Health
Murrumbidgee
Local Health District

Murrumbidgee Local Health District

Board Governance Charter

Revised October 2023

Review and Revision

The Murrumbidgee Local Health District (MLHD) Governance Charter is to be reviewed at least every three years following a review of the MLHD Strategic Plan.

The MLHD Governance Charter is a MLHD Board endorsed document and may only be amended by formal MLHD Board decision.

The Chair may elect to task any individual to undertake a review of the MLHD Governance Charter or may form a Board Subcommittee to oversee or conduct such a review.

The Chief Executive and Board members have the right to propose an amendment to the MLHD Governance Charter under the protocols pertaining to the conduct of Board meetings.

Document control

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1. Purpose of the Murrumbidgee Local Heath District Board Charter

1.1. General Purpose of the MLHD Board Charter ("the Charter")

The Charter seeks to outline and as far as possible, define, the legal framework within which the Murrumbidgee Local Health District ("MLHD") Board operates, specifically with reference to the requirements of the NSW Health Ministry Corporate Governance and Accountability Compendium, which outlines the governance requirements that apply to all statutory bodies within NSW Health including the MLHD. The Compendium lists a variety of directives, resources and checklists which have been utilised, referred to or acknowledged in the Charter. The Charter references the policies, legal mandates and other responsibilities that the Board is required to meet, and assists the MLHD Board in delivering good governance and allows communication of the Board's policies and expectations to the Chief Executive ("the CE") and other executive directors and sets out the functions and responsibilities of the Board and of the CE. The Charter provides assurance that the Board has implemented robust governance processes and is a point of reference in the event of disputes. Further, the Charter serves as an induction tool for new directors, executives and senior managers, and directs the MLHD Board to focus on continuous improvement in governance processes for the benefit of the community. Finally, the Charter provides a forum for discussing 'hard-to-mention' governance issues.

1.2. NSW Health Corporate Governance and Accountability Compendium ("the Compendium")

The Charter directly references and follows the principles as stated in the Compendium, which is able to be accessed on the following link: https://www.health.nsw.gov.au/policies/manuals/Pages/corporate-governance-compendium.aspx

1.3. Standards of Governance

The MLHD Governance Charter seeks to achieve a corporate governance arrangement that complies with the seven standards of governance that the Compendium details. The standards are:

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

2. New South Wales Health System Overview

2.1. NSW Health Organisation Chart

NSW Health organisation chart

2.2. **Minister for Health and Minister for Regional Heath;** 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 (LHD) is failing and urgent intervention is required. 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. 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 Minister is supported by the Minister for Mental Health and the Minister for Medical Research, who, together with the Minister, is responsible for the health portfolio of the NSW Government.

2.3. **The Secretary, NSW Ministry of Health ("the Secretary")**
The Secretary 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 Secretary has the function of giving directions to LHDs, to ensure that they fulfil their statutory and financial obligations and to assist the State meet its own obligations as system manager. The Secretary is also responsible for entering into performance and Service Agreements with LHDs and employing staff of local health districts on behalf of the State. The Chairs of LHD and Specialty Network Boards come together on a regular basis as the Council of Board Chairs to confer with the Minister for Health and the Secretary. The Council

provides a key leadership group for NSW Health.

2.4. **The Ministry of Health**

The NSW Ministry of Health ("the MOH") 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 statewide planning, purchasing and performance monitoring and support of health services. The MOH 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 LHDs, specialty networks and non-government affiliated health organisations, known collectively as NSW Health.

2.5. **NSW Health Pillars**

NSW Health has a number of statutory health corporations commonly referred to as 'The Pillars. At the State level The Pillars are a focal point for clinical engagement, clinical planning and design and review functions in their area. The Pillars have a close working relationship with both the Ministry of Health and the LHDs and speciality networks and play a key role in the respective areas of healthcare design, standards, reporting, education and associated policy. The Pillars are:

- Agency for Clinical Innovation https://aci.health.nsw.gov.au/
- Bureau of Health Information https://www.bhi.nsw.gov.au/
- Cancer Institute NSW https://www.cancer.nsw.gov.au/
- Clinical Excellence Commission https://www.cec.health.nsw.gov.au/
- Health Education and Training Institute https://www.heti.nsw.gov.au/

2.6. **Shared Services and State-wide Health Services**

To support LHDs in their service delivery, and the Pillars in their support and mentoring functions, there are three statewide shared health services. These are:

- HealthShare NSW providing food and linen services and supplying disability services and equipment http://www.healthshare.nsw.gov.au
- eHealth NSW providing statewide 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 http://www.ehealth.nsw.gov.au/
- Health Infrastructure managing and coordinating approved major Health capital works projects, and provides capital project delivery support services to public health organisations http://www.hinfra.health.nsw.gov.au/

The three state-wide health services are:

- NSW Ambulance - responsible for the delivery of front line pre-hospital care, medical retrieval and health related transport

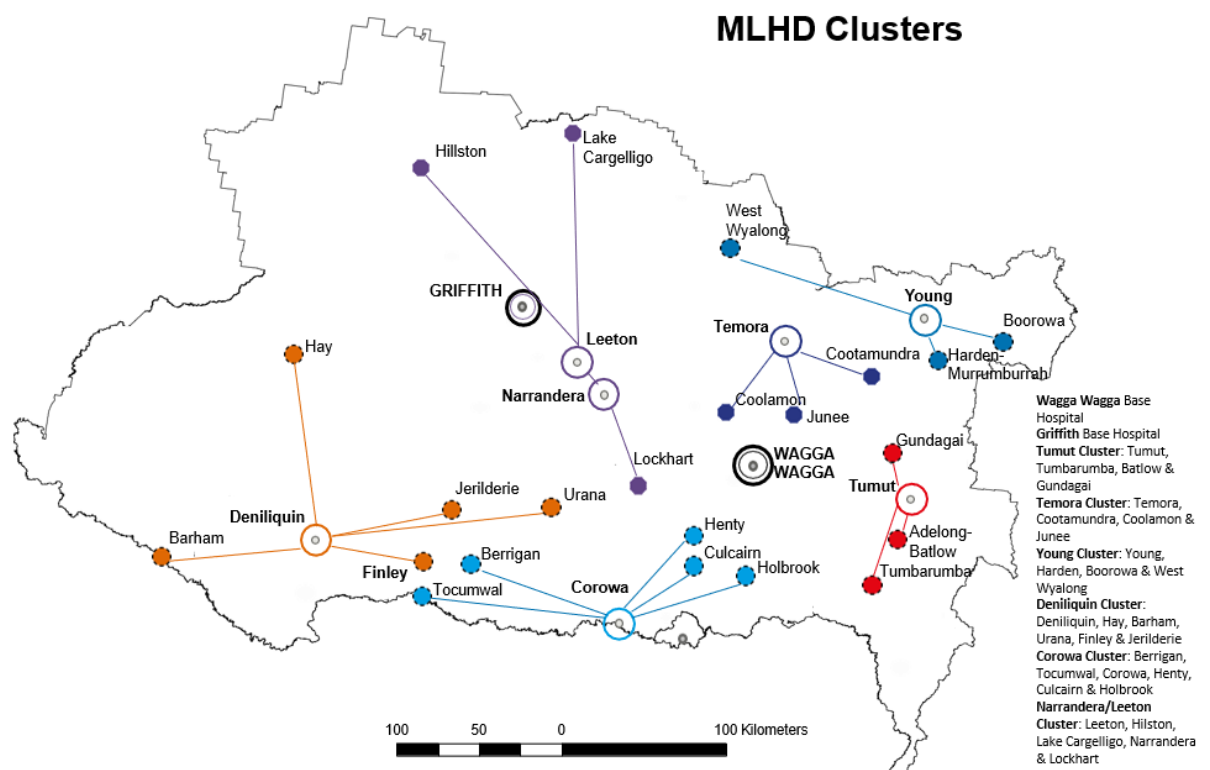
- Health Protection NSW - responsible for surveillance and public health response in NSW
- NSW Health Pathology - provides quality, reliable public pathology, forensic and analytical science services across NSW

3. Murrumbidgee Local Health District

3.1. Overview of NSW LHDs

The public health system in NSW is recognised or established under the *Health Services Act 1997*. LHDs, statutory health corporations, and affiliated health organisations are referred to under the *Health Services Act 1997* as Public Health Organisations. MLHD Board is responsible for managing public hospitals and health institutions and for providing health services to the people of Murrumbidgee NSW. The primary purposes of a LHD, as set out in 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 to promote, protect and maintain the health of the community.

