Administration Corporation. The delegations contained in this Manual are based on the Health Administration Corporation (HAC) being the overarching entity under the auspice of which the work of HealthShare NSW will occur. It outlines the administrative, financial and staff type delegations conferred on HealthShare NSW by the HAC.

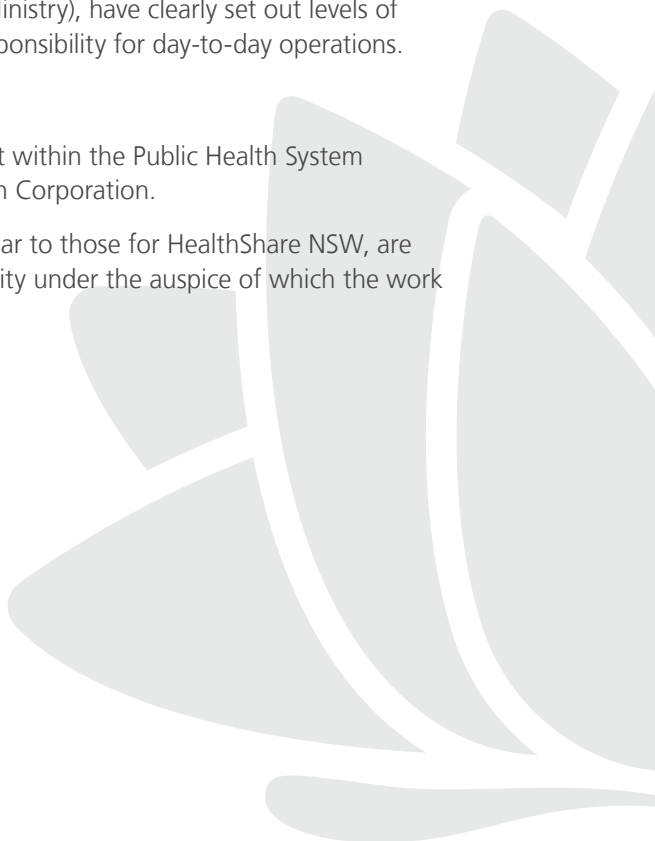
eHealth NSW Delegations

eHealth NSW is an administration unit within the Public Health System Support Division of the Health Administration Corporation (HAC). The delegations manual has been compiled to ensure both eHealth's appointed office holders and staff, and where eHealth NSW is an entity undertaking goods and services procurement under Agency Accreditation (issued by the Ministry), have clearly set out levels of authority and clarified accountability and responsibility for day-to-day operations.

Health Infrastructure Delegations

Health Infrastructure is an administration unit within the Public Health System Support Division of the Health Administration Corporation.

The delegations detailed in this Manual, similar to those for HealthShare NSW, are based on the HAC being the overarching entity under the auspice of which the work of Health Infrastructure occurs.



Legal & Policy Requirements – Resources & References

Legal

Australian legal database

Australasian Legal Information Institute; for all Australian Acts of Parliament (Commonwealth and State) and access to law journals and databases:
<http://www.austlii.edu.au/>

NSW Government legal database

NSW Government NSW Legislation website:
<http://www.legislation.nsw.gov.au/>

NSW Health legal, policy and procedural resources

NSW Health Legal compendium:
<http://www.health.nsw.gov.au/aboutus/legislation/pages/default.aspx>

NSW Health Human Resources E-Compendium:
<http://www.health.nsw.gov.au/careers/hrcompendium/pages/default.aspx>

NSW Health Policy Distribution System:
<http://www.health.nsw.gov.au/policies/pages/default.aspx>

NSW Health Policy and procedure manuals and delegation manuals:
<http://www.health.nsw.gov.au/policies/manuals/pages/default.aspx>

For information on public health sector record keeping, visit the State Records website:
<http://www.records.nsw.gov.au/recordkeeping/resources-for/public-health-sector/public-health-sector>

NSW Health Policy Directive Delegations of Authority – Local Health Districts and Specialty Health Networks (PD2012_059):
http://www.health.nsw.gov.au/policies/pd/2012/PD2012_059.html

NSW Health Policy Directive, Corrupt Conduct – Reporting to the Independent Commission Against Corruption (ICAC): (PD2011_070)
http://www.health.nsw.gov.au/policies/pd/2011/PD2011_070.html

NSW Health Policy Directive, Legal Matters of Significance to Government (PD2014_011):
http://www.health.nsw.gov.au/policies/PD/2014/PD2014_011.html

NSW Health Policy Directive, Prosecution Policy and Guidelines (PD2014_021):
http://www.health.nsw.gov.au/policies/PD/2014/PD2014_021.html

Combined Delegations Manual
<http://www.health.nsw.gov.au/policies/manuals/Pages/combined-delegations.aspx>

Health Infrastructure Delegations
<http://www.health.nsw.gov.au/policies/manuals/Pages/hlth-infras-delegations.aspx>

Public Health Delegations
<http://www.health.nsw.gov.au/policies/manuals/Pages/public-health-delegations.aspx>

HealthShare NSW Delegations
<http://www.health.nsw.gov.au/policies/manuals/Pages/healthshare-delegations.aspx>

eHealth NSW Delegations
<http://www.health.nsw.gov.au/policies/manuals/Pages/ehealth-delegations.aspx>

Useful websites

Commonwealth

Australian Health Practitioner Regulation Agency
<http://www.ahpra.gov.au/>

NSW Government Bodies & Agencies

Privacy NSW
http://www.ipc.nsw.gov.au/privacy/ipc_index.html

NSW Ombudsman
<http://www.ombo.nsw.gov.au/>

Advocate for Children and Young People
<http://www.acyp.nsw.gov.au/>

NSW Health Care Complaints Commission
<http://www.hccc.nsw.gov.au/>

Health Professional Councils of Australia (HPCA)
<http://www.hpca.nsw.gov.au>

Independent Commission Against Corruption
<http://www.icac.nsw.gov.au/>

NSW Office of Environment and Heritage
<http://www.environment.nsw.gov.au/>

Industrial Relations Commission of NSW
<http://www.industrialrelations.nsw.gov.au/Home.html>

For information on public health sector record keeping, visit the State Records website:
<http://www.records.nsw.gov.au/recordkeeping/resources/for-the-public-health-sector/for-the-public-health-sector>

Local Documentation

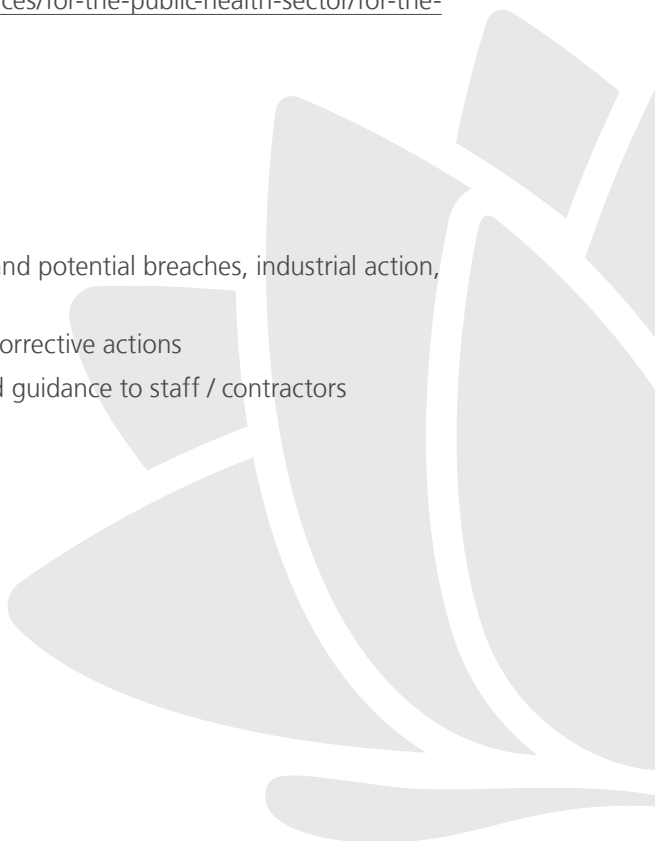
Model By Laws

Delegations Manuals

Local Registers – for example for licensing, litigation and potential breaches, industrial action, practice restrictions

Reports on compliance monitoring, compliance and corrective actions

Policies and procedures – which provide direction and guidance to staff / contractors



5 Clinical Governance

5.1 Clinical Governance Entities

5.1.1 Public Health Organisation Clinical Governance Units

Public health organisations are responsible for the quality and safety of the services provided by their facilities, staff and contractors. A common clinical governance framework has been embedded in public health organisations with local health districts and specialty networks having a consistent organisational structure, including a Clinical Governance Unit (CGU) directly reporting to the chief executive.

The roles of the CGUs are to develop and monitor policies and procedures for improving systems of care. CGUs contribute to the NSW Patient Safety and Clinical Quality Program by ensuring it is uniformly implemented across the State, and overseeing the risk management of patient safety and clinical quality by building upon existing incident management and investigation systems.

Where CGUs identify a concern with clinician performance, such must be reported to the chief executive for prompt action and management. Depending on the particular circumstances, such action might include; internal investigation; external investigation by a recognised expert; referral to the HCCC; referral to the professional registration council; or another appropriate agency (e.g. NSW Ombudsman, Department of Family and Community Services).

5.1.2 Clinical Excellence Commission

The Clinical Excellence Commission (CEC) was established to promote and support improved clinical care, safety and quality across the NSW health system.

The mission of the CEC is to build confidence in healthcare in NSW by making it demonstrably better and safer for patients and a more rewarding workplace. The CEC has an important role in assisting public health organisations to achieve and maintain adequate standards of patient care through system analysis and improvement. It does this by working collaboratively with key partners to facilitate safe, quality care for patients.

Following new governance arrangements in 2011, the CEC has taken on a broader role, including:

- providing system wide clinical governance leadership with local health districts and specialty networks, including supporting the implementation and ongoing development of local quality systems;
- developing policy and strategy related to improvements of clinical quality and safety across the NSW public health system and promoting and supporting improvement in clinical quality and safety in public and private health services;
- reviewing adverse clinical incidents arising in the NSW public health system and developing responses to those incidents including (but not limited to) co-ordinating responses to specific incidents with system or state-wide implications and providing advice to the Ministry of Health on urgent or emergent patient safety issues and staff safety issues in a clinical setting;
- building capacity within the system to identify and respond to risks and opportunities.

Clinical governance framework, role of Clinical Governance Units and reporting requirements

NSW Patient Safety & Clinical Quality Program

5.1.3 **Agency for Clinical Innovation**

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

- *Service redesign and evaluation* – applying redesign methodology to assist healthcare providers to review and improve the quality, effectiveness and efficiency of services.
- *Specialist advice on healthcare innovation* – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment.
- *Initiatives including Guidelines and Models of Care* – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system.
- *Implementation support* – working with ACI Networks and healthcare providers to assist healthcare innovations into practice across metropolitan and rural NSW.
- *Knowledge sharing* – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement.
- *Continuous capability building* – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to design improved models of patient care.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

5.1.4 **Bureau of Health Information**

The Bureau of Health Information (BHI) was established in 2010, to support transparency in health data and allow greater local control of information analysis.

The primary role of the BHI is to provide independent reports to government and the community on the performance of the NSW public sector health system. Performance measures include activity, access, effectiveness, efficiency, outcomes and safety and quality measures.

The key features of the BHI include:

- it operates at arms length from the local health districts, specialty networks and the NSW Ministry of Health;
- it provides a source of excellence for data about the NSW Health system for government, the community, and clinicians; and
- the ability to analyse data, commission research and extensively report on the quality, performance and effectiveness of services provided by NSW Health.

The BHI uses existing NSW Health data collections and, will over time, use other data sets to develop and report on the performance of NSW Health at a cascading level – whole of system, by local health network, by hospital and by clinical service. The BHI will, over time, also report benchmarked comparative data.

The reports and other data will be available to the public, clinicians, health care managers, media and researchers with an interest in health system performance.

The BHI works closely with the Clinical Excellence Commission, the Australian Institute of Health, the NSW Ministry of Health and other health performance information analysis groups to strengthen and enhance the quality and capability of health system performance analysis and reporting in NSW.

5.2 **Health District / Service Clinical Management and Advisory Structures**

5.2.1 **Clinical management structures**

For clinical governance and quality assurance structures and processes to be effective, it is important that they operate at all levels of the organisation and that those staff providing front line patient care are aware of and working within these structures and processes.

The successful implementation of clinical governance requires:

- the identification of clear lines of responsibility and accountability for clinical care and ensuring these are communicated throughout a public health organisation; and
- the development of strong and effective partnerships between clinicians and managers.

A key accountability of the chief executives of public health organisations is to ensure that the clinical governance and quality assurance structures and processes are known, respected and followed by all staff.

To attract clinicians with leadership capability to clinical management roles, the positions need to be genuinely supported by management, and recognised and promoted as having influence. At the local health district level, it is important that clinical stream director roles (where they are established), have well-defined responsibilities and their relationship to the health district management structure (at both hospital and local health district level) is clearly identified.

At the hospital level, the roles and responsibilities of general managers and heads of departments need to be clearly defined. Similarly, where hospitals function as part of a network, there should be clearly defined responsibilities and lines of communication between key personnel.

There should also be clear rules of engagement between clinical stream directors, general managers and the local health district executive to ensure that all parties have appropriate input into the development, operation and standard of clinical services within their stream/facilities and across their local health district.

5.2.2 **Bodies established under by-laws**

Model By-Laws for Local Health Districts establish a number of clinical governance bodies and provide for a number of functional and advisory committees including:

- A Health Care Quality Committee of the Board;
- Medical Staff Councils and Medical Staff Executive Councils ;
- Hospital Clinical Councils and/or Joint Hospital Clinical Councils; and
- a Local Health District Clinical Council.

Local Health District Clinical Council

The role of the local health district clinical council is to provide a forum for discussing strategic planning, priorities for service development, resource allocation, clinical policy development and providing professional (expert) clinical guidance (where appropriate and when needed).

Local health district councils facilitate the input of clinicians into the strategic decision making process and bring together the local health district executive, clinical stream directors and general managers of hospitals/hospital networks on a regular basis.

Under the Model By-Laws the council provides the board and the chief executive with advice on clinical matters affecting the local health district, including on:

- improving quality and safety in the hospitals within the local health district;
- planning for the most efficient allocation of clinical services within the local health district;
- translating national best practice into local delivery of services;
- developing innovative solutions that best address the needs of the local communities; and
- such other related matters as the board or chief executive may seek advice on from time to time.

The Model By-Laws also provide that LHD Clinical Councils can be given additional functions to enable them to operate as Local Council Groups within Commonwealth requirements.

Hospital Clinical Councils / Joint Hospital Clinical Councils

Local health clinical councils operate at hospitals or hospital networks to promote clinician engagement in local management decision making. These forums are multi-disciplinary (i.e. involve medical, nursing and allied health staff).

The objectives of a hospital clinical council are to:

- provide a local structure for consultation with, and involvement of, clinical staff in management decisions impacting public hospitals and related community services;
- be a key leadership group for its public hospital or hospital network and work with the management team in ensuring that the hospital/s deliver high quality health and related services for patients;
- facilitate effective patient care and service delivery through a co-operative approach to the efficient management and operation of public hospitals with involvement from medical practitioners, nurses, midwives and allied health practitioners and clinical support staff; and
- be a forum for information sharing and providing feedback to staff (through the members of the councils) on issues affecting the hospital(s).

In determining whether to establish individual hospital clinical councils or joint hospital clinical councils, the chief executive and board have regard to:

- the size and budget of the public hospitals within the local health district;
- the number of clinical staff working at each public hospital within the local health district;
- whether a joint structure is the most practicable alternative for smaller hospitals; and
- whether the relevant hospitals are under a common executive management structure.

Medical staff councils

Under the Model By-Laws local health districts are to establish a medical staff council (in the case of a statutory health corporation) and a medical staff executive council and at least two medical staff councils (in all other cases).

Establishment, composition and role of Medical Staff Councils

Medical staff councils are to be composed of visiting practitioners, staff specialists, career medical officers and dentists with appointments to the public health organisation or the public hospital/s which the council represents.

All visiting practitioners, staff specialists, career medical officers and dentists of the public health organisation are members of the medical staff council. Sufficient medical staff councils should be established to ensure that all visiting practitioners, staff specialists, career medical officers and dentists of the public health organisation can participate, if they choose to.

The medical staff executive council or the medical staff council (if there is only one council) is to provide advice to the chief executive and board on medical matters.

Under clause 15 of Schedule 1 of the *Health Services Regulation 2013*, the Chair of the Medical Staff Council is entitled to attend Board meetings as an invitee.

Medical and Dental Appointments Advisory Committee

The Model By-Laws also provide for establishing a Medical and Dental Appointments Advisory Committee (MADAAC) to provide advice, and make recommendations to the chief executive concerning matters relating to the appointment or proposed appointment of visiting practitioners or staff specialists.

Establishment and role of Medical and Dental Appointments Advisory Committee and sub-committees

The MADAAC considers any application that has been referred to it for:

- appointment of a visiting practitioner or staff specialist; or
- a proposal to appoint a person as a visiting practitioner or staff specialist.

The MADAAC also provides advice, and where appropriate, makes recommendations to the chief executive concerning the clinical privileges (scope of clinical practice) which should be allowed to visiting practitioners, staff specialists and dentists.

The MADAAC committee may form sub-committees to provide advice or other assistance to enable it to perform its duties referred to in this clause.

The MADAAC committee must establish at least one subcommittee called the Credentials (Clinical Privileges) Subcommittee for the purposes of providing advice to the MADAAC on matters concerning the clinical privileges of visiting practitioners or staff specialists.

The minutes of the MADAAC should be submitted to the board for noting.

The chief executive is responsible for ensuring that the medical appointment process is also compliant with NSW policy PD2014_008 Model Service Contracts – VMO & HMO.

5.3 Quality Assurance Processes

5.3.1 Incident management

Incident
Management
Policy
(PD2014_004)

It is an underlying principle of the NSW Patient Safety and Clinical Quality Program that the public health system must operate in an environment of openness about failure, where errors are reported and acknowledged without fear or inappropriate blame and where patients and their families are told what went wrong and why.

The NSW Health incident management framework is set out in the Incident Management Policy (PD2014_004). This policy outlines the roles and responsibilities across the NSW Health system with respect to the management of both clinical and corporate incidents.

The objectives of the Incident Management Policy Directive are to:

- assist health districts with timely and effective management of incidents;
- establish a standard approach to incident management including the establishment of performance indicators to monitor compliance;
- ensure a consistent and coordinated approach to the identification, notification, investigation, and analysis of incidents with appropriate action on all incidents;
- allow the lessons learned to be shared across the whole health system;
- provide an essential resource for developing the skills required to effectively manage all health care incidents;
- ensure health districts establish processes that comply with the legal aspects of health care incident management including provisions in the *Health Administration Act 1982* for SAC 1 reportable incidents, and RCA investigations as well as the management of Reportable Incident Briefs (RIB) submitted to the Ministry.

The Incident Management policy can be accessed at: http://www.health.nsw.gov.au/policies/pd/2014/PD2014_004.html. All staff have responsibilities for the elimination and minimisation of clinical and corporate risks that could emerge within the health service environment.

Management of incidents requires a number of steps to be taken, including:

- i) assessment of risks;
- ii) taking any action necessary to address the immediate risk;
- iii) short to mid-term actions to manage the incident and make improvements to local health district practices and systems.

To support the implementation of the policy and program, the electronic Incident Information Management System (IIMS) [based on the Advanced Incident Monitoring System (AIMS)] has been developed and implemented throughout the NSW Health system. IIMS has been established to provide a system for notification of all incidents, including those with corporate consequences.

Appropriate resources should be allocated to support the incident management program. Longer term actions to improve quality and safety should include analysis of incident data and best practice initiatives.

The *Health Administration Act 1982*, requires chief executives to appoint a team to undertake a Root Cause Analysis of serious clinical incidents allocated a Severity Assessment Code (SAC) of 1. The chief executive may also conduct an RCA on SAC 2, 3 or 4 events if this is considered justified.

Root cause analysis
requirement:
*Health
Administration
Act 1982*

The *Health Administration Act 1982* also establishes a statutory privilege to protect the internal workings of Root Cause Analysis (RCA) Teams conducting investigation of serious clinical incidents (with a SAC of 1) via the Root Cause Analysis methodology.

The privilege will also apply if the chief executive directs an RCA to occur for a SAC 2, 3, or 4 clinical incident. Similar protections are also afforded to Quality Assurance Committees approved by the Minister.

5.3.2 Accreditation

The ten National Safety and Quality Health Service (NSQHS) Standards address the following patient focused areas:

- Standard 1: Governance for Safety and Quality in Health Service Organisations
- Standard 2: Partnering with Consumers
- Standard 3: Preventing and Controlling Healthcare Associated Infections
- Standard 4: Medication Safety
- Standard 5: Patient Identification and Procedure Matching
- Standard 6: Clinical Handover
- Standard 7: Blood and Blood Products
- Standard 8: Preventing and Managing Pressure Injuries
- Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care
- Standard 10: Preventing Falls and Harm from Falls

Each NSQHS Standard comprises a number of actions which are designated as either core (all core actions must be met to achieve accreditation) or developmental (developmental actions require activity but do not need to be fully met to achieve accreditation).

A health service must select an accrediting agency, approved by the Australian Commission on Safety and Quality in Health Care, to undertake its assessment against the NSQHS Standards over a three or four year cycle. If, at the time of an assessment, the accrediting agency determines that a health service does not meet a core action the health service has 90 days to implement quality improvement strategies to address the unmet action.

If, during an assessment, an accrediting agency identifies one or more *significant patient risks* the accrediting agency must notify the NSW Ministry of Health of this risk once identified. Examples of significant patient risks are described for each of the NSQHS Standards.

In addition to undergoing assessment against the NSQHS Standards by the accrediting agency, a health service is required, at each assessment, to provide to its accrediting agency evidence to demonstrate implementation of the NSQHS Standards. This evidence comprises information in response to measures relevant to the Standards.

Accreditation – Resources and References

For further information on accreditation and the National Safety and Quality Health Services Standards visit the Australian Commission on Safety and Quality in Health Care website at: <http://www.safetyandquality.gov.au/our-work/accreditation/>

The NSQHS Standards can be accessed at: <http://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/>

Details about the evidence of implementation measures (page 13) are available under collection and reporting of accreditation evidence by accrediting agencies and can be accessed at: <http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/information-for-health-service-organisations/#Collection-and-reporting-of-accreditation-evidence-byAAs>

Details about *significant patient risk* can be accessed at: <http://www.safetyandquality.gov.au/publications/advisory-a1301-notification-of-significant-risk/>

For information on NSW Health resources to support the accreditation and the National Safety and Quality Health Services Standards visit the Clinical Excellence Commission website at: <http://www.cec.health.nsw.gov.au/resources/nsqhs>

Clinical Governance – Resources & References

For further information on the NSW Patient Safety and Clinical Quality Program visit the NSW Health website at: <http://www.health.nsw.gov.au/quality/index.asp>
http://www0.health.nsw.gov.au/policies/pd/2005/PD2005_608.html

For a listing of policy directives and guidelines relating to clinical governance visit the NSW Health website at: <http://www0.health.nsw.gov.au/policies/owner/cec.html>

The NSW Health Enterprise Risk Management policy can be accessed at: http://www0.health.nsw.gov.au/policies/pd/2015/PD2015_043.html

Useful websites

Clinical Excellence Commission: <http://www.cec.health.nsw.gov.au>

Agency of Clinical Innovation: <http://www.aci.health.nsw.gov.au>

Bureau of Health Information: <http://www.bhi.nsw.gov.au>

Health and Education Training Institute: <http://www.heti.nsw.gov.au>

Excellence and Innovation in Health Care: <http://www.eih.health.nsw.gov.au/>

Local Documentation

Health Services Act 1997 Model By-laws

Board and committee terms of reference or charter

Enterprise-wide risk management program specific to each local health district and specialty network

Local protocols to facilitate implementation of Ministry of Health policies and procedures; and the incident management program

Accreditation survey results

6 Strategic & Service Planning

6.1 Strategic Planning Responsibilities

6.1.1 Role of Local Health Districts and Specialty Networks in Planning

Local health districts and specialty networks have a responsibility to effectively plan services over the short and long term to enable service delivery that is responsive to the health needs of its defined population. It is noted that for a number of clinical services, the catchment population extends beyond the geographic borders of the local health district or specialty network.

Generally, local health districts and specialty networks are responsible for ensuring that relevant Government health policy goals are achieved through the planning and funding of the range of health services which best meet the needs of their communities (whether those services are provided locally, by other local health districts, specialty networks or other service providers).

Under the *Health Services Act 1997*, Boards have the function of ensuring that strategic plans to guide the delivery of services are developed for the local health district or specialty network, and for approving those plans.

Local health districts and specialty networks, oversighted by their Board (where established), have responsibility for developing the following organisational plans:

- Strategic Plan;
- Health Care Services Plan;
- Corporate Governance Plan;
- Annual Asset Strategic Plan; and
- Operations/Business plans at all management levels of the local health district or specialty network.

Furthermore, local health districts and specialty networks, oversighted by their Board (where established), have responsibility to undertake the following planning activities:

- undertaking detailed service planning and workforce planning to ensure a sound foundation for investment decisions, both capital and recurrent;
- developing plans required by legislation, or as a result of specific requests from central agencies, such as the NSW Department of Premier and Cabinet;
- any planning considered necessary at the local level to respond to particular health issues, emergencies or service needs;
- developing plans to improve health outcomes in response to national, state and local health priority areas;
- developing and maintaining reliable information systems to support services planning and delivery, and the monitoring and evaluation of performance and health outcomes; and
- undertaking appropriate planning for primary care services, involving those stakeholders and service providers outside of NSW Health.

Boards also have the role of ensuring that the views of providers and consumers of health services, and other members of the community served by the local health district or specialty network, are sought in relation to the organisation's policies and plans for the provision of health services.

6.1.2 Role of the NSW Ministry of Health in Planning

The NSW Ministry of Health has responsibility for coordinating the planning of system-wide services, workforce, population health, asset planning and portfolio management, and providing advice to the Minister for Health and the Minister for Mental Health on these matters.

The Ministry also has a role in informing national initiatives and coordination of system-wide responses to national health initiatives.

The role played by the NSW Ministry of Health in planning processes lies along a continuum, from setting broad directions to leading specific planning exercises. Activities include:

- setting policy and strategic directions for the overall NSW health system;
- planning for key services and as a result of national and state priorities;
- system-wide planning for information management, assets and procurement;
- providing direction and policy regarding population health issues;
- system-wide planning and strategy development for the workforce;
- capacity analysis to support and purchase some supra local health district and specialty network clinical services;
- providing guidelines, information and tools to facilitate local health service planning;
- providing advice and feedback to local health districts and specialty networks on local planning exercises as required;
- reviewing local planning in respect to achieving whole of system goals and objectives; and
- ensuring that the NSW Department of Premier and Cabinet, NSW Treasury and other central agency requirements are met.

6.2 Planning Documents

A range of planning and policy documents govern the operation of the NSW public health system and individual health agencies. Key plans include:

6.2.1 The NSW 2021 Plan

The NSW Government's State Plan, titled *NSW 2021 A Plan to Make NSW Number One* sets out clear targets for improved outcomes and service delivery, including health services.

6.2.2 The NSW State Health Plan

The *NSW State Health Plan Towards 2021* sets the overall strategy for NSW Health, aligns with NSW Government policy and reflects the goals and targets for Health in the NSW State Plan.

The *NSW State Health Plan* provides a strategic framework which brings together NSW Health's existing plans, programs and policies and sets priorities across the system for the delivery of 'the right care, in the right place, at the right time'.

The NSW State Health Plan highlights strategies to deliver on health priorities and improved health outcomes, and builds on previous reforms focusing on devolved decision-making, health system integration and increased transparency of funding and performance.

Key planning documents include the State Plan, NSW Health Workplace Culture Framework, Closing the Gap Aboriginal Health Impact Statement and Guidelines, Keep Them Safe.

It has three directions:

1. Keeping people healthy;
2. Providing world class care; and
3. Delivering truly integrated care.

These directions are supported by four strategies:

1. Supporting and developing our workforce;
2. Supporting and harnessing research and innovation
3. Enabling eHealth; and
4. Designing and building future-focused infrastructure.

The delivery of the State Health Plan is the responsibility of the whole NSW Health system.

6.2.3 **NSW Health Workplace Culture Framework**

The Workplace Culture Framework has been designed to embed cultural improvement strategies as part of the core business of every health organisation. It embodies the CORE values for the NSW Health system of Collaboration, Openness, Respect and Empowerment, and identifies the characteristics and elements of workplace culture which are expected to be embedded at every level of service

Chief executives are expected to implement the framework, including the CORE values, in their workplace culture planning and all aspects of their service delivery.

6.2.4 **NSW Health Professionals Workforce Plan 2012-22**

Workforce is the most significant input into the delivery of health services. However, it can become a significant constraint when there are insufficient skilled and qualified health professionals available to meet workforce requirements. There are many factors which affect service provision, including inadequate supply or distribution of the workforce and changing work practices and demands. As such, service development strategies need to be integrated with workforce analysis and workforce strategy development.

The *NSW Health Professionals Workforce Plan 2012–2022* seeks to address the long term projected workforce needs of NSW Health. The Plan provides the policy objectives, and local and collaborative activities – between the Ministry, local health districts, specialty networks, Pillar agencies, the Commonwealth Government, specialty medical colleges and universities – to ensure that New South Wales trains, recruits and retains appropriate numbers of doctors, nurses and midwives and allied health professionals in the appropriate locations.

6.2.5 **Closing the Gap**

Closing the Gap is a commitment by all Australian governments to improve the lives of Indigenous Australians, and in particular provide a better future for Aboriginal and Torres Strait Islander children. A national integrated strategy has been agreed through the Council of Australian Governments (COAG) including specific timeframes for achieving targets relating to Indigenous life expectancy, infant mortality, early childhood development, education and employment.

The NSW Implementation Plan for Closing the Gap addresses five key priority areas:

- tackling smoking;
- healthy transition to adulthood;

- making Indigenous health everyone's business;
- primary health care services that can deliver; and
- fixing the gaps and improving the patient journey through the health system.

The NSW Ministry of Health has responsibility for the roll out, management, delivery and evaluation of outcomes of the Implementation Plan. This includes coordinating and managing the delivery of a range of inter-sectoral initiatives which involve local health districts, Aboriginal Community Controlled Health Services and the Aboriginal Health and Medical Research Council NSW. All public health organisations will play an important role in achieving the Closing the Gap targets, particularly in relation to life expectancy, child mortality and employment.

6.2.6 **Aboriginal Health Impact Statement and Guidelines**

NSW Health Policy Directive PD2007_082 *NSW Aboriginal Health Impact Statement and Guidelines* ensures the needs and interests of Aboriginal people are embedded into the development, implementation and evaluation of all NSW Health initiatives. The Impact Statement should be used as a tool to assist with appropriate consultation and engagement with Aboriginal stakeholders to ensure that any potential health impacts (of the initiative) to Aboriginal health and health services are adequately identified and addressed.

6.2.7 **Keep Them Safe**

Keep Them Safe is a whole of Government program responding to the Report of the Special Commission of Inquiry into Child Protection Services in NSW (November 2008). The plan aimed to fundamentally change the way children and families are supported and protected, to improve the safety, welfare and wellbeing of all children and young people in NSW.

Keep Them Safe is focused on shared responsibility and intends to build on the strengths of the current child protection system. It includes actions to enhance the universal service system, improve early intervention services, better protect children at risk, support Aboriginal children and families, and strengthen partnerships with non-government organisations in the delivery of community services.

It also includes the new risk of significant harm reporting threshold for mandatory reporters with concerns about children and young people. The Online Mandatory Reporter Guide can be accessed at: http://www.keepthemsafe.nsw.gov.au/reporting_concerns/mandatory_reporter_guide

NSW Health is lead agency for 28 actions in Keep Them Safe and is involved in many key actions requiring cross-agency collaboration. NSW Health's actions have been organised into 21 projects, which are being implemented by the Ministry of Health in collaboration with local health districts and specialty networks.