3.2. MLHD Area Map



3.3. MLHD Overview

MLHD provides a range of public health services to the Riverina and Murray regions of NSW stretching from the Snowy Mountains in the east, to the plains of Hillston in the north-west and along the Victorian border. MLHD operates 33 public hospitals which include a rural referral hospital, a base hospital, multi purpose services, residential aged care facilities, community health services and posts, mental health inpatient and recovery service and a brain injury rehabilitation service. MLHD

employs over 5000 staff3,443FTE and associated employment classifications), and is supported by 33 Local Health Advisory Committees and hundreds of volunteers. The District covers 125,243 square kilometres and services a population of approximately 248,087 of which 5.9% identify as First Nations people.

3.4. **Key Functions of LHDs**

The key functions of all LHDs, including MLHD, under the *Health Services Act 1997*, reflect these responsibilities and primary purposes. They include:

3.4.1. to promote, protect and maintain the health of residents of its area

3.4.2. to conduct and manage public hospitals, health institutions, health services and health support services under its control;

3.4.3. to achieve and maintain adequate standards of patient care and services;

3.4.4. to ensure the efficient and economic operation of its health services and health support services and use of its resources;

3.4.5. to cooperate with other local health districts and the Secretary, NSW Health in relation to the provision of services;

3.4.6. to make available to the public information and advice concerning public health and health services available within its area.

3.5. **Service Level Agreement**

Each year the MLHD Board is required to enter into a Service Agreement with the Secretary of NSW Health. This service agreement sets out the service delivery and performance expectations for the funding and other support provided to MLHD to ensure the provision of equitable, safe and high quality and human centred health care services. The agreement articulates direction, responsibility and accountability for the delivery of NSW Government and NSW Health priorities. The Chair of the Board and Chief Executive (CE) of the MLHD are the signatories to the Service Agreement with their signatures to be given following a Resolution of the Board agreeing to the elements of the service agreement. A link to the Service Level Agreement can be accessed here

3.6. **Responding to Premier Priorities**

Premier priorities have been introduced to ensure a safer, more efficient health service. These priorities represent the government's commitment to making a significant difference to enhance the quality of life of the people of NSW.

4. MLHD Board

4.1. Board Composition

The MLHD Board consists of a selection of 6-13 members appointed by the NSW Minister of Health. 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:

4.1.1. expertise and experience in matters such as health, financial or business management

4.1.2. expertise and experience in the provision of clinical and other health services

4.1.3. representatives of universities, clinical schools or research centres

4.1.4. knowledge and understanding of the community

4.1.5. other background, skill, expertise, knowledge or expertise appropriate to the organisation

4.1.6. 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.

4.2. Terms of Office

Board members will be appointed for a term up to five years and are eligible for reappointment for an additional term up to five 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.

4.3. Attendance of Chief Executive at Board meetings

The Chief Executive (CE) is not a member of the Board, but under the *Health Services Regulations 2013* is entitled to attend Board meetings in an ex officio capacity.

5. Role of the Board

5.1. General

The role of the Board is focused on leading, directing and monitoring the activities of the MLHD and driving overall performance.

5.2. Statutory Functions

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

5.2.1. 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 MLHD and to approve those frameworks;

5.2.2. to approve systems to support the efficient and economic operation of MLHD; to ensure the district manages its budget to ensure performance targets are met; to ensure that district resources are applied equitably to meet the needs of the community served by MLHD;

5.2.3. to ensure strategic plans to guide the delivery of services are developed for the MLHD and to approve those plans.

5.2.4. to provide strategic oversight of and monitor MLHDs financial and operational performance in accordance with the State-wide performance framework against the performance measures in the service agreement for the district;

5.2.5. to make recommendations for the appointment of the CE of MLHD and to provide accountability for CE performance. The Board may make recommendations concerning performance management, discipline or removal of a CE should that be necessary;

5.2.6. to confer with the CE of MLHD 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);

5.2.7. to approve the service agreement for the MLHD under the NHRA;

5.2.8. to seek the views of providers and consumers of health services and of other members of the community served by the MLHD, as to policies, plans and initiatives for the provision of health services, and to confer with the CE on how to support, encourage and facilitate community and clinician involvement in the planning of district services;

5.2.9. to advise providers and consumers of health services and other members of the community served by the MLHD, as to the district's policies, plans and initiatives for the provision of health services;

5.2.10. 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; and

5.2.11. 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.