6.3 **Local Planning Documents**

6.3.1 **Health Care Services Plans**

Each local health district or specialty network will undertake a full range of strategic and operation planning. As part of this process, the Health Care Services Plan (HCSP) will be the most comprehensive plan, providing the service direction and detail of priorities for a local health district or specialty network over a five to ten year horizon, with specific focus on those issues which affect the health of the catchment population and the delivery of services.

The information and analysis provided by the Health Care Services Plan is particularly important with regard to strategic planning and priority setting for appropriate capacity to respond to demand. It is vital that there be an appropriate balance between investments in various services. The value and quality of a Health Care Services Plan will depend on the quality of a number of separate, but inter-dependent foundation planning processes, which focus more specifically on areas such as clinical services, health improvement, workforce and assets. This Plan should also consider the provision of safe and efficient health care within the available recurrent budget through the Activity Based Funding (ABF) framework and the best approach to service delivery. This is the planning mechanism where value for money opportunities are investigated and may include partnering with other service providers, public or private, not-for-profit and / or other non-governmental organisations (NGOs).

6.3.2 Business plans

Business plans describe the operational intentions of identified administrative groupings for each financial year. In general, they present information on goals, detailed annual strategies, targets, accountabilities and performance measures.

Business plans are prepared at various levels in the system and integrate unit and organisational activities with the Health Care Services Plan. They are distinguished from annual Service Agreements and performance agreements by their stronger focus on the detail of operational activities, which might also reflect a more “bottom-up” approach.

Some local health districts and specialty networks may choose to prepare Strategic Resource Plans (SRPs), as this provides an opportunity to examine the interaction of plans and investment decisions across financial, human and capital dimensions. The Asset Strategic Plan is an example of a Strategic Resource Plan.

The Ministry of Health and individual local health districts and specialty networks should put in place processes for business planning to ensure the coordination and articulation of the various plans developed are communicated along with any local priorities or strategies, to their subordinate locations such as divisions, branches, streams, facilities and units, within the Ministry of Health, local health districts and / or specialty networks.

Business plans should be finalised at the beginning of each financial year. The Ministry has no involvement in the development of business plans by local health districts or specialty networks, or units within local health districts and / or specialty networks. However, local health districts and specialty networks embarking on Strategic Resource Plans should discuss this with the Ministry to put in place a collaborative planning process.

6.3.3 Specific service plans

The form, scope and content of service plans are influenced by the nature of service under consideration and the objectives of the particular planning exercise. However, they have the common elements of documenting, reviewing, gap analysis, priority identification and costing.

Service plans may focus on a particular type of service, such as community health care; a particular category of services, such as maternity; a particular population group, such as Aboriginal people or those with chronic illness; or a particular health issue, such as drug and alcohol use.

In some cases, such plans may be required as part of agreements with the Commonwealth and other State Government agencies. Local clinicians, clinical networks and Pillar organisations, such as the Agency for Clinical Innovation; Clinical Excellence Commission; Health Education and Training Institute; NSW Kids and Families and the Cancer Institute NSW will also provide valuable reference points for the development of these plans.

Each local health district and specialty network must develop an Aboriginal Health Implementation Plan with Key Performance Indicators (KPIs) that are reported against to monitor progress towards Commonwealth and State commitments to reducing the health disparity between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

Health improvement is an integral aim of service planning, and all service plans should address, among other things, desired health outcomes and how these will be measured for the specified service. Service plans should also take into account evidence of effectiveness of interventions, where this is available. The timetable for producing specific service plans will vary and may be influenced by the requirements of central agencies, the framework provided by relevant state-wide policy or planning documents, and/or targets negotiated in annual Service Agreements.

6.3.4 **Workforce strategy plans**

Local health districts and specialty networks have lead roles in the implementation of strategies contained in the NSW Health Professionals Workforce Plan 2012-22 in some cases jointly with other institutions and Pillars, in other cases as the sole lead organisation.

Local health districts and specialty networks report progress against each of the strategies in which they have a lead implementation role.

Local health districts and specialty networks also undertake more detailed local workforce plans that identify the numbers and types of staff required to meet service needs. A long lead time is important in order to provide advice to the Ministry and education and training agencies on the numbers and types of health service staff required to meet population demand in the future.

In addition, each local health district, specialty health network and other NSW Health organisation, in response to the NSW Health Aboriginal Workforce Strategic Framework 2011-2015, is required to develop and implement a local Aboriginal Workforce Action Plan. This Action Plan is to outline actions locally to meet the NSW Government's commitment to achieve 2.6% employment of Aboriginal staff by 2015 and halve the gap in employment outcomes between Aboriginal and non-Aboriginal people. The local actions should reflect the proportion of Aboriginal and Torres Strait Islander people at the local level. Local health districts, specialty networks and other NSW Health organisations are required to provide regular reports against Key Performance Indicators for consideration by the NSW Aboriginal Workforce Strategic Steering Committee.

6.3.5 **Financial plans**

Financial planning is inherent in most management activities undertaken within the health system. It is primarily concerned with identifying the sources and applications of funds, with the aim of achieving value for money. In addressing these issues, financial planning should take into account issues of relative need, equity, efficiency, effectiveness and appropriateness.

Financial planning occurs at the Ministry, local health district, specialty network and individual division / service levels. The Ministry of Health is not directly involved in the development of local health districts or specialty networks detailed financial plans, but has separate financial reporting arrangements to manage and monitor local health districts and specialty networks state-wide budget performance.

6.3.6 **NSW Health Total Asset Management and Asset Strategic Plans**

Total Asset Management (TAM), as defined by NSW Treasury, is a strategic approach to physical asset planning and management, whereby an agency aligns its ten year asset planning with its service delivery priorities and strategies, within the limits of resources available.

The development of the NSW Health Total Asset Management submission is guided by the NSW Government's overarching asset management policy. The policy sets out the Government's directives on how its Departments, Ministries and Agencies should undertake the management of assets to enable service delivery objectives to be met effectively and to provide a foundation for economic growth. The NSW Ministry of Health is currently developing a NSW Health specific Asset Management Framework that will embrace and enhance government and internal asset management policy and provide further guidance and direction in the discipline of portfolio asset management.

Its purpose is to advance the management of assets and better integrate assets and service provision. The Total Asset Management policy is part of the overall NSW capital expenditure submission framework, also comprising of the procurement policy framework with business cases and Gateway Reviews, and the commercial policy framework, including Statement of Business Intent (SBI), Statement of Corporate Intent (SCI), and projects of State Significance.

The NSW Health annual Total Asset Management submission comprises the NSW Health Asset Strategy, Total Asset Management Data Tables and individual capital business cases for specific programs and projects as applicable.

The NSW Health Asset Strategy is a high level strategic plan for Health to demonstrate the relationship between the performance of its physical asset portfolio and the services it delivers.

The Asset Strategy is developed to determine whether assets should be enhanced by capital investment, maintained, or disposed of, or retained to continue their role in supporting service delivery.

As part of informing the NSW Health Asset Strategy, Asset Strategic Plans by each of the local health districts and specialty networks are a key input to this process, in providing detail of potential future capital investments; asset maintenance; and asset disposals.

Each local health district or specialty network is responsible for the development of their Asset Strategic Plan. The objective of asset strategic planning is to demonstrate the alignment of NSW Health assets with service needs and where appropriate, identify the gaps between asset supply and future requirements for assets. These requirements may relate to unmet or forecast service demand requiring increased infrastructure capacity or a change in the nature of the health service model of care or technology.

The Asset Strategic Plan of a local health district or specialty network will be based on the Health Care Services Plan. The outcome of the Asset Strategic Plan process is an assessment of whether assets should be retained and enhanced through capital investment; continue to be maintained, or to be disposed.

The priority and timing of implementation of capital investment and asset disposal strategies of individual local health districts and specialty networks is influenced and determined by resource availability and other investment priorities that may be approved in the Ministry of Health's State-wide Asset Strategy and Capital Investment Strategic Plan.

6.3.6.1 **Capital Investment Strategic Plan (CISP)**

The Capital Investment Strategic Plan has a ten year horizon and outlines the aggregation of NSW Health's capital projects based on needs and priorities, including estimated total costs and cash flow for the annual budget process (Year 1) and forward estimates period (Years 2-4). Future priority projects that are likely for inclusion in the outer years (Years 5-10) are also identified.

Capital investment projects approved for inclusion in the NSW Health Asset Strategy and Forward Capital Investment Strategic Plan are prioritised in the context of competing State-wide investment needs and the constraints of funding allocations made available to NSW Health through the annual Budget process.

Planning and delivery of approved investment projects is to be undertaken in accordance with PD2010_035 Process of Facility Planning (POFP) and other relevant Ministry of Health policy directives.

6.3.6.2 **Asset Maintenance Strategic Plan**

The Asset Maintenance Strategic Plan aims to identify and define operational maintenance, repairs and replacement needs and provides a guide to proactive management and minimisation of risk from the asset failure or the inability of assets to support service delivery needs. The outcome sought is a more productive, safe and reliable asset portfolio and efficient use of available resources.

6.3.6.3 **Asset Disposal Plan**

A key component and outcome of the asset strategic planning process is the identification, declaration and shedding of under-utilised or obsolete property assets, which are determined, within the Health Care Services Plan horizons, by service planning and infrastructure strategies to be surplus to the requirements of constituent entities within the Health Cluster. Noting there is a need to adhere to specific conditions of trusts or grants.

The reference to property asset includes, but is not limited to all owned and leased land (including vacant land), buildings, and improvements including hospitals, health service facilities, ambulance facilities, dwellings and administrative facilities.

6.3.6.4 **Office Accommodation Plan**

The purpose of office accommodation planning is to demonstrate the methodology used by NSW Health to determine accommodation requirements while remaining consistent with the Government's accommodation strategies and targets.

Strategic and Service Planning – Resources & References

NSW State Plan:

<http://2021.nsw.gov.au>

NSW State Health Plan

<http://www.health.nsw.gov.au/statehealthplan/Pages/NSW-State-Health-Plan-Towards-2021.aspx>

NSW Health Workplace Culture Framework:

<http://www.health.nsw.gov.au/workforce/pages/workplace-culture-framework.aspx>

Council of Australian Governments National Indigenous Reform Agreement:

<http://www.coag.gov.au/node/145> <http://www.coag.gov.au/node/65>

Other resources available at:

Publications

<http://internal.health.nsw.gov.au/policy/ssdb/publication.html>

- NSW Acute Inpatient Projections –Final Report (2010)
- aIM2012 Data Book Version 1.0
- Acute/Subacute Modelling Tool aIM2012 and SiAM2012 User Guide Version 2.0
- Projecting Demand for Subacute Inpatient Activity – Final Report (2010)
- Activity Planning Guidelines for Subacute Inpatient Care Services (2010)
- SiAM2012 Data Book Version 1.0
- FlowInfo Version 11.0 – NSW Health Admitted Patient Service Planning Tool User Manual
- Guide to Role Delineation of Health Services – Rural Companion Guide (2004)
- Guide to Role Delineation of Health Services, Third Edition (2002)
- NSW Local Health Districts – Information Pack and Attachments
– LHD by LGA and LHD by SLA
- Principles for Emergency Care Models in NSW Small Rural Hospitals (August 2010)
- Defining Specialist Paediatric Activity Report – 2009 (2010)
- Service Planning Handbook for Rural Health Planners (September 2006)
- Guide for the Development of Area HealthCare Services Plans (2005)
- Asset planning documents

Local Documentation

Strategic Plan

Health Care Services Plan Corporate Governance Plan Asset Strategic Plan

Operations/Business plans (at all management levels) Specific service plans

Clinical and Population Service Plans Asset Strategy Plan

Total Asset Management Plan Asset Maintenance Plan

Asset Disposal Plan Workforce Strategy Plan Financial plans

Capital Investment Strategic Plan (CISP)

Disaster Plan

Office Accommodation Plan



7 Finance & Performance Management

7.1 Financial and Performance Management Obligations

Organisation performance monitoring and review of financial management form a key part of the system of internal controls for public health organisations. Chief executives and Boards are responsible for putting into place appropriate arrangements to:

- ensure the efficiency and effectiveness of resource utilisation by public health organisations; and
- regularly review the adequacy and effectiveness of organisational financial and performance management arrangements.

7.1.1 Budget allocations and conditions of subsidy

The State Budget is handed down in June each year reflecting the culmination of budget planning and negotiation between agencies and NSW Treasury, and decisions of Government over the preceding months to meet the costs of both ongoing services and also new services.

The Minister for Health approves initial cash allocations to public health organisations in accordance with s127 of the *Health Services Act 1997*. The Ministry issues budgets on or around State Budget day as detailed within Schedule C of the annual Service Agreement between the Ministry of Health and public health organisations.

It is a condition of subsidy payment to all public health organisations that the allocation of funds are expended strictly in accordance with the Minister's approval, as specified in the annual Service Agreement. The Financial Requirements and Conditions of Subsidy (Government Grants) a supporting document to the Service Agreement outlines NSW Health policy and expectations in relation to financial matters including accountability, budget and liquidity management, budget devolution, Auditor-General compliance, taxation, superannuation and leave. Section 2.2 of the of the Conditions of Subsidy requires Chief Executives to report monthly to the Ministry of Health's Finance Branch and to the Board of Board governed organisations.

Schedule C of the Service Agreement issued to public health organisations sets out the base budget, ABF and block funding and specific enhancements funded by the Commonwealth, NSW Government or internal to NSW Health.

When reviewing and monitoring the financial aspects of the administration of their organisation, the LHD Chief Executives and Boards must ensure:

- arrangements are in place to enable the proper conduct of the public health organisation's financial affairs and to monitor the adequacy and effectiveness of these arrangements;
- arrangements are in place so that the public health organisation's financial affairs are conducted in accordance with the law and relevant regulations;
- the financial standing of the public health organisation is soundly based and complies with statutory financial requirements, financial obligations, relevant codes and guidelines, level of reserves and provisions, financial monitoring and reporting arrangements, and the impact of planned future policies and known foreseeable future developments on the organisation's financial position;

- proper arrangements are in place to monitor the adequacy and effectiveness of the public health organisation's systems of internal controls including systems of internal financial control;
- adequate arrangements are in place to maintain proper standards of financial conduct, and to prevent and detect fraud and corruption;
- systems of internal controls are in place to ensure the regularity of financial transactions and that they are lawful;
- the maintenance of proper accounting records; and
- preparation of financial statements that give a true and fair view of the financial position of the health organisation and its expenditure and income.

7.1.2 Finance and Performance Committee

7.1.2.1 Establishment

The Model By-Laws provide that local health districts must establish a Finance and Performance Committee to assist the board and the Chief Executive to ensure the operating funds, capital works funds and service outputs required of the organisation are being managed in an appropriate and efficient manner, and consistent with the requirements of the LHD's Service Agreement with the Secretary, NSW Health.

The Finance and Performance Committee is required to be established as a subcommittee of the board, or the board itself may act as the Finance and Performance Committee. Where the full board fulfils the role of the committee, financial reports should be received and discussed at each ordinary meeting of the board (i.e. they must not be noted or deferred).

7.1.2.2 Membership

Where a Finance and Performance Committee is established as a sub-committee of the board it should include the Chief Executive as a member and provide for attendance of the Director of Finance. Under the By Laws, the chair of the Audit and Risk Management (ARM) committee cannot also be appointed as the chair of the finance and performance committee.

7.1.2.3 Meeting and procedures

Minutes

Where the Finance and Performance Committee is established as a sub-committee of the board, its deliberations and minutes must be submitted to the board for approval.

Reporting

Reporting processes must be in place to allow the Finance and Performance Committee to review the efficiency and effectiveness of the organisation in delivering its strategic objectives and in meeting its accountabilities as prescribed in the annual Service Agreement.

The main purpose of reporting is to provide relevant information to enable the committee to understand the organisation's performance against service and activity levels and the management of resources applied for the delivery of these services set out in the Service Agreement. This indicates but is not limited to budget consideration, use of staff resourcing and other inputs used in service delivery. Identification of any exposure to financial risks and the extent to which they are being effectively managed are key considerations when assessing the impact of these risks on the overall performance of the organisation.

**Key elements of
monthly financial
reports**

.....

Reports prepared for the Finance and Performance Committee must represent a fair and true view of the performance of the organisation, and should include effective strategies which the Chief Executive proposes to utilise to mitigate and resolve risks. All reports to the Finance and Performance Committee should include advice from management which reconciles the information within any report to the committee with monthly reports provided to the Ministry of Health.