5.3. **Governance**

5.3.1. The Board is responsible for exercising and administering the powers contained in the *Health Services Act,* other applicable legislation, the Regulations or other policy or directions from the Ministry of Health, and ensuring the terms of such are complied with within delegation, ensuring public funds assigned it in accordance with funding instruments or agreements are appropriately budgeted, administered and accounted for, and generally providing good stewardship over the governance of the LHD.

5.3.2. The Board must oversee the corporate and clinical governance framework via setting of a reporting schedule, to ensure that MLHD is acting in accordance with its legislative and regulatory compliance requirements.

5.3.3. The Board is responsible for the recruitment of a CE, in consultation with the Ministry of Health. The Board may, when required, appoint an Interim or Acting CEO. The Board is responsible for the performance monitoring and accountability of the CE, and may instigate performance management, discipline or dismissal actions as may be appropriate.

5.4. **Strategy**

5.4.1. MLHD has a responsibility to effectively plan over the short and long term to enable service delivery that is responsive to the health needs of the people of the Murrumbidgee area.

5.4.2. A range of plans, which the Board endorse, underpin the delivery of the overall strategic plan. These include, but are not limited to, workforce plans, asset plans, ICT plans, clinical services plan, and Aboriginal Health Impact Statement and Guidelines (detailed in 5.5. of this Charter)

5.4.3. A link to the current Strategic Plan for MLHD can be found here:https://www.mlhd.health.nsw.gov.au/getmedia/a4086e0f-1bf0-4d14-9c16-f21dcf193483/mlhd-strategic-plan-2021-2026.pdf.aspx?ext=.pdf

5.5. **Aboriginal Health Impact Statement and Governance**

The MLHD Strategic Plan ensures the needs and interests of Aboriginal people are embedded into the development, implementation, and evaluation of the Strategic Plan. The Strategic Plan references the Aboriginal Health Impact Statement and uses this tool to guide 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. MLHD First Nations Acknowledgment of Country and Commitment Statement is available here

5.6. **Monitoring and Compliance**

5.6.1. The Board endorses a schedule of reports, returns and attestations to be monitored annually. This includes quarterly review of the Strategic Plan and monthly Integrated Operational Reports. The Board monitors Service Level Agreement performance via the Board committees throughout the year and annually.

5.6.2. Each year the MLHD must publish an annual Corporate Governance Attestation Statement, which outlines the governance arrangements and includes key information on MLHD operations. Compliance with the actions in the governance statements does not ensure the quality of governance, rather it provides the minimum structural elements for good governance which is necessary to support MLHD to meet its objectives and obligations.

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

5.6.3.1. certified by the CE and Board chair (where applicable) as accurately reflecting the corporate governance arrangements for the preceding financial year

5.6.3.2. submitted to the Ministry of Health by 31 August each year to ensure the information is available during the organisation's annual performance review

5.6.3.3. published (whole statement) on the MLHD internet page

5.7. **Risk Management**

5.7.1. MLHD is committed to developing a risk management culture, where risk is seen as integral to the achievement of our aims at all levels of the organisation.

5.7.2. Risks can be strategic or operational. Strategic risks broadly have the potential to impact the Strategic Plan while operational risks impact the delivery of services as defined in the Service Agreement. Risks must be identified and managed at the appropriate level for an organisation to be

effective. Opportunities and threats should be addressed through a risk management process in order to maintain and improve performance and achieve identified objectives.

5.7.3. MLHD is required to implement a risk management approach in line with the NSW Health Enterprise-Wide Risk Management Policy and Framework PD2015_04

5.7.4. MLHD 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:

5.7.4.1. *Public Finance & Audit Act 1983;*

5.7.4.2. *Government Sector Finance Legislation (Repeal and Amendment) Act 2018;*

5.7.4.3. *Annual Reports (Departments) Regulation 2015;*

5.7.4.4. *Annual Reports (Statutory Bodies) Regulation 2015;*

5.7.4.5. *Government Information (Public Access) Act 2009;*

5.7.4.6. *Workplace Health & Safety Act 2011;*

5.7.4.7. *Protection of the Environment Operations Act 1997*

5.7.5. The MLHD Board will:

5.7.5.1. ensure an effective risk management framework (including risk appetite and risk tolerance) is established and embedded into the clinical and corporate governance processes of the organisation

5.7.5.2. provide strategic oversight and monitoring of organisation's risk management activities and performance

5.7.5.3. seek information from the CE as necessary to satisfy itself that risks are being identified and mitigation strategies are in place and effective