Reports to the Finance and Performance Committee should be succinct and focus on key issues that require attention, in a narrative style rather than voluminous pages of detailed figures. They should be prepared in accordance with accounting standards and statutory requirements as well as guidelines issued from time to time by the Ministry of Health.

An executive summary should be included in the Finance and Performance Committee report to highlight key financial and performance issues requiring the attention of the Committee.

The Finance and Performance Committee should ensure it receives monthly reports that include the following information as a minimum:

- year to date and end of year projections regarding the financial performance and financial position of the organisation;
- financial performance of each major cost centre;
- any mitigation strategy to resolve financial performance issue in order to achieve budget;
- liquidity performance;
- the position of Special Purpose and Trust funds;
- the financial impact of variations to activity targets;
- advice on any investments;
- bad debts and write-offs;
- activity performance against indicators and targets in the service agreement for the organisation;
- advice on the achievement of strategic priorities identified in the service agreement for the organisation;
- year to date and end of year projections on capital works and private sector initiatives; and
- year to date and end of year projections on expenditure; and achievements against efficiency improvements and other savings strategies;
- progress against targeted strategies in Financial Recovery Plans required under the NSW Health Performance Framework (where the LHD/SHN has been escalated to Performance level 2 or above).

A copy of the monthly narrative report and supporting documentation provided to the Ministry of Health is to be tabled by management at the next Finance and Performance Committee following month end.

Letters to management from the Auditor-General, Minister for Health, and the NSW Ministry of Health relating to significant financial and performance matters should be tabled at the next meeting of the Finance and Performance Committee.

Treasury Managed Fund results – both at premium and hindsight – for workers' compensation, motor vehicle, property, liability and miscellaneous insurance policies must be considered by the Finance and Performance Committee on, at least, a quarterly basis.

Attendance

The Chief Executive and Director of Finance should attend all meetings of the Finance and Performance Committee unless on approved leave.

7.2 **National Health Funding Reform**

7.2.1 **Health Reform Agreement**

The National Health Reform Agreement is referenced in the National Health Reform Act 2011 and all jurisdictions passed legislation to establish the National Health Funding Pool and Funding Administrator.

The Agreement, existing legislative instruments and national agencies remain in place until the Commonwealth negotiates changes.

The 2014-15 Federal Budget foreshadows that the Commonwealth will fund states through a combination of CPI and population growth from 2017-18.

7.2.2 **Activity Based Funding**

NSW continues to be committed to Activity Based Funding. The funding model incorporates activity based funding (ABF)- a funding approach based on a unit price for the number and types of services provided. It is a way of allocating funds based on the activity or services provided.

Using ABF helps make public health funding more effective because health service management can allocate their share of available State and Commonwealth funding based on real levels of patient care.

This ensures greater accountability for expenditure. The ABF approach allows public health planners, administrators, consumers and clinicians to see how and where taxpayer funding is being allocated.

ABF aims to fund the actual work performed within agreed targets. Essential elements are:

- *Targets* to specify level of activity to be undertaken by each LHD/SHN
- A *classification system* to group activity into classes with similar clinical profiles and resource use
- *Weighting* of activity-to indicate relative resource intensity of patients treatment
- A *price* at which the weighted activity will be paid



7.2.3 Activity Based Management

Activity Based Management (ABM) is an evidence based management approach that focuses on patient level data to inform strategic decision making. Through clinical costing results and other activity data, ABM allows clinicians and managers to identify areas for improvement and make informed decisions relating to patient care through the optimisation of resource allocation. It is a system for continuous improvement and it provides a link with service Key Performance Indicators (KPIs) where activity, cost and performance information is used to attain strategic and operational objectives.

ABM is underpinned by:

- Counting and reporting the services provided (timely and accurate coding and classification)
- Improving the accuracy and timeliness of costing services
- Understanding the relationship between price and cost, in order to make more informed decisions on services within the available funding parameters

7.2.4 The funding models in practice

Local Health Districts (LHDs) and Specialty Networks (SHNs) are funded on the basis of meeting local needs within agreed activity targets since 2012/13 when implementation of activity based funding (ABF) commenced. Initially ABF was applied to acute inpatients, emergency departments and non-admitted services.

In 2013/14, the second year of funding reform in NSW, ABF was extended to apply to sub and non-acute services and admitted mental health services. It was also the first time payments were made to LHDs with small rural and regional hospitals, on the basis of the NSW Small Hospitals Model.

The principles of ABF remain unchanged in 2014/15 with the focus now on embedding the ABF process as part of mainstream operational strategy and shifting to ABM, improving quality of data which informs funding allocation and using the available data to refine and improve funding allocation.

However, there are services that are not suitable for this type of funding such as teaching, training and research, population health and other activities not easily classified, these will continue to be funded as a total program or “block” funded until suitable funding mechanisms are decided.

7.3 NSW Health Performance Framework

Engagement of Local Health Districts and Specialty Networks with the NSW Health Performance Framework (PF) contributes to the realisation of NSW Health's CORE values – Collaboration, Openness, Respect and Empowerment.

Performance framework, assessment of PHO and service agreements

The Performance Framework provides a clear and transparent outline of how performance is assessed and how responses to performance concerns are structured. It applies to the following Health Services: the 15 NSW geographical Local Health Districts, the Ambulance Service NSW, Sydney Children's Hospitals Network, the Justice Health and Forensic Mental Health Network and the St Vincent's Health Network. In addition, from 2013/14, the Framework also applies to the following Support Organisations: the Agency for Clinical Innovation, Bureau of Health Information, Cancer Institute NSW, Clinical Excellence Commission, Health Education and Training Institute, HealthShare NSW, NSW Kids and Families, and NSW Health Pathology.

The Framework and its Key Performance Indicators are also relevant to clinical networks, units and Health Service teams within each Health Service.

The key attributes of the Framework are:

- **Transparency** clear agreed performance targets and responses to performance issues
- **Accountability** clear roles and responsibilities of the Ministry and Health Services.
- **Responsiveness** performance issues are identified early and responses are timely.
- **Predictability** Health Services will know what constitutes good performance and when a performance concern arises, the response that is required.
- **Recovery** the focus is on having a clear and practical path of recovery.
- **Integrated** the Framework incorporates NSW Health Strategic Priorities and links the objectives of safe, effective, patient centred and efficient health service delivery.
- **Consistency** responses to poor performance are proportionate to the issue being addressed.
- **Recognition** sustained and/or superior performance is appropriately recognised.
- **Informed Purchasing** The Framework provides the basis for clear communication and dialogue on policy and resources to support state and local planning and decision making.

The Performance Framework outlines the performance expected of Health Services and Support Organisations to achieve the levels of health improvement, service delivery and financial performance as set out in their Service Agreements or Service Compacts, respectively. The Framework, and the associated Key Performance Indicators (KPIs) listed in each organisation's Service Agreement or Service Compact, apply at both whole of Health Service or Support Organisation level and at facility/service levels, promoting and supporting a high performance culture.

The Framework also sets out the performance improvement approaches, responses to performance concerns and management processes that support the achievement of these outcomes in accordance with Government policy.

Service agreements and compacts

Service Agreements support the devolution of decision-making, responsibility and accountability for the provision of safe, high quality, patient centred care to Health Services by setting out the service and performance expectations for the funding and other support provided to these organisations. The objectives of Local Health District Service Agreements are:

- To enable the Local Health District to deliver high quality effective services that promote, protect and maintain the health of the community, and provide care and treatment to sick and injured people.
- To promote accountability to Government and the community.
- To ensure NSW Government and national health priorities, services, outputs and outcomes are achieved.
- To establish with the Local Health District a Performance Management and Accountability System that assists in the achievement of effective and efficient management and performance.
- To provide the framework for the Chief Executive to establish service and performance agreements within the Local Health District.
- To outline the Local Health District's roles and responsibilities as a key member organisation of a wider NSW public health network of services and support organisations
- To facilitate the progressive implementation of a purchasing framework incorporating activity-based funded services.
- To develop effective and working partnerships with Aboriginal Community Controlled Health Services and ensure the health needs of Aboriginal people are considered in all health plans and programs developed by the Local Health District
- To provide a framework from which to progress the development of partnerships and collaboration with Medicare Locals.
- To address the requirements of the National Health Reform Agreement in relation to Service Agreements.

Service Agreements for the other Health Services listed above, and Service Compacts for the Support Organisations, are individualised to reflect each organisation's functions and their legal status under Health legislation.

Performance requirements

Health Services are to meet the performance requirements as set out in the Service Agreements, within the allocated budget, and specifically:

- Successfully implement agreed plans that address the Strategic Priorities and Governance requirements;
- Meet activity targets within the set tolerance bands; and
- Achieve Key Performance Indicator targets. The KPIs and their contextual Service Measures are grouped under the current five performance domains:
 - Safety and Quality
 - Service Access and Patient Flow
 - Finance and Activity
 - Population Health
 - People and Culture

Key Performance Indicators (KPIs) have been established with related targets and performance thresholds. Performance against these indicators is reported in the monthly Health System Performance Report prepared by the NSW Ministry of Health and is assessed as follows for each KPI:

- **Performing:** Performance at, or better than, target
- **Underperforming:** Performance within a tolerance range
- **Not performing:** Performance outside the tolerance threshold

Each KPI has been designated into one of two categories:

- **Tier One:** Will generate a performance concern when the Health Service performance is outside the tolerance threshold for the applicable reporting period.
- **Tier Two:** Will generate a performance concern when the Health Service performance is outside the tolerance threshold for more than one reporting period.

In addition to KPIs, a range of Service Measures are included in the Health System Performance Report. They have been included to assist the Health Service or to improve the safety and efficiency of patient care through the provision of contextual information against which to assess performance.

In addition to the KPIs and Service Measures, the NSW Ministry of Health continues to monitor a broad range of measures for a number of reasons including strategic priorities, emerging health issues, implementation of new service models, reporting requirements to NSW Government central agencies, to the Commonwealth and participation in nationally agreed data collections with which the Health Service needs to comply.

Should a performance issue emerge with one or more of the monitoring measures, the issue is discussed with the Health Service. If the performance issue continues, the NSW Ministry of Health may determine to notify the Health Service of a transfer of the Measure(s) to become a KPI(s) until the performance issue is resolved.

Performance Review

A range of performance considerations are made to assess whether escalation/de-escalation is required. A performance concern does not always trigger an escalation in a Health Service's Performance level under the Framework (refer section below for a description of each Performance Level).

The performance of a Health Service is assessed in terms of whether it is meeting the performance targets for individual KPIs and, where applicable, is on track against agreed Recovery Plans. Response to performance concerns within the Performance Framework are not escalated or de-escalated solely on the basis of KPI results. Rather, KPI performance concerns act as signals that are viewed in the context of the Health Service's overall performance.

The level of performance concern in each case will be determined by the particular indicator(s), the seriousness of the issues, the speed with which the situation could deteriorate further and the time it would take to achieve turnaround. Whether or not an indicator is on trajectory to meet target within a reasonable and agreed time frame will also influence the level of performance concern.

Escalation and De-escalation processes

The following processes are undertaken to determine whether the performance of the Health Service warrants escalation/de-escalation. The NSW Ministry of Health monitors performance and:

- For Health Services with no existing performance concerns, if a performance concern arises, the Ministry will:
 1. Discuss the issue with the Chief Executive of the Health Service.
 2. If appropriate to the issue, formally request the Health Service to respond (Level 1 response).
 3. Based on the response from the Health Service, determines whether there is a need to escalate the performance review (to Level 2 or 3) and initiate a meeting with the Health Service to consider the proposed recovery plan and then continue to meet with the Health Service to monitor the implementation of the recovery plan.

Recovery plans are written plans prepared by the Local Health District, other Health Service or Support Organisation, signed off by the respective Board and submitted to the Ministry for agreement. The Ministry has the discretion to escalate the response to higher levels, based on assessment of progress with the recovery plan.

- For Health Services with an existing performance concern, assess whether sufficient progress has been made or whether performance escalation is required to a higher level of response.

The Ministry also assesses overall performance at quarterly meetings with all Health services and progress with addressing Strategic Priorities six-monthly.

Following a Performance Review meeting, the Ministry advises the Health Service chief executive of the proposed performance rating. Chief Executives advise their Boards of this advice. Where escalation to level 3 or 4 is proposed, the Ministry advises the Board Chair directly as well as the Chief Executive.

If there is a differing assessment of performance status by the Health Service to that proposed by the Ministry, the issue is discussed by the Deputy Secretary, System Purchasing and Performance and the Health Service Chief Executive.

If the matter is not resolved at that level, the issue is referred to the Secretary, NSW Health for resolution. The Secretary, NSW Health will consult with the Board Chair in determining the matter.

The performance rating of a Health Service and/or the level of response can be escalated or de-escalated at any time. When it is proposed to change a performance rating, the reasons for the change will be clearly explained in writing. In the case of an escalation, a clear summary of actions required to improve performance will also be provided.

Performance
response,
escalation and
recovery

The following table summarises the steps that guide a decision to escalate or de-escalate.

| Point of Escalation | Point of De-escalation | Response |
|---|--|--|
| Level 1: "Under review" – Assessment and advice | | |
| Performance issue identified | The issue is satisfactorily resolved. | <p>The Ministry notifies the Health Service Chief Executive of escalation to Level 1.</p> <p>The Health Service Chief Executive advises the Board of performance rating.</p> <p>The Health Service chief executive will be required to provide formal advice on:</p> <ul style="list-style-type: none"> • The reasons that led to the performance issue. • Whether any action is required and if so the intended action and timeframe. |
| Level 2: "Underperforming" – Recovery Plan required | | |
| The Ministry considers that the original performance issue that triggered a Level 1 response warrants a formal recovery plan and/or other performance issue(s) emerge warranting Level 2. | The performance issue is resolved and does not reemerge for at least one more reporting period (month/quarter as appropriate). | <p>The Ministry notifies the Health Service chief executive of escalation to level 2</p> <p>The Health Service chief executive advises the Board of performance rating.</p> <p>The Health Service will be required to:</p> <ul style="list-style-type: none"> • Undertake an in-depth assessment of the problem and identify options to address the problem • Provide a detailed recovery plan and a timetable for resolution. The plan is signed off by the Board. • Meet with the Ministry to formally monitor the recovery plan. <p>The time frame for recovery will be as agreed with the Ministry.</p> |
| Level 3: "Serious underperformance risk" – Additional support and involvement of the Ministry | | |
| The recovery plan is not progressing well and is unlikely to succeed without additional support and input from the Ministry. A revised recovery strategy has been developed. | The revised recovery strategy has succeeded and the performance issue shows no indication of reemerging in the ensuing three months. | <p>The Ministry will meet with the Health Service chief executive and Board Chair to formally advise of escalation to Level 3.</p> <p>The Health Service is to develop a recovery strategy satisfactory to the Ministry of Health. The Ministry may require the strategy to include:</p> <ul style="list-style-type: none"> • Assigning staff identified by the Ministry to work collaboratively with the Health Service to develop and implement the Strategy; and/or • Assigning staff identified by the Ministry to have a more direct involvement in the operation of the Health Service. <p>Progress will be formally monitored over a time frame agreed with the Ministry.</p> <p>The Minister may appoint a representative for the specific purpose of assisting the Board to effectively oversee necessary performance improvements including attending Board meetings for that purpose.</p> <p>The timing and scope of any action will be determined by the nature of the performance issues.</p> |

| Point of Escalation | Point of De-escalation | Response |
|---|--|---|
| Level 4: "Health Service challenged and failing" – Changes to the governance of the Health Service may be required | | |
| The recovery strategy has failed and changes to the governance of the Health Service may be required. | The performance issue has improved and there is demonstrable evidence that the Health Service now has the capability to have full responsibility for the operation of the service. | <p>The Secretary, NSW Health will meet with the Health Service chief executive and Board Chair to formally advise of escalation to Level 4.</p> <p>The timing and scope of any action will be determined by the nature of the performance issues.*</p> <p>These may include:</p> <ul style="list-style-type: none"> • the Secretary, NSW Health commissioning an independent review of Health Service governance and management capability; and/or • the Minister: <ul style="list-style-type: none"> – requiring the Board Chair to demonstrate that the chief executive is able to achieve turnaround within a reasonable time frame;* – determining to change the membership of the Board and/or appointing an Administrator.* <p>NOTE * Nothing in this document is to be taken as affecting or limiting the discretion to exercise powers under sections 29, 52 or 121N of the Health Services Act.</p> |

Escalation and de-escalation may not be sequential. The initial level of escalation and response is based on the seriousness of the performance issue, the likelihood of rapid deterioration and the magnitude of the issue. For example, there may be circumstances where the seriousness of the situation calls for an escalation from Level 2 directly to Level 4.