5.7.5.4. establishing an Audit and Risk Committee to provide independent assistance by monitoring, reviewing and providing advice about MLHD's governance processes, risk management and control frameworks, and its external accountability obligations

5.7.6. With oversight of the Board, the CE will maintain a Risk Register. This will contain both strategic and operational risks, their probability, severity, potential impact and mitigation strategies. It is an input to Executive Team meetings, and the Audit & Risk Committee will review risks and their mitigation. In particular the CE is responsible for ensuring:

5.7.6.1. a corporate culture of risk management

5.7.6.2. appropriate risk assessments, evaluation and prioritisation occur

5.7.6.3. mitigation strategies are implemented

5.7.6.4. risk management systems are communicated and implemented

5.7.6.5. significant breaches of risk management procedures are reported

5.7.6.6. allocation of appropriate resources within budget to ensure implementation of risk management programs

5.7.6.7. business continuity/disaster recovery plans are in place

5.7.6.8. Reporting on significant risks, and progress in dealing with them, is a mandatory component of each MLHD Board meeting.

Further information on Risk Management is available in The NSW Health Compendium.

5.8. Stakeholder communications

5.8.1. 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.

5.8.2. In line with the Regulations, an Annual Public meeting is to be held between 1 July and 31 December each year. Any person is entitled to attend the annual public meeting and seek leave to address the meeting. The agenda and conduct of the MLHD Annual Public Meeting is to be developed after discussion between the Chair and the CE but is to include a report on the affairs of the MLHD since the last public meeting including audited financial statements for the MLHD. The holding of the annual public meeting is to be advertised in at least one newspaper circulating generally in the areas of the MLHD and by such other means as the Board determines.

5.8.3. The Board will endorse community engagement plans in order to ensure key stakeholder groups are engaged, and without being exhaustive, such as patients, families, carers, volunteers, aged care providers, schools, local government, community organisations and Local Health Advisory Committees (LHACs).

5.8.4. Local Health Advisory Committees (LHACs):

5.8.4.1. LHACs are a central connection between the local community and MLHD activities. Local committees work with facility managers to identify local service needs, ways to improve access to services, and to assist in planning and development.

LHAC's were created as a platform for community members to raise concerns and provide support for the district.

5.8.4.2. The groups provide valuable input into planning health services and sharing information with the local community. LHACs have the opportunity to get together twice a year; sharing information, networking and building alliances. These forums are an ideal opportunity for Board members to engage with LHAC members and build linkages to the disparate communities in the MLHD.

5.8.4.3. The Board will seek to ensure that it receives reports from LHACs, and where possible, directly engage with the LHACs in an appropriate manner.

5.8.5. Clinician Engagement:

5.8.5.1. The Board (under the auspices of the CE) is to establish the following structures and forums to provide input for medical, nursing and allied health staff:

5.8.5.1.1. Medical Staff Councils and Medical Staff Executive Councils

5.8.5.1.2. Hospital Clinical Councils and Joint Hospital Clinical Councils

5.8.5.1.3. A Local Health District Clinical Council

6. Roles and Responsibility of Individual Directors

6.1. **General**

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. Directors are expected to be forthright in meetings, to be adequately prepared and consider all aspects of any issue that influences the strategic direction of the organisation. The Board Directors must respect the MLHD Executive's operational role in execution of the Board strategy. Outside the Boardroom Directors must support all Board decisions to stakeholders.

6.2. **General legal duties applicable to Board members**

6.2.1. Compliance with laws and policy directives

6.2.1.1. Requirement to comply with relevant legislation including regulations; and

6.2.1.2. Requirement to comply with the Department of Premier and Cabinet Guidelines for Members of NSW Government Boards and Committees, and the NSW Health Code of Conduct;

6.2.2. Fiduciary duties of good faith:

6.2.2.1. Duty to act honestly and properly for the benefit of the organisation;

6.2.2.2. Duty to disclose interests in matters before the Board, including potential conflicts of interest; and

6.2.2.3. Duty not to divert (without properly delegated authority) the organisation's property, information and opportunities.

6.2.3. Duty to act honestly and properly for the benefit of the organisation:

6.2.3.1. 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;

6.2.3.2. 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;

6.2.3.3. A Board member has a duty to demonstrate leadership and stewardship of public resources.

6.2.4. Duty to disclose interest:

6.2.4.1. A Board member must disclose to the Board any direct or indirect interest the member has in a matter before them;

6.2.4.2. 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;

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

6.2.4.4. Duty of confidentiality of information about the affairs of the Board or its organisation obtained as a Board member;

6.2.4.5. Release of information by a Board member must be both lawful and either required by law or authorised by the Board;

6.2.4.6. The use of the organisation's property, information or opportunities must be authorised by the Board and be for the benefit of the organisation.