In assessing recovery plans and monitoring progress, the Ministry is assisted by the Clinical Excellence Commission and/or the Agency for Clinical Innovation, where relevant, to consider the performance issues of concern.



Finance & Performance Management – Resources & References

Funding Reform – NSW Health Performance Framework

<http://www.health.nsw.gov.au/Performance/pages/frameworks.aspx>

NSW Health, Accounts and Audit Determination for public health organisations:

<http://www.health.nsw.gov.au/policies/manuals/Pages/accounts-audit-determination.aspx>

NSW Health, Accounting Manual for public health organisations:

<http://www.health.nsw.gov.au/policies/manuals/Pages/accounting-manual-pho.aspx>

NSW Health, Fees Procedures Manual for public health organisations:

<http://www.health.nsw.gov.au/policies/manuals/Pages/fees-manual.aspx>

NSW Health, Goods and Services Procurement Policy Manual:

<http://www.health.nsw.gov.au/policies/manuals/Pages/goods-services-procurement.aspx>

NSW Health Policy Directive, *Episode Funding Policy 2008/2009 – NSW* (PD2008_063)

http://www.health.nsw.gov.au/policies/pd/2008/PD2008_063.html

NSW Health, Accounting Manual for the Ministry of Health:

<http://www.health.nsw.gov.au/policies/manuals/Pages/accounting-manual-for-moh.aspx>

NSW Health, Goods and Services Tax and Fringe Benefits Tax Manuals:

<http://internal.health.nsw.gov.au/finance/taxissues.html>

NSW Ministry of Health, Finance and Business Management Branch intranet site:

<http://internal.health.nsw.gov.au/finance/index.html>

NSW Public Sector, Community of Finance Professionals:

<http://www.finacc.net.au/>

Council of Australian Governments (COAG) National Health Reform Agreement:

<http://www.coag.gov.au/node/96>

Local Documentation

Service Agreement – annual agreement between the public health organisation and the Ministry of Health.

Individual Performance Agreements – Chief Executive and Tier 2 of Local Health District and the Ministry of Health

Recovery plans (if needed). A Recovery plan is generally an agreed strategy and timeline to address a specific performance concern.



8 Workforce & Employment

8.1 Employment Powers and Functions

8.1.1 The NSW Health Service

The NSW Health Service consists of those staff employed by the NSW Government in the service of the Crown, under Part 1 of Chapter 9 of the *Health Services Act 1997*. The NSW Government can employ staff to enable the Secretary, NSW Health and public health organisations to exercise their functions.

8.1.2 Role of the Secretary, NSW Health

Under section 116 of the *Health Services Act 1997*, the Secretary, NSW Health exercises the employer functions of the Government in relation to the staff employed in the NSW Health Service. These functions can be delegated by the Secretary, NSW Health, under section 21 of the *Health Administration Act 1982*.

The Secretary, NSW Health approves:

- all non-standard contracts of employment / engagement; and
- state-wide industrial matters.

As set out in the Combined Delegations Manual, the Secretary, NSW Health has nominated line managers (including chief executives) to conduct the performance review for non-chief health executives. The Secretary, NSW Health has delegated to the Board Chair of Local Health Districts the responsibility for conducting the performance review of its chief executive. Only the Secretary, NSW Health can remove a health executive from an executive position and terminate his/her employment contract. A board may recommend to the Secretary, NSW Health the removal of a chief executive of a local health district.

8.1.3 Role of Chief Executives

The Combined Delegations Manual provides chief executives with general responsibilities to manage staff of the NSW Health Service within the local health districts and other public health organisations.

This delegation is subject to:

- compliance with all Policy Directives and Instructions;
- compliance with specific delegations relating to particular aspects of the employment function:
 - conditions for approval of voluntary redundancies; and
 - conditions for re-grading and/or re-classification of positions.
- the provisions of all industrial awards, agreements and determinations where they prescribe the criteria to be followed in the grading / classification of positions – and the views of grading committees where relevant;
- maintenance of a staff profile in accordance with any instructions issued by the Ministry for the relevant Division of the NSW Health Service;
- the involvement of the Secretary, NSW Health's nominee in the selection process where an appointment requires the approval of the Secretary, NSW Health;

Secretary, NSW Health has employer function of government under s116 of the Health Services Act

Combined Delegation Manual and compliance requirements

- compliance with the Ministry's policy regarding the right to private practice for salaried senior medical and dental practitioners; and
- prior written approval from the Deputy Secretary, NSW Health, Governance, Workforce & Corporate or Director, Workplace Relations in respect of the settlement of any employment or industrial dispute or termination of employment, of any member of the NSW Health Service which involves the payment of money or benefits over and above award or statutory conditions and entitlements.

Chief executives may authorise, in writing, the exercise of functions relating to managing staff to another person from within their Division of the NSW Health Service. However, only chief executives are authorised to:

- offer displaced staff members' voluntary redundancy or
- terminate staff of the NSW Health Service

These powers cannot be further delegated.

The chief executive's approval is required for the following functions:

- transferring health services employees between districts;
- re-grading and/or re-classifying positions; and
- developing a workforce strategy consistent with the NSW Health Professionals Workforce Plan 2012-22.

Health executives, including chief executives, cannot approve self-related matters under any of the Health Executive Service delegations (such as appointment to positions, salary rates and variations, approval of leave and acting in higher duties).

Other employment functions which must be approved by the Secretary, NSW Health include:

- determining any non-standard conditions for visiting practitioners; and
- determining any over-award payments or benefits.

8.2 Workforce Recruitment

The key NSW Health policy directives dealing with workforce recruitment are PD2012_028 *Recruitment and Selection of Staff of the NSW Health Service* and PD2014_001 *Appointment of Visiting Practitioners in the NSW Public Health System*. Other policy directives deal with more specific aspects of recruitment. The information contained in this section is a summary of those matters which are considered to be of particular importance to the board to assist with fulfilling its governance responsibilities.

8.2.1 Aboriginal Workforce Participation

There are currently two major Frameworks which guide NSW Health services in improving Aboriginal participation in the health workforce.

PD2011_048 NSW Health Good Health – Great Jobs Aboriginal Workforce Strategic Framework 2011 - 2015

Aboriginal employees currently make up 1.9% (Premier's Workforce Profile, EEO data) of the total NSW Health workforce. The NSW Government has set a target of 2.6% across the public sector by the year 2015. There are a number of key performance indicators against which all health services must measure their success and report six monthly. Health services are required to have an Aboriginal Workforce plan which links the Good Health – Great Jobs framework.

PD2011_069 Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health

This State-wide Framework outlines the learning outcomes for Aboriginal Cultural Training across the sector. By providing appropriate Aboriginal cultural training, organisations will become more culturally safe, providing better health services and improved health outcomes to the Aboriginal community.

Health services staff must participate in the Respecting the Difference Aboriginal Cultural Training program comprised of eLearning and face to face elements. eLearning is available online for all staff members. Health services should have developed and be in the process of delivering their local face to face training packages.

8.2.2 **Recruitment of Medical Staff – Area of Need**

The Area of Need program was developed to assist the recruitment of suitably qualified International Medical Graduates (IMGs) to vacant medical positions approved by the NSW Ministry of Health as an Area of Need.

The program is a strategy to temporarily assist services and locations experiencing medical workforce shortages. Certified positions are valid for up to three years, over which time it is expected the IMG progresses toward general or specialist registration with the Medical Board of Australia.

Eligibility for an Area of Need position requires an employer – either local health districts or private facilities – to apply to the Ministry of Health and satisfy the following criteria:

- Labour Market Testing (LMT): applicants must provide documented evidence that genuine attempts have been made through advertising over a period of time to recruit to the position locally.
- Evidence of Need: Non-public health employers must show that the position either provides services that have District of Workforce Shortage (DWS) determination or is located in an area that has a DWS classification. All applicants must detail the impact on service delivery if the position is not filled, and demonstrate that alternative ways have been explored to address the shortage of medical services in their facility prior to applying for Area of Need status.
- Stakeholder consultation has been undertaken prior to applying for Area of Need status with:
 - the chief executive or nominated delegates of the public health organisation in which the facility is located, and
 - the relevant Specialty College, and
 - the relevant Medicare Local (for GP positions only).

When recruiting through the Area of Need program, local health districts should be diligent with respect to a number of matters, including but not limited to:

- confirmation of qualifications;
- verification that the applicant does not have a criminal history which would preclude employment;
- confirmation of competency in both written and verbal communication skills;
- provision of induction and ongoing support to the IMG towards obtaining specialist registration; and
- continuation of their efforts to permanently fill vacancies with Australian citizen/permanent resident medical practitioners holding specialist registration.

8.2.3 **Recruitment of Junior Medical Officers**

The annual recruitment campaign of approximately 3,500 Junior Medical Officers (JMOs) to positions in hospitals across NSW Health commences in July each year. JMOs are primarily doctors seeking positions in vocational training programs, but can also include non-vocational positions, career medical officers and clinical superintendents.

Recruitment is conducted online through an e-Recruitment system accessed through the JMO Recruitment webpage on the NSW Health website. The campaign is also supported and marketed through targeted media both nationally and internationally.

The e-Recruitment system is managed by the Ministry of Health and HealthShare NSW in accordance with PD2012_028 *Recruitment and Selection of Staff of the NSW Health Service*. The loading of advertisements, co-ordination of interviews and processing of successful and unsuccessful applicants are managed by the Local Health District at an individual facility level, by training networks or statewide recruitment panels.

Outside of the annual recruitment campaign, *ad hoc* recruitment of JMOs is conducted online through the general e-Recruitment system (NSW Health eRecruit).

8.2.4 **Employment Arrangements for Medical Officers**

NSW Health policy directive PD2010_074 *Medical Officers: Employment Arrangements* outlines the employment arrangements to be applied by public health organisations when engaging medical officers under the Public Hospital (Medical Officer) Award and to facilitate a consistent application of employment provisions by public health organisations when medical officers are required to rotate between facilities as part of their pre-vocational or vocational training program.

8.2.5 **Locum Medical Officers**

The NSW Health *Register of Medical Locum Agencies* contains details of Medical Locum Agencies that comply with NSW Health requirements. Public health organisations may only use Medical Locum Agencies listed on this Register.

The NSW Ministry of Health Policy Directive PD2012_046 *Remuneration Rates for non-specialist medical staff – short term/casual (locum)* regulates the remuneration rates payable to medical staff engaged as employees on a short term or locum basis. The rates vary by location. Chief executives are able to approve above-cap rates, and reporting of such approvals is required by the Ministry.

These policies do not apply to the appointment of Visiting Medical Officers (VMOs), Dentists, Staff Specialists or any medical professional whose appointment requires recommendation through the Medical and Dental Appointments Advisory Committee (MDAAC).

8.2.6 **Recruitment from Overseas**

When engaging the services of a recruitment agency to carry out overseas recruitment of health professionals, employers must use a member of the Panel of Overseas Recruitment Agencies (PORA).

The approved agencies on the PORA are available on the NSW Health website.

NSW Health Policy Directive PD2013_041: *Recruitment of Overseas Health Professionals – Panel of Overseas Recruitment Agencies (PORA)* outlines the roles of the employer, the PORA and the NSW Ministry of Health in the process of overseas recruitment and implementation of the policy by those parties. The internet link to this policy directive is provided under 'Workforce & Employment – Resources & References' at the end of this section.

When recruiting from overseas, local health districts should be diligent with respect to a number of matters, including, but not limited to: confirmation of qualifications; verification that the applicant does not have a criminal history which would preclude employment; confirmation of competency in both written and verbal communication skills; provision of induction and ongoing support.

8.3 Workforce Development

8.3.1 The NSW Health Professionals Workforce Plan

The NSW *Health Professionals Workforce Plan 2012-2022* (HPWP) was released in September 2012. Its central tenets include effective workforce planning, support for local decision making and recognition of the value of generalist and specialist skills. These principles will provide the platform to realise the vision of right people, right skills, and right place. The implementation of the HPWP, combined with effective Local Health District initiatives and continued dialogue with all stakeholders, will lead to better regional health services and better local outcomes. The implementation of the HPWP is evaluated regularly.

8.3.2 Health Education and Training Institute (HETI)

The Health Education and Training Institute (HETI) was established in April 2012 and has a broad role to lead, develop, conduct, coordinate, support and evaluate clinical education and training programs across the NSW public health system. HETI works closely with LHDs, specialty health networks, other public health organisations and health education and training providers to ensure the development and delivery of health education and training across the system.

HETI is responsible for prevocational accreditation and also manages a broad range of programs including: the Financial Management Education Program; the Hospital Skills Program; Interdisciplinary Clinical Training Networks and ClinConnect. HETI is also one of the leaders of the implementation of the *Health Professionals Workforce Plan*.

8.3.3 Medical Training Networks

Medical Training Networks link rural and regional hospitals with metropolitan hospitals to encourage equity of access to high-quality care for patients and training for all trainees.

They also include specialist training programs. Training Networks cross local health district boundaries to ensure a complete and varied experience for trainees in different clinical contexts and hospital settings.

Training Networks currently operate for pre-vocational training, basic physician training, psychiatry, surgery, paediatrics, cardiology and emergency medicine. The specialty training networks are typically resourced by a part-time Network Director of Training (medical specialist) and a full-time Education Support Officer (Health Manager). Both these positions have accountability for all sites within the Training Network, which will span across local health district boundaries. Area Directors of Hospital Training and an Education Support Officers are funded to support training for non-specialist medical staff.

Local health districts are required to support the specialist training programs and networks.

8.3.4 **Specialist Training Program**

The Specialist Training Program is a Commonwealth-funded program to expand specialist training positions outside major teaching hospitals. New positions in rural and regional public hospitals have been funded through the program, as well as community positions and positions in private hospitals.

Where the position is funded in a public hospital, a contract exists with the Specialist College administering the program for that particular speciality.

The Treasury Managed Fund does not provide insurance coverage for doctors while they are in the non-public hospital setting.

Local health districts are encouraged to seek funding opportunities through this program where appropriate to support growth in available NSW vocational training positions in specialities of workforce need.

8.3.5 **Specialist Medical Training**

To be eligible for specialist registration, medical practitioners must have fellowship qualifications from an Australian Medical Council-accredited specialist medical college. While specialist medical colleges conduct examinations and determine the curriculum, the specialty training itself occurs in hospitals. To ensure quality training and uniformity of training across sites, medical colleges have developed training standards. Speciality training can only occur in those sites/hospitals that have been accredited by the relevant medical college as meeting the training standards. Public health organisations should maintain a record of the status of accreditation for speciality training, including positions accredited in each speciality.

It is recognised that specialist trainees do have a service role while they undertaking training, however, in considering whether to apply for accreditation or to expand the number of accredited positions at the facility, it is important to consider local as well as state and national workforce requirements. Where specialist workforce requirements are adequate at a state/national level, local service requirements may be met through other workforce such as Senior hospitalists or career medical officers or non-accredited registrar positions.

Employment arrangements by public health organisations for Medical Officers can be found in PD2010_074 *Medical Officers: Employment Arrangements*.

8.3.6 **Pre-vocational General Practice Placement Program**

The Pre-vocational General Practice Placement Program is a Commonwealth-funded program where a pre-vocational doctor rotates to a GP practice for a term.

These positions must be accredited by HETI.

The Treasury Managed Fund does not provide insurance coverage for doctors while they are in the non-public hospital setting.

Local health districts are encouraged to support access to the pre-vocational general practice placement program as a way of expanding training opportunities for interns and second post-graduate year doctors and providing them with valuable general practice experience.

8.3.7 Emergency Department Workforce Planning Process

The Emergency Department Workforce Analysis Tool (EDWAT) is a web-based application that provides a step-by-step guide for Emergency Departments to review their staffing profile in relation to skill mix and workforce planning guidelines. Completion of the tool will result in the identification of strategies to optimise existing staffing resources, as well as prioritising strategies for implementation to ensure alignment with recommended guidelines.