6.2.5. **Duty of care and diligence:**

6.2.5.1. Board members are required to exercise care and diligence in the exercise of their powers;

6.2.5.2. A Board member need show no greater skill than may reasonably be expected from a person of his/her knowledge and experience;

6.2.5.3. 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;

6.2.5.4. 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

All Directors are required to sign declarations of Interests, Ethical Behaviour and Confidentiality.

7. The Chair and Deputy Chair of the Board

7.1. General

The Chair is responsible for the leadership and effective conduct of the Board, The Chair serves as the official representative and spokesperson for the Board and is the principal link between the Board and the CE. The role of the Board Chair is specified in the NSW Government Boards and Committees Guidelines. The Chair is responsible for leading the activities of the Board or committee including, but not limited to:

7.1.1. ensuring that the Board or committee performs its functions, acting within any relevant statutory powers, legal obligations and complying with approved policies relevant to the entity (including whole of government policies);

7.1.2. facilitating the conduct of meetings to allow frank and open discussion;

7.1.3. ensuring individual members make an effective contribution;

7.1.4. developing the capability of the Board or committee and its members;

7.1.5. facilitating the flow of information to members and stakeholders;

7.1.6. liaising with the relevant Ministers, Secretary and CEs;

7.1.7. reviewing the performance and contribution of members.

7.2. Deputy Chair

While not a strict requirement for the Board to have a Deputy Chair in place, the Board may nominate a Director, with the consent of the Chair and approved by the Minister, to act as Deputy to the Chair.

8. The CE and Executive

8.1. General

The CE of MLHD is employed in the Health Executive Service (part of the NSW State Executive Service) by the Secretary, NSW Health under section 116 of the *Health Services Act* on behalf of the NSW Government. The role of the CE is set out in section 24 of the *Health Services Act*. The CE manages the day to day affairs of the MLHD. The CE can commit the MLHD contractually and legally within delegation and is the employer delegate for all staff working in the organisation. CEs are, in the exercise of their functions, accountable to their Board.

8.2. Appointment

The CE is appointed by the Board subject to the terms and conditions specified in the instrument of appointment. The CE is an ex-officio member of the Board without voting rights.

8.3. CE Performance

The CE is to receive an annual performance appraisal from the Chair. The process and format of the appraisal is to be consistent with requirements and policy directives for the Health Executive Services under which the CE is employed. The basis for the appraisal is as follows:

- 8.3.1. monitoring of CE to be only against stated expected job outputs;
- 8.3.2. monitoring to determine CE compliance with Board policies;
- 8.3.3. CE to provide the board with monitoring data;
- 8.3.4. CE to provide evidential data addressing board pre-stated expectations;
- 8.3.5. Board may also use third parties to provide external reporting;
- 8.3.6. the Board may utilise direct inspection to assess compliance with policy;
- 8.3.7. Board is final arbiter of ‘reasonableness’ of compliance;
- 8.3.8. policies instructing the CE will be regularly reviewed by the Board

8.4. Termination

Under the circumstances whereby the Chair considers the performance of the CE to be deficient, the matter of CE performance may be discussed as an agenda item of either a regular MLHD Board meeting or as an extra-ordinary meeting. Such discussion is to be conducted as a Confidential matter under the provisions of this Charter. The Chair has the discretion to advise the Secretary of NSW Health and/or the NSW Minister that the performance of the CE is being formally discussed by the MLHD Board. Where the MLHD Board formally votes by a simple majority that it has no confidence in the ability of the CE to continue in that position, the NSW Minister of

Health and the Secretary NSW Health must be immediately advised by the Chair by e-mail and subsequently by formal letter within 24 hours of the vote being taken. The Chair may determine to establish a Board Subcommittee to consider the performance of the CE. Any consideration of CE performance must include provision for negotiation of contractual terms prior to any advice to any party outside the MLHD Board that the CE's performance is considered inadequate.

8.5. **Director protocols concerning CE and other staff**

To guide the Board to CE interface the following protocols are to be observed:

8.5.1. Board connection to operations is only through the CE and not via other MLHD staff

8.5.2. Only Board decisions as per the provisions of this governance charter are binding on the CE

8.5.3. Individual Board member instructions are not binding on the CE unless authorised by a Board decision

8.5.4. Individual directors are not to participate in day-to-day management (unless board authorised or through a formal employment contract)

8.5.5. Individual directors are not to make representation or agreements (unless authorised by a Board decision and so delegated)

8.5.6. The CE is to respect the right of Board members to inspect LHD records/documents where such requests are registered by respective Board members at a Board meeting during General Business

8.5.7. Board members may arrange to discuss issues of interest with the CE at times of mutual convenience. Such discussions may be private or publicly known but are not in themselves binding on either party

9. Board Meetings and Decision Making

9.1. Board meetings

9.1.1. Board meetings are to be chaired by the Board Chair or nominee who must be a Board member.

9.1.2. A quorum, defined as at least half of the existing appointed Board members, is required for a formal Board meeting with the authority to make determinations or to direct actions within the MLHD.

9.1.3. Any vote of the MLHD requires a simple majority of those Board members present, being a quorum or greater.

9.1.4. The Board may from time to time invite non-Board Members or non-Ex Officio Members to the Board Meetings to speak to the Board about strategic issues or other matters of importance.

9.1.5. Board meetings are to be conducted in accordance with the following guidelines:

9.1.5.1. decisions are to be by an open vote of hands with a majority of Board Members recorded as attending the meeting voting in support of a motion;

9.1.5.2. decisions taken are to be framed as one of the following:

9.1.5.2.1. a motion to ***direct*** a specific individual to undertake an action including:

9.1.5.2.1.1. the individual responsible for the action

9.1.5.2.1.2. the specific action required

9.1.5.2.1.3. the timeframe by which the action is to be completed

9.1.5.2.2. a motion to ***approve*** whereby the Board is approving a specific action

9.1.5.2.3. a motion to ***endorse*** whereby the Board is supporting a decision made by an individual or body

9.1.5.2.4. a motion to ***note*** whereby the Board is acknowledging information presented to the Board;

9.1.5.3. if the number of votes for and against a proposal by the Board members recorded as attending the Board meeting is equal, the Chair (or presiding member) has a second or casting vote;

9.1.5.4. subject to the provisions for making decisions the directors may determine, by a majority vote, to make additional rules about the conduct of meetings providing such determinations are conveyed to all directors attending a meeting.

9.1.5.5. In circumstances where the Board determines to defer a formal motion on an issue considered during any form of Board meeting, the Chair may determine to seek an out-of-session vote by email. The formal motion is to be circulated in writing, that is, by email or, letter, to each Board member not less than 24 hours prior to the closure time for voting on the motion. Each Board member is to vote on the proposed motion with the vote to be made in writing to the Chair by the nominated time detailed in the motion statement. Amendments to the proposed motion are not permitted. The motion may be passed if a simple majority of Board members vote in favour of the out-of-session motion.

9.2. **Board agendas**

9.2.1. The agenda for each MLHD Board meeting is to be promulgated no less than five working days prior to the scheduled time for that meeting. The agenda is to be formulated by the MLHD Chair in consultation with the CE.

9.2.2. The agenda is to be distributed by email to a NSW Health email address and Board MS Teams page.

9.2.3. Agenda items distributed less than five working days prior to the scheduled meeting must be held over to a subsequent scheduled meeting, or be subject to a special meeting, or be subject to an out-of-session vote however requested by any Board member by communication to the Chief Executive.

9.2.4. Each agenda must make provision for the following:

9.2.4.1. conflict of interest declarations

9.2.4.2. review of minutes of the immediately previous meeting

9.2.4.3. review and discussion of Board subcommittee minutes

9.2.4.4. review of uncompleted actions arising from any previous Board meeting

9.2.4.5. discussion of risk

9.2.4.6. review of critical issues

9.2.4.7. discussion of future planning

9.2.4.8. questions without notice to the CE from Board Members

9.2.4.9. raising of non-agenda items through chair

9.3. **Board papers**

With the exception of the publicly released Minutes or where the Board has determined that specific documents are able to be released, all Board documents are to be regarded as Confidential. Board members have an individual responsibility for

protecting and maintaining this confidentiality of both electronic and paper documents.

9.4. **Board calendar**

9.4.1. The Board is required to hold at least six ordinary meetings in any twelve month period with such meetings being held at regular intervals.