8.3.8 Internships

Completion of a medical internship is a requirement for a medical graduate to gain general medical registration. The Medical Board of Australia Registration Standard "Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training" sets out internship requirements.

At the 14 July 2006 Council of Australian Governments (COAG) meeting, states and territories agreed to guarantee intern training for Commonwealth Supported Places medical students. NSW has expanded this guarantee to include domestic full fee paying students of NSW universities.

Intern positions are accredited by the Health Education and Training Institute (HETI).

All Local Health Districts are required to increase and maintain the number of available intern positions in line with projected growth of medical graduates and to ensure that NSW continues to meet its COAG commitment.

8.3.9 International Medical Graduates

NSW Health policy directive PD2009_011 *International Medical Graduates: Overseas Funded*, sets out the minimum requirements for the engagement of overseas funded international medical graduates in the NSW public health system, including assessment of competence, employment screening, checks, letters of offer, written agreements with the overseas funding body, supervision, and record keeping. It also provides guidance on indemnity and insurance, professional; registration and visa matters.

8.4 Local Health District – Training Responsibilities and Programs

Local health districts have a responsibility to:

- provide training and development opportunities for staff, including access to both mandatory (e.g. fire, Work Health and Safety, CPR [specified staff]) and other programs which will enhance staff skill level;
- assess individual staff competency and skill and, where identified, improve these through training and development opportunities;
- undertake training needs analysis and facilitate access to appropriate training programs;
- support staff undertaking educational initiatives;
- facilitate compliance with relevant NSW Health policy and award provisions (e.g. staff specialist training, education and study (TESL); and
- maintain training records.

8.5 Workforce Reporting

NSW Health regularly reports on the performance of the public health system in regards to its workforce. This is undertaken on a monthly, quarterly and annual basis. Reports are generated from the Health Information Exchange (HIE) which is a data warehouse repository with local instances and a State HIE.

Payroll and workforce demographic data is recorded weekly in local HIE instances with monthly transfers of data to the State HIE. The process of transfer to the State HIE creates workforce reporting on the monthly cost of staffing and the number of full-time equivalent employees (FTE) by staff grouping (e.g. medical, nursing, allied health) and other dimensions such as employment type. The HIE is configured to ensure that all payroll-related data and calculations of FTE are consistent and standard across the whole of the health system.

It is expected that this methodology will be replaced with a weekly reporting solution using the State Management Reporting Tool (SMRT) during 2014. From the data produced, reporting on particular issues can be generated such as sick leave and overtime, front line/back office ratios, performance reviews undertaken and use of premium labour. A copy of the information transferred to the State HIE is retained within each local HIE instance enabling local reporting requirements from the same data sets.

Routine reporting from the State HIE enables ongoing monitoring of performance and key performance indicators on monthly, year to date, previous period comparisons and trend indicators. This data also provides valuable information for workforce relations matters.

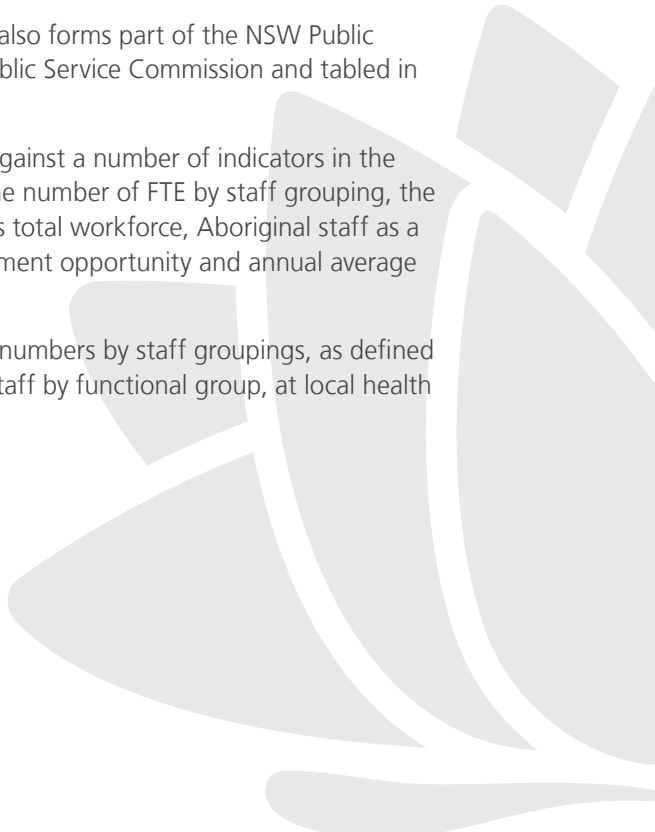
Three financial year to date reporting periods occur in September, February and June through the HIE which are then published by the Public Service Commission in the NSW Public Sector Workforce Profile. This data collection is a mandatory requirement of the Public Service Commission, and is used by both the Ministry and the Public Service Commission for workforce reporting and planning.

Information provided for the June collection also forms part of the NSW Public Sector Workforce Profile published by the Public Service Commission and tabled in parliament annually.

The Ministry of Health is required to report against a number of indicators in the NSW Health Annual Report. These include the number of FTE by staff grouping, the percentage of clinical staff as a proportion its total workforce, Aboriginal staff as a proportion its total workforce, equal employment opportunity and annual average sick leave per FTE.

Chief executives are required to confirm FTE numbers by staff groupings, as defined by the Ministry, including corporate service staff by functional group, at local health district level, for the Annual Report.

Workforce reporting requirements, performance monitoring and planning



Workforce & Employment – Resources & References

NSW Health policy directives relating to Personnel / Workforce – by functional group

Conditions:

http://www.health.nsw.gov.au/policies/groups/pers_conditions.html

– General employment conditions applicable to staff of the NSW Health Service.

Employment Screening:

http://www.health.nsw.gov.au/policies/groups/pers_employscr.html

Mandatory requirements and procedures for the undertaking of Employment Screening of preferred applicants seeking employment.

Industrial and Employee Relations:

http://www.health.nsw.gov.au/policies/groups/pers_employrel.html

Wage rates and conditions of employment in accordance with the relevant industrial Instrument

Learning and Development:

http://www.health.nsw.gov.au/policies/groups/pers_learning.html

A framework of key components to develop local learning and development strategies.

Leave:

http://www.health.nsw.gov.au/policies/groups/pers_leave.html

Rules associated with all the types of leave available.

Recruitment and Selection:

http://www.health.nsw.gov.au/policies/groups/pers_recruitment.html

NSW Health policies on recruitment and selection, as well as a step-by-step guide for any staff in the NSW Health Service involved in recruitment and selection processes.

Other NSW Health policy directives / guidelines / information bulletins relating to Personnel / Workforce

NSW Health Policy Directive, *Managing Excess Staff of the NSW Health Service* (PD2021_021)

http://www.health.nsw.gov.au/policies/pd/2012/PD2012_021.html

NSW Health Policy Directive, *Locum Medical Officers – Employment and Management* (PD2013_022)

http://www.health.nsw.gov.au/policies/pd/2013/PD2013_022.html

NSW Health Policy Directive, *Remuneration Rates for Non-Specialist Medical Staff – Short Term/Casual* (Locum) (PD2012_046)

http://www.health.nsw.gov.au/policies/pd/2012/PD2012_046.html

NSW Health Policy Directive, *Recruitment of Overseas Health Professionals – Panel of Overseas Recruitment Agencies (PORA)* (PD2013_041)

http://www.health.nsw.gov.au/policies/pd/2013/PD2013_041.html

NSW Health Guideline, *Allied Health Assistant Framework* (GL2013_005)

http://www.health.nsw.gov.au/policies/gl/2013/GL2013_005.html

NSW Health Policy Directive, *Engagement of Therapists on a Sessional Basis* (PD2013_008)

http://www.health.nsw.gov.au/policies/pd/2013/PD2013_008.html

NSW Health Policy Directive, *Aboriginal Workforce Strategic Framework 2011-2015* (PD2011_048)

http://www.health.nsw.gov.au/policies/pd/2011/PD2011_048.html

NSW Health Policy Directive, *Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health* (PD2011_069)
http://www.health.nsw.gov.au/policies/pd/2011/PD2011_069.html

NSW Health Information Bulletin, *Definition of an Aboriginal Health Worker* (IB2014_001)
http://www.health.nsw.gov.au/policies/ib/2014/IB2014_001.html

Other resources and references

NSW Health Professionals Workforce Plan 2012-2022:
<http://www.health.nsw.gov.au/workforce/hpwp/pages/default.aspx>

NSW Health *Register of Medical Locum Agencies*:
<http://www.health.nsw.gov.au/aboutus/business/locums/index.asp>

NSW Health *Combined Delegations Manual*:
<http://www.health.nsw.gov.au/policies/manuals/Pages/combined-delegations.aspx>

Health Education and Training Institute: <http://www.heti.nsw.gov.au/>

Local Documentation

Workforce strategic plans, including initiatives and support for learning and development

Aboriginal workforce plans

Needs analysis to identify priorities for staff learning and development

Training records

Selection, recruitment and employment records



9 Ethical Framework & External Agency Oversight

9.1 NSW Health Framework for Promotion of Ethical Behaviour

The government sector core values are consistent with the standards contained in the NSW Health Code of Conduct.

9.1.1 NSW Health Code of Conduct

A Code of Conduct ensures a clear and common set of standards of ethical and professional conduct that apply to everyone working in NSW Health, the outcomes we are committed to, and the behaviours which are unacceptable and will not be tolerated.

A Code of Conduct assists with building a positive workplace culture based on NSW Health Core Values.

- **Collaboration** – everyone who works in the health system, from the public to the private sector, are part of one team in one health system.
- **Openness** – processes must be transparent; people have a right to know how and why decisions are made, and who is making them.
- **Respect** – everyone engaged in providing health care has a valued role; everyone can make a contribution and should be given the opportunity to be involved, especially to a process of continuous improvement.
- **Empowerment** – patients should be given an opportunity to take greater control of their own health care in collaboration with care providers; decisions should be based on clear information about what works best.

The Code provides a framework to promote ethical day-to-day conduct and decision making. It does not and cannot cover every situation that can arise in the workplace. The Code does not replace the need for common sense in how staff conduct themselves. If staff are in doubt as to what conduct is appropriate in any particular situation, or how the Code should be applied, they should seek advice and direction from their manager or a more senior member of staff.

Managers have a key role in ensuring staff understand the Code and in enforcing the standards it sets, consistently and fairly. However, the most important responsibility of managers, and their most valuable contribution to ensuring that the standards set out by the Code are implemented, is to lead by example.

The Code also provides guidance on how to raise and report breaches of the standards it sets.

An internet link to the NSW Health Code of Conduct (PD2012_018) is included at the end of this section.

9.1.2 Declaration of Ethical Behaviour and Confidentiality Undertaking

To ensure members of boards and committees are aware of the standards expected of a member of a NSW Health board/committee, the Ministry of Health has developed standard 'Declaration of Ethical Behaviour and Confidentiality Undertaking' for board and committee members of public health organisations. Refer to the Resources & References in this section.

NSW Health
Code of Conduct
standards,
implementation
and reporting
requirements
.....

By signing the declaration board and committee members make a commitment to abide by ethical principles in carrying out their duties as a member, including:

- to act honestly and in good faith and in the overall interest of the public health organisation.
- to use due care and diligence in fulfilling the functions of the officer and exercising powers, duties and functions under the *Health Services Act 1997*.
- to not use the powers of office for any improper purpose or take improper advantage of the position a member holds.
- to not allow personal interests or the interests of an associated person to conflict with the interest of the public health organisation.
- to become acquainted with Government policy and NSW Health policy as they apply to the public health organisation.
- to take all reasonable steps to be satisfied as to the soundness of all decisions taken by the public health organisation.
- to not engage in conduct likely to bring discredit upon the public health organisation.

It is recommended that board members read and accept the undertakings contained in this document at, or prior to attending their first meeting of the board.

9.2 Major NSW External Oversight Agencies

9.2.1 Public Service Commissioner

The establishment of the NSW Public Service Commission (PSC) under the *Government Sector Employment Act 2013* recognises that delivering improved services to the public can only be achieved through having a capable, ethical, service-oriented, accountable public service that is able to serve successive governments in a non-partisan manner.

The principal objectives of the Commissioner are:

- (a) to promote and maintain the highest levels of integrity, impartiality, accountability and leadership across the government sector,
- (b) to improve the capability of the government sector to provide strategic and innovative policy advice, implement the decisions of the Government and meet public expectations,
- (c) to attract and retain a high calibre professional government sector workforce,
- (d) to ensure that government sector recruitment and selection processes comply with the merit principle and adhere to professional standards,
- (e) to foster a public service culture in which customer service, initiative, individual responsibility and the achievement of results are strongly valued,
- (f) to build public confidence in the government sector,
- (g) to support the Government in achieving positive budget outcomes through strengthening the capability of the government sector workforce.

The core values for the government sector and the principles that guide their implementation are as follows:

Integrity

- (a) Consider people equally without prejudice or favour.
- (b) Act professionally with honesty, consistency and impartiality.
- (c) Take responsibility for situations, showing leadership and courage.
- (d) Place the public interest over personal interest.

Trust

- (a) Appreciate difference and welcome learning from others.
- (b) Build relationships based on mutual respect.
- (c) Uphold the law, institutions of government and democratic principles.
- (d) Communicate intentions clearly and invite teamwork and collaboration.
- (e) Provide apolitical and non-partisan advice.

Service

- (a) Provide services fairly with a focus on customer needs.
- (b) Be flexible, innovative and reliable in service delivery.
- (c) Engage with the not-for-profit and business sectors to develop and implement service solutions.
- (d) Focus on quality while maximising service delivery.

Accountability

- (a) Recruit and promote employees on merit.
- (b) Take responsibility for decisions and actions.
- (c) Provide transparency to enable public scrutiny.
- (d) Observe standards for safety.
- (e) Be fiscally responsible and focus on efficient, effective and prudent use of resources.

9.2.2 Independent Commission Against Corruption

The Independent Commission Against Corruption (ICAC) is established by the *ICAC Act 1988*. Its aims are to protect the public interest, prevent breaches of public trust and guide the conduct of public officials. The ICAC is a public authority, but is independent of the government of the day, and is accountable to the people of NSW through the Parliament.

The principal objectives of the *ICAC Act* are to promote the integrity and accountability of public administration through the establishment of the ICAC to:

- investigate, expose and prevent corruption involving or affecting public authorities or public officials, and
- educate public authorities, public officials and members of the public about corruption and its detrimental effects on public administration and on the community.

The NSW community expects public officials (including members appointed to public sector boards) to perform their duties with honesty and in the best interests of the public. The ICAC has the authority to investigate any matter involving public sector corruption in NSW.

Complaints,
investigations and
public interest
disclosures

Corrupt conduct could involve:

- the dishonest or partial exercise of official functions, or
- a breach of public trust, or
- the misuse of information or material acquired in the course of official functions.

All principal officers of NSW public agencies have an obligation under section 11 of the *ICAC Act* to report any matter that the officer suspects on reasonable grounds, concerns or may concern corrupt conduct. A principal officer is the person who heads the agency, its most senior officer or the person who usually presides at its meetings. This is most commonly the chief executive or Secretary, NSW Health of a state government agency, or the general manager of a local council. For health organisations, the principal officer is the chief executive.

Chief executives are required to report allegations of corrupt conduct to the ICAC in accordance with NSW Health policy. Where matters are reported by local health districts, the ICAC can adopt a monitoring role to confirm that appropriate investigations are conducted, findings made, and recommendations implemented. For more serious matters, the ICAC may decide to take a more active role.

The ICAC also accepts public interest disclosures from public sector staff and officials about corrupt conduct and publishes a range of publications of probity, tendering and other issues which provide useful guidance to agencies (see Public Interest Disclosures below).

9.2.3 **NSW Ombudsman**

The NSW Ombudsman deals with complaints about NSW public sector agencies including councils, public health organisations, government departments, correctional centres and universities. The complaints may include:

- complaints about maladministration (for example conduct by an agency or its employee that is contrary to the law, unreasonable, unjust, oppressive, discriminatory or made without giving proper reasons);
- public interest disclosures from public sector staff and officials about maladministration;
- reportable allegations against employees of designated agencies and other public authorities, and complaints about how such allegations were handled by the agency concerned;
- complaints from members of the community about unfair treatment by a NSW government agency or employee, or certain non-government service providers and their employees; and
- complaints about the provision, failure to provide, withdrawal, variation or administration of a community service.

The NSW Ombudsman's Office is a public authority, but is independent of the government of the day, and is accountable to the people of New South Wales through the New South Wales Parliament.



Public interest disclosures

The *Public Interest Disclosures Act 1994 (PID Act)* protects public officials when they disclose information of serious wrongdoing, including corrupt conduct, maladministration, serious and substantial waste or failure to deal appropriately with Government information.

Public interest disclosures can be made internally to the public health organisation or externally to the appropriate agency including the Independent Commission Against Corruption, the Attorney General, NSW Ombudsman, Police Integrity Commission or the Information Commissioner. The *PID Act* provides protection to staff from reprisals.

The *PID Act* provides the Ombudsman's Office with an oversight role concerning the management of public interest disclosures by public authorities.

9.2.4 **NSW Audit Office**

The New South Wales Auditor-General is responsible for audits and related services under the *Public Finance and Audit Act 1983*, the *Corporations Act 2001* and other New South Wales Acts. The Auditor-General also provides certain assurance services in respect of Commonwealth grants and payments to the State under Commonwealth legislation.

The NSW Audit Office is a public authority, but is independent of the government of the day, and is accountable to the people of New South Wales through the Parliament. The Audit Office's core services are:

Financial audits

Financial audits provide an independent opinion on NSW government agencies' financial reports. They identify whether public sector agencies (including statutory health corporations) comply with accounting standards and relevant laws, regulations and government directions. A report on each financial audit is provided to the Minister responsible for the agency, to the agency and the Treasurer and to the Parliament through the Auditor-General's Reports to Parliament.

Compliance audits

Compliance reviews seek to confirm that specific legislation, directions and regulations have been adhered to by government agencies.

Performance audits

Performance audits determine whether an agency is carrying out its activities efficiently, economically and in compliance with the law. These audits may review all or part of an agency's operations. Some audits consider particular issues across a number of agencies. Results of these audits are reported to the chief executive officer of the agency concerned, the responsible Minister, the Treasurer and Parliament.

9.2.5 **The Information and Privacy Commission NSW**

The Information and Privacy Commission NSW (IPC) is an independent statutory authority that administers New South Wales' legislation dealing with privacy and access to government information.

The IPC was established on 1 January 2011 to support the Information Commissioner and the Privacy Commissioner in fulfilling their legislative responsibilities and functions and to ensure individuals and agencies can access consistent information, guidance and coordinated training about information access and privacy matters.

The IPC administers the following NSW legislation:

- *Government Information (Public Access) Act 2009* (GIPA Act)
- *Government Information (Information Commissioner) Act 2009* (GIIC Act)
- *Privacy and Personal Information Protection Act 1998* (PPIP Act)
- *Health Records and Information Privacy Act 2002* (HRIP Act)

The IPC reviews the performance and decisions of agencies and investigates and conciliates complaints relating to government agencies, health service providers (both public and private) and some large organisations that deal with health information.

The IPC also provides feedback about the legislation and relevant developments in the law and technology.

The Information and Privacy Commissioners report to the Parliamentary Joint Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission, which oversees their functions.

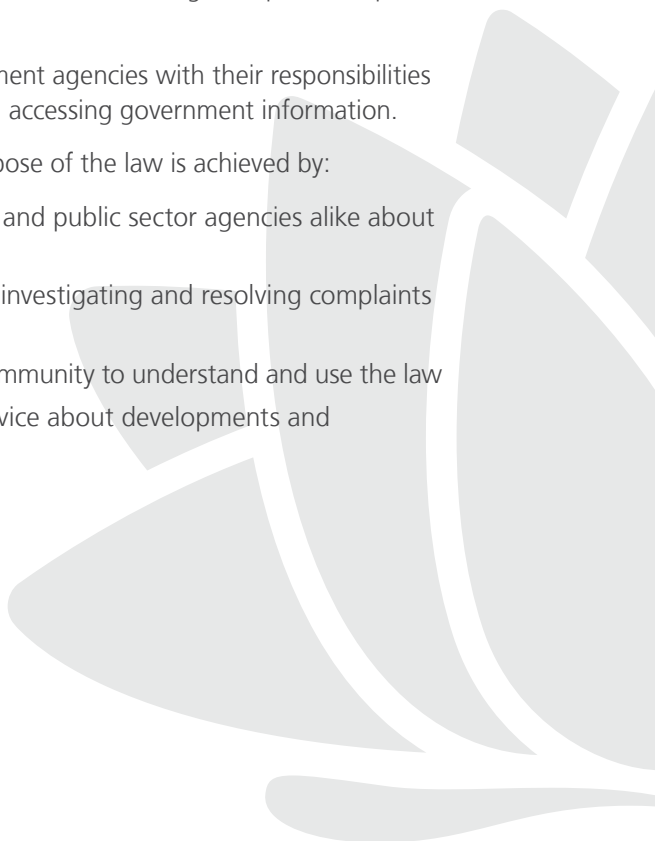
Office of the Information Commissioner

The *Government Information (Public Access) Act 2009* (GIPA Act) was established to provide an open and transparent process for giving the public access to information from New South Wales public sector agencies and to encourage the proactive public release of government information.

The IPC provides support by helping government agencies with their responsibilities under the GIPA Act and helping the public in accessing government information.

The goal of the IPC is to ensure that the purpose of the law is achieved by:

- promoting and educating the community and public sector agencies alike about rights and roles in accessing information
- reviewing public sector agency decisions, investigating and resolving complaints and monitoring agency performance
- assisting public sector agencies and the community to understand and use the law
- providing feedback about the law and advice about developments and technology relevant to the law.



Office of the Privacy Commissioner

The role of the Office of the Privacy Commissioner includes promoting the adoption of and compliance with the two privacy laws in NSW:

- The *Privacy and Personal Information Protection Act 1998* (the PPIP Act)
- The *Health Records and Information Privacy Act 2002* (the HRIP Act)

The role of the Office of the Privacy Commissioner includes:

- promoting the adoption of and compliance with the privacy principles set out in each of the privacy laws
- assisting agencies manage personal and health information
- assisting in the resolution of privacy complaints
- implementing privacy management plans
- initiating privacy codes of practice
- recommending legislative, administrative or other action in the interests of privacy
- conducting inquiries and investigations into privacy related matters.



Ethical Requirements – Resources & References

NSW Health Policy Directive, *Code of Conduct* (PD2012_018):
http://www.health.nsw.gov.au/policies/pd/2012/PD2012_018.html

NSW Health Policy Directive, *Conflicts of Interest and Gifts and Benefits* (PD2010_010):
http://www.health.nsw.gov.au/policies/pd/2010/PD2010_010.html

For a listing of policy directives and guidelines relating to Conduct and Ethics:
http://www.health.nsw.gov.au/policies/groups/pers_conduct.html

NSW Health Policy Directive *Physical Assaults* (PD2012_043)
http://www.health.nsw.gov.au/policies/pd/2012/PD2012_043.html

NSW Health Policy Directive *Public Interest Disclosures* (PD2011_061)
http://www.health.nsw.gov.au/policies/pd/2011/PD2011_061.html

Declaration of Ethical Behaviour and Confidentiality Undertaking for board and committee members: http://www.health.nsw.gov.au/resources/lhdboards/ethical_conduct_nsw_healt_doc.asp

Information presented in this compendium about the role and functions of key external review agencies has been sourced from the relevant websites for each organisation as follows:

Further information about the Public Service Commission is available at www.psc.nsw.gov.au

Further information about the Ombudsman and the types of issue the Ombudsman may investigate is available at www.ombo.nsw.gov.au.

Further information about the ICAC and what constitutes corrupt conduct is available at www.icac.nsw.gov.au

Further information about the Audit Office of NSW is available at www.audit.nsw.gov.au

Further information about the Information and Privacy Commission and the GIPA Act is available at www.ipc.nsw.gov.au

Local Documentation

Code of Conduct – easily accessible to all staff

Signed Declarations of Ethical Behaviour and Confidentiality Undertaking, by all board members

Conflict of Interest Register and signed Conflict of Interest declaration forms

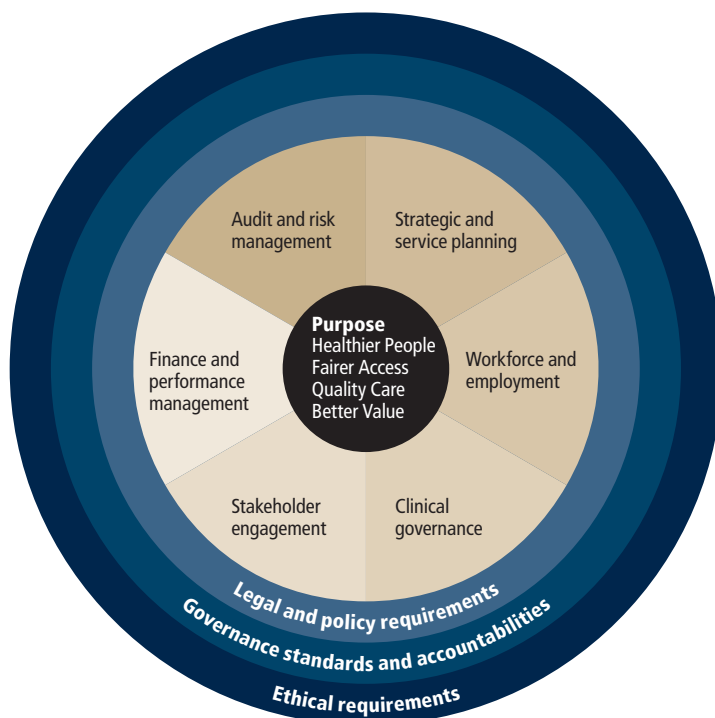
Register of ethical issues, arising within the clinical setting, and which need to be managed in accordance with NSW Health policy

Documented procedure for receipt of protected disclosures, including nominated officers

Register of issues which are reported to, or notified by, the external oversight agencies: the ICAC, NSW Ombudsman, NSW Audit Office, Privacy Commissioner

10 Stakeholder Engagement

10.1 Stakeholder Engagement



Engagement with stakeholders is a key activity for public health organisations, as required both in Local Health District functions under the *Health Services Act* and through Standard 6 in the corporate governance framework, which emphasises the importance of stakeholder engagement in decisions that affect them (see section 2.2.6).

Engagement with stakeholders develops an open and inclusive environment where information, comment, opinion and criticism is valued and utilised.

Government organisations must be open and transparent, act with integrity and be accountable to the public they serve. Government oversight agencies, such as the Audit Office of NSW⁵ have stated that government organisations, should engage key stakeholders, to ‘shine a light’ on who they are, how they operate, what they are doing and how well they are doing it.

With these objectives in place, well managed stakeholder participation is fundamental to the effective planning, and delivery of health service delivery formulated to improve patient safety and better health outcomes for the consumer and the community.

The recent structural reforms to the NSW public health sector has demonstrated a strong commitment to devolve decision making to the local level and to actively involve clinicians, Medicare Locals, aged care and other care providers, patients and the community in public health services.

Public Health Organisations are expected to have Stakeholder Management Plans and ongoing consultation programs in place

5 NSW Auditor-General's Report Volume Two 2011 CORPORATE GOVERNANCE – STRATEGIC EARLY WARNING SYSTEM 2011 p13

Effective and meaningful stakeholder engagement is fundamental to achieving the public health organisations objectives in the planning, development and delivery of improved outcomes to our stakeholders.

Public health organisations should have stakeholder management plans and ongoing consultative programs in place as part of their strategic planning processes and performance requirements.

It is also important that public health organisations comply with the principles of publicly available information concerning health services and management. There are key legislative requirements concerning the recording, access and availability, storage and retention of public information which must be complied with as well as NSW Health policy directives.

Areas where a public health organisation may engage stakeholders and the community include:

- the development and implementation of a Community Participation Framework;
- development of a Communications Plan with key internal and external stakeholders;
- active engagement with community organisations and groups to promote positive health, quality integrated and co-ordinated care and the open exchange of information;
- community participation in the development, implementation and review of health service plans, operations and health programs;
- the development of strategic priorities and plans for the organisation;
- activity based funding programs and services;
- the integration of diversity and innovation into health services to reduce social disadvantages and to meet community health needs;
- consulting with the Aboriginal community regarding the development and delivery of health and related programs and services to meet their needs;
- the availability and provision of public health information including emerging health issues and public health trends;
- the outcomes of research and technological innovations and developments;
- participation in specialist technical, clinical and consumer forums;

The stakeholder engagement program should consider the participation of clinician, consumer, carer and the community in a wide range of activities such as:

- strategic planning and priority setting;
- health services planning and service delivery;
- finance/budget planning and the allocation of funds;
- local policy making and related procedures;
- specific service reviews and setting service standards;
- project working groups;
- quality and accreditation processes;
- advisory processes and other district committees.



Some of the types of stakeholder engagement involving clinicians, consumers and the community by local health districts and specialty networks are:

- Health services forums
- Consumer advisory committees;
- Consumer and community groups;
- Aboriginal health councils and advisory committees;
- Community health participation forums;
- Community reference groups;
- Quality councils;
- Nursing, allied and clinical councils;
- Medical staff councils;
- GP liaison committees/Medicare Locals.



Stakeholder Engagement – Resources & References

Local Documentation

Documentation which demonstrates community consultation e.g. Community Engagement Plan; Communication Plans etc

Documentation which demonstrates consultation with and involvement of Aboriginal and Torres Strait Islander communities



11 Audit & Risk Management

11.1 Audit and Financial Governance Framework

The NSW Health System operates within a range of Whole of Government policies issued through NSW Treasury and adopted by NSW Health policy. These require public health organisations to maintain effective, independent audit framework and corporate governance practice, as described in this compendium, that is consistent with the “best practice” attributes for the NSW public sector.

Specifically, the audit framework of public health organisations is established within a suite of legislative, policies, procedures, reporting and review requirements. There are several governance mechanisms that oversee the responsible use of government resources and the efficiency and effectiveness of health services delivery in NSW. The legislative basis includes:

- *Charitable Fundraising Act 1991;*
- *Charitable Trusts Act 1993;*
- *Dormant Funds Act 1942;*
- *Health Administration Act 1982;*
- *Health Services Act 1997;*
- *Independent Commission Against Corruption Act 1988;*
- *Local Health District By-Laws;*
- *Public Authorities (Financial Arrangements) Act 1987;*
- *Public Finance & Audit Act 1983;*
- *Public Health Act 2010;*
- *Ombudsman Act 1974;*
- *Trustee Act 1925.*

In addition, there are several State and Commonwealth Government administrations that are involved in overseeing the audit and governance framework of public health organisations within NSW. Some of the key NSW administrations are NSW Treasury, Department of Premier and Cabinet and the Audit Office of NSW.

**Key legislation
oversighting
financial
management,
reporting and audit
responsibilities**

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11.2 **Audit Requirements**

11.2.1 **Internal audit unit**

The chief executive must establish and maintain an effective internal audit function. This function is directly responsible to the chief executive for:

- regular appraisal of the adequacy and effectiveness of the organisation's:
 - systems of internal control; and confirmation of compliance with those systems;
 - risk management program; and
 - governance processes.
- review of operations or programs, to ascertain if results are consistent with established or appropriate goals and objectives and if the operations or programs are being carried out as planned;
- reporting directly at regular intervals to the chief executive and board on the result of any audit appraisal, inspection, investigation, examination or review made by the internal audit organisation
- monitoring and confirming implementation of recommendations made following any audit appraisals, inspections, investigations, examinations or reviews.

Internal audit units and internal auditors are to comply with the Standards for the Professional Practice of Internal Auditing issued by the Institute of Internal Auditors.

The Manager, Internal Audit or the internal auditor as the case may be is to have direct access to the Chairperson of the Audit and Risk Management Committee and the Chairperson of the board.

11.2.2 **Employment of an internal auditor**

A public health organisation must not engage an Internal Audit Manager without the prior consent of the Ministry of Health. The Associate Director, Corporate Governance and Risk Management of the Ministry, or a nominee, shall be represented in the selection process⁶. Once employed, under terms and conditions agreed between the public health organisation and the Ministry of Health, action will not be initiated or implied to the detriment of the terms of employment/engagement by the public health organisation, without the prior consent of the Director, Legal and Regulatory Services Branch.

The public health organisation should not terminate or otherwise dispense with the service of the Internal Audit Manager, without the prior written notification to the Director, Legal and Regulatory Services Branch, Ministry of Health.

11.2.3 **External audit**

The affairs and operations of a public health organisation as disclosed in its accounts and associated financial and other records shall be audited in respect of each financial year.

The Audit Office of NSW undertakes the external audit function for NSW public health organisations.

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6 Section 1.3 Internal Audit Policy Directive 2010-39

11.3 Audit and Risk Management Committee

11.3.1 Role of the Audit and Risk Management Committee

Each public health organisation must establish an Audit and Risk Management Committee.

The Audit and Risk Management Committee plays a key role in assisting the board and the Chief Executive perform their duties under the *Health Services Act 1997* particularly in relation to the organisation's financial reporting, internal control, risk management and internal and external audit functions. The role of the Audit and Risk Management Committee is separate from that of executive management of the organisation. Its role is to provide advice and it has no decision-making powers or supervisory functions.

The Audit and Risk Management Committee has a duty to provide assurance to the public health organisation that financial information reported to it reasonably portrays the organisation's financial condition, results of operations, plans and long-term commitments and contingencies.

The Audit and Risk Management Committee is responsible for independently reviewing the financial statements and external reporting prior to approval by the public health organisation. If any technical or operational issues arise in relation to the finalisation of such reports, the Committee can act as a useful forum for resolving such issues. A sound understanding of the financial reporting requirements and significant policies and principles that underpin these reports is crucial for Audit and Risk Management Committee members.

The Audit and Risk Management Committee should thoroughly review the financial statements for compliance with all prescribed accounting and other requirements; assess the appropriateness of the public health organisation's accounting policies and performance measures; identify and investigate any unusual financial or operational trends or variations from forecasts; review the impact of any materially adverse findings; ensure that the financial statements provide a true and fair view of the activities of the organisation for the period under review and of its affairs at the balance date. Of particular relevance are the notes and disclosures that complement the statements.

In addition, NSW Health policy (Enterprise-wide Risk Management – PD2009_039) requires the Audit and Risk Management Committee to maintain oversight of risk management within the organisation, to review systems and the control frameworks. It is required to provide reasonable assurance to the chief executive and the board that an enterprise-wide risk management system which addresses both clinical and non-clinical risks has been effectively implemented.

11.3.2 Membership of the Committee

The Audit and Risk Management Committee consists between 3 and 5 members. The Chair and majority of members are independent, being selected from the Department of Premier and Cabinet prequalification panel.

The role and responsibilities of the Audit and Risk Management Committee in a Health District's Governance structure, including procedures for the appointment and remuneration of committee members is set out in NSW Health Policy Directive, *Internal Audit* (PD2010_039).

See the NSW Health Model Charter for an Audit & Risk Management Committee.

Health Agencies must complete an Audit & Risk Management Attestation Statement for the financial year by 31 July each year

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11.4 Enterprise-wide Risk Management Framework

Requirement to establish an enterprise-wide risk management framework and compliance with State laws.

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Risk is the effect of uncertainty on objectives⁷. Risk management involves developing systems to identify and analyse risks with the aim of reducing any harmful consequences and benefiting from any opportunities. Managing risks –identifying, assessing and controlling them- is part of everyday activity throughout NSW Health.

Risk management is a critical component of good management practice and effective corporate governance and is essential to ensure that decisions are made with sufficient information about risks and opportunities.

As public health organisations are exposed to a wide variety of corporate and clinical risks on a daily basis, effective risk management is important and should be promoted as a way of meeting organisational responsibilities and objectives.

Effective enterprise risk management is a key component of strategic planning and monitoring of organisational systems that are fundamental to evidence based decision making, responsible management and good governance. Enterprise wide risks are best managed through a structured enterprise-wide risk management process involving continuous monitoring and risk control (policy, procedures and guidelines) in an integrated and systematic manner.

This best practice is reflected in the NSW Health Policy Directive Risk Management –Enterprise-Wide Policy and Framework (PD2009-039) which requires each public health organisation to establish and implement an enterprise-wide risk management framework.

Each public health organisation is required to ensure that it complies with various state laws relating to its operations, especially those that directly impose legal responsibilities for managing risk:

- *Public Finance & Audit Act 1983;*
- *Annual Reports (Departments) Regulation 2010;*
- *Annual Reports (Statutory Bodies) Regulation 2010;*
- *Government Information (Public Access) Act 2009;*
- *Workplace Health & Safety Act 2011;*
- *Protection of the Environment Act.*

Application of an effective enterprise –wide risk management framework requires the examination of all aspects of an organisation’s functions and responsibilities in order to identify and manage opportunities and risks.

11.4.1 Governance and risk

Effective risk management is built into governance and organisational structures, planning and operational processes in order to minimise the likelihood and impact of potential risks. This systematic and integrated approach enables public health organisations, to deliver on its performance objectives and meet its responsibilities and accountabilities to its stakeholders.

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7 AS/NZS ISO 31000:2009 Risk management – Principles and guidelines

A responsive, open and consultative approach benefits the organisation and its stakeholders through active consultative processes, clear communication and education in risks, effective risk controls and the responsible management of risks at all levels of the organisation.

The NSW Auditor General's 2011 report *Corporate Governance – Strategic Early Warning System*, identified sound risk management as essential to good corporate governance.

Governance, risk management and compliance are three highly related but distinct disciplines, being that.

- Governance is performance and conformance and provides the direction and structure required to meet organisational objectives and enables your agency to properly manage your business;
- Risk Management provides the foundation for resilience, the policies and procedures enable your agency to continue to function effectively in a changing environment;
- Compliance is adherence to both external and internal requirements.

See also Clinical Governance section 5 of the Compendium.

11.4.2 Risk Management Framework⁸

Key areas of risk control include identification, assessment, management and integration into strategic and operational risk assessment. In order to achieve this requirement, all public health organisations must:

- have a risk management plan that identifies how the organisation will minimise, manage, record and monitor risk, including procedures for escalating risk reports to the chief executive and board.
- include risk management planning as a part of the strategic, operational and annual business planning activities of the organisation, its facilities and/or networks.
- have a risk register that is used to record, rate, monitor, report risk; and that facilitates the minimisation and management of risk.
- have an established process for monitoring and reviewing risk controls and governance systems.

11.4.3 Responsibilities

Management and all staff of public health organisations have a responsibility to ensure risk management principles are integrated into the organisation's daily operations. Risk identification, assessment and effective risk management is considered to be a core accountability of boards, chief executives and organisational staff and contractors.

Public health organisations have a responsibility to ensure that systems are in place to enable the organisation to deal responsibly and effectively in identifying, managing and mitigating risks through an enterprise –wide risk management plan and risk registers.

⁸ Risk management framework : "a set of components that provide the foundations and organizational arrangements for designing , implementing, monitoring, reviewing and continually improving risk management throughout the organization" AS/NZS ISO 31000:2009 Risk management –Principles and guidelines p2

A key document on governance and risk is the NSW Auditor General's 2011 report *Corporate Governance – Strategic Early Warning System*

Boards

Boards of public health organisations, are responsible for establishing an Audit and Risk Management Committee to oversee, monitor, control, review and report on the implementation of policies, procedures programs and standards relating to organisational governance, services, functions, performance, compliance and risks.

Chief executives

Chief Executives of public health organisations are accountable for multiple dimensions of performance – financial, clinical, management, quality, risk, community expectations and health outcomes. Their key risk performance accountabilities will relate primarily to ensuring appropriate robust clinical, organisational and financial management structures are in place within the organisation.

Chief Executives need to ensure that there is:

- a robust risk management plan in place within the public health organisation and that this system is consistent with and embraces principles articulated by risk management approaches developed by the Ministry;
- an assessment, communication and reporting of risk that is clearly defined and differentiated;
- a regular review of the performance of the risk management plan and that review results are utilised as a basis for improvement;
- clear definition, allocation and documentation of the responsibility, accountability, authority and clearly defined interrelationships of those within the organisation who perform and verify work affecting risk management to an action plan;
- the identification and provision of adequate resources, particularly trained staff for the management performance of work and verification activities including internal review; and
- appropriate communication with internal and external stakeholders that has regard to their objectives and perceptions, and their needs for appropriate communication about risk management issues.

Audit & Risk Management Committee

The Audit & Risk Management Committee is a key component in the public health organisations corporate governance framework involved in the monitoring, review, oversight and reporting on:

- internal controls;
- enterprise risk management;
- business continuity plans;
- disaster recovery plans;
- corruption and fraud prevention;
- external accountability (including financial statements);
- compliance with applicable laws and regulations;
- internal audit and
- external audit.

The Audit & Risk Management Committee does not have executive powers or delegated financial responsibility, or management functions. The Committee is directly responsible to the governing board, or to the chief executive in a chief executive controlled public health organisation for the exercise of its responsibilities.

The Audit & Risk Management Committee has the ability to seek explanations and additional information concerning financial and risk management matters and to provide reports to the governing board or chief executive. Primary responsibility for the management of the organisation rests with the chief executive or board.

11.4.4 Risk Management Process, Methods and Resources⁹

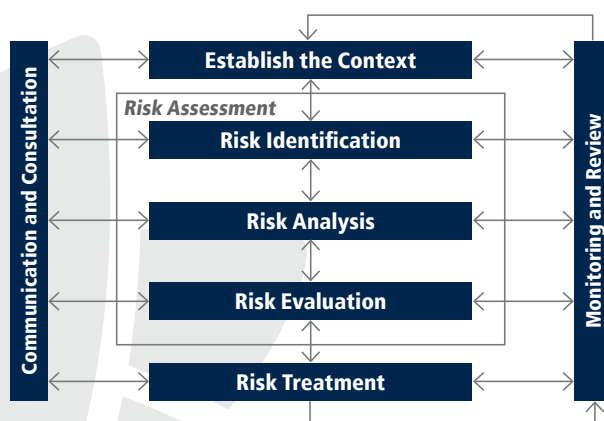
Policies, procedures, systems and internal controls for risk management should be clearly defined and communicated throughout the public health organisation. Appropriate resources should be in place to support risk management policy and practice.

To implement risk management across the organisation, boards and chief executives should:

- champion risk management within the organisation.
- ensure appropriate resources are allocated to managing and monitoring risk and to implementing risk minimisation and mitigation strategies which have been identified through risk planning activities.
- implement and keep current a risk management plan for the organisation.
- include risk assessments in strategic planning and decision making.
- ensure communication of risk management requirements to management and staff.
- establish and monitor the risk register for the organisation that provides for the recording, monitoring and management of risk.
- ensure that there is a formal delegation of authority from the chief executive to various levels of management within the entity to accept risks or take-up opportunities.
- review and action risks escalated from within the organisation.

Key documents
NSW Health Policy Directive Risk Management Enterprise-wide Policy & Framework NSW Policy Directive PD 2009_039 & AS/NZS ISO 31000:2009 Risk Management Principles & Guidelines

Elements in the enterprise risk management processes framework¹⁰ p11.



Source: NSW Treasury

9 See NSW Health Policy Directive Risk Management –Enterprise-Wide Policy and Framework NSW Health PD2009-039
 10 Also see diagram in PD2009_39 diagram page 11 NSW Health Policy Directive Risk Management-Enterprise-Wide Policy and Framework – NSW Health PD2009_39 and AS/NZS ISO 31000:2009 Risk Management – Principles and Guidelines

Risk Management Process

Establishing the context

An important first step is to consider the strategic, organisational and risk management context in which risks will be identified, managed and evaluated within organisational structures and the processes.

Risk identification

Identify what may happen, compile a comprehensive list of events (both risks and opportunities) that may affect the organisation, the sources of the risk and the areas of impact., Some of the examples of key risk categories identified in relation to health service delivery include the following:

- clinical care & patient safety;
- health of the population;
- workforce risks;
- communication & information;
- facilities and asset management;
- emergency & disaster response;
- finance & legal risks;
- safety & security;
- leadership and management;
- community expectations.

Risk analysis

Risks are then analysed to understand the nature of the risks, to identify the potential likelihood of occurrence, the consequences and impacts.

Risk assessment

Risk assessment then involves the comparison with the level of risk identified in the risk analysis stage against pre-determined criteria to determine whether the risk is acceptable within tolerable limits, or, if not then how it should be treated, controlled and prioritised.



Risk treatment & controls

Risks may be treated in several approaches ranging from rejection and risk avoidance, reducing the likelihood of the risk occurring, reducing the potential consequences, transferring the risks or retaining the risk within a specified strategy.

For public health organisations there are several key areas of risk control which require the rigorous application of risk identification, assessment, management and integration into strategic and operational risk assessment. Some examples include:

- fraud prevention and control plans;
- internal audit charters or plans;
- budget management strategies and plans;
- clinical services plans;
- asset (capital) management plans;
- workforce and human resource management plans;
- information technology plans;
- community engagement plans;
- safe practice environment plans;
- leadership and management plans.

Monitoring and review of risks

Identified risks need to be continually monitored and reviewed to ensure that risk management plans are appropriate and risk control processes are effective and the overall risk management approach remains relevant.

Communication and consultation within the organisation and with stakeholders throughout the risk management cycle is critical to achieving an effective risk management process.



Audit and Risk Management – Resources & References

NSW Health Policy Directive, Risk Management – Enterprise-Wide Policy and Framework – NSW Health (PD2009_039):

http://www.health.nsw.gov.au/policies/pd/2009/PD2009_039.html

NSW Health Policy Directive, Internal Audit – NSW Health (PD2010_039):

http://www.health.nsw.gov.au/policies/pd/2010/PD2010_039.html

NSW Health Guideline, Disaster Risk Management Guidelines (GL2009_004):

http://www.health.nsw.gov.au/policies/gl/2009/GL2009_004.html

NSW Treasury, Internal Audit and Risk Management Policy for the NSW Public Sector, available at:

<http://www.treasury.nsw.gov.au/tppdex>

NSW Treasury

http://www.treasury.nsw.gov.au/Internal_Audit_and_Risk_Management and NSW Treasury Office of Financial Management Policy & Guidelines Paper: Internal Audit and Risk Management Policy for the NSW Public Sector tpp09-05

Audit Office of NSW website:

<http://www.audit.nsw.gov.au/>

SAI Global AS/NZS ISO 31000:2009 Risk Management –Principles and Guidelines (previously the Australian/ New Zealand Standard 4360;2004, Risk Management).

The following documents are available on the NSW Health intranet only:

NSW Health Risk Matrix:

http://internal.health.nsw.gov.au/cgrm/rmra/risk_management/1_risk_matrix.pdf

NSW Health Risk Report Form

http://internal.health.nsw.gov.au/cgrm/rmra/risk_management/2_risk_report_form.pdf

Guidance Sheet for NSW Health Risk Report Form

http://internal.health.nsw.gov.au/cgrm/rmra/risk_management/3_guidance_sheet_risk_report_form.pdf

NSW Health Risk Management Self Assessment Checklist

http://internal.health.nsw.gov.au/cgrm/rmra/risk_management/4_self_assessment_checklist.pdf

NSW Health Risk Management Staged Implementation Plan

http://internal.health.nsw.gov.au/cgrm/rmra/risk_management/5_implementation_plan.pdf

Facilitating Risk Workshops

http://internal.health.nsw.gov.au/cgrm/rmra/risk_management/6_facilitating_risk_workshops.pdf

Identifying and Categorising Risks within NSW Health's priorities

http://internal.health.nsw.gov.au/cgrm/rmra/risk_management/7_identifying_categorising_risks.pdf

Risk Management Glossary

http://internal.health.nsw.gov.au/cgrm/rmra/risk_management/8_glossary.pdf

Local Documentation

The enterprise-wide risk management plan, developed using the NSW Health policy directive framework

Risk register with both clinical and non-clinical risks

Documentation with clearly identified responsibilities for the management of clinical and non-clinical risk

The Audit and Risk Management Committee Terms of Reference; and minutes of meetings.

Disaster Management plan

Audit reports and any documentation which demonstrates the implementation of recommendations and system improvements, following audit appraisals, investigations, and reviews

Risk assessments which have been conducted to facilitate a safe environment

OHS and risk management training records

Records of OHS consultation