9.4.2. A timetable of MLHD Board Meetings will be promulgated annually and at least four months prior to the commencement of that timetable. The proposed timetable will be presented by the Board Chair, requesting a formal motion of approval by the MLHD Board.

9.4.3. Special meetings of the Board can be called in accordance with the Health Service Amendment (Local Health Networks) Regulation 2010, Section 14.

9.4.4. Special meetings are to be called by the CE:

9.4.4.1. At the direction of the Chair; or

9.4.4.2. Within 48 hours of receipt by the CE of a written request for a special meeting signed by at least three members of the Board.

9.4.5. The special meeting is to be held no later than seven days after receipt by the CE of the above.

9.4.6. The CE is to give at least 24 hours written notice to each members and each person invited to attend. Notice of the meetings is to specify the business to be considered at the meeting and contain such material relevant to the business as the CE considers appropriate. Only business specified in the notice of a special meeting is to be considered at the special meeting.

10. Committees

10.1. General

The Board is required to establish committees to provide advice or other assistance to enable the MLHD to perform its functions under the Act. These committees are to include:

10.1.1. Audit and Risk Management Committee

10.1.2. Planning, Resources and Performance

10.1.3. Healthcare, Safety, Quality and Research

10.1.4. Other committees as the Board determines

- MLHD Aboriginal Health Governance Committee
- Murrumbidgee Primary Health Network and MLHD Collaboration Agreement – Joint Board Sub Committee

10.1.5 At least one board director will be appointed to the Murrumbidgee Health and Knowledge Precinct Working Group.

10.2. Terms of Reference for Committees

The criteria under which these structures and forums function are set out in The Compendium and in the NSW Health Model By-Laws. Each of these committees has established Terms of Reference.

10.3. Medical and Dental Appointments Advisory Committee

The Board is also required to establish a Medical and Dental appointments Advisory Committee that advises the CE.

10.4. Ad Hoc or Special Purpose Sub-Committees or Working Parties

In accordance with the By-Laws, the MLHD Board may direct the formation of Board Sub-Committees or Working Parties to examine and consider specific issues and subsequently provide advice to the MLHD Board. These subcommittees are to be formed, dissolved and operate under the rules outlined in the By-Laws.

10.5. Committee Chairs

The Board may appoint Chairs to its Committees. The Chair of a committee:

10.5.1. approves committee meeting agendas for distribution;

10.5.2. approves draft committee minutes for distributions;

10.5.3. reports to the Board on significant issues discussed at committee meetings;

10.5.4. provides recommendations to the Board on behalf of the committee as appropriate.

11. Board Effectiveness

11.1. Director protection

Section 133B of the *Health Services Act* 1997 provides 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.

11.2. Indemnity cover

The Treasury Managed Fund Statement of Cover 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.

11.3. Board evaluation

The performance of the Board is appraised annually. The appraisal consists of three parts:

11.3.1. A self-appraisal of the collective performance of the Board;

11.3.2. A self-appraisal by each Board member of their own performance;

11.3.3. An review by the Board Chair of each Board member's performance according to the following criteria:

- 11.3.3.1. Attendance at not less than 75% of Board meetings
- 11.3.3.2. Meeting preparation at an acceptable level
- 11.3.3.3. Involvement with the Board, pursuant to the responsibilities of the Board, sufficient to justify the individuals continued Board membership
- 11.3.3.4. Individual conduct consistent with the relevant legislation and this Charter

11.4. Performance Management of Individual Director by the Chair

Where at any stage the individual performance of a Board member, in the judgement of the Chair, is assessed as not satisfactory the member is to be advised in writing by the Chair. After such advice, and not before the expiration of six months, if the Chair views that the individual Board member is still not performing adequately, the Chair may advise the NSW Minister of Health suggesting such action as is deemed appropriate by the Chair. Such communication does not require the endorsement of the MLHD Board however the Board member under scrutiny is to be advised in writing that such a representation has been made.

12. Director Remuneration

12.1. Remuneration

Board appointees are remunerated at the rates set for public sector Boards approved through the Ministry of Premier and Cabinet. These fees are in line with the Public Service Commission's Classification and Remuneration Framework for NSW Boards and Committees and described in IB2013_013.

12.2. Public sector employees

Public sector employees are not entitled to be paid remuneration (neither an annual fee nor sitting fee) for work on Government committees. Public sector employees include Health Service employees, staff specialists and officers of other NSW Government agencies.

12.3. Expenses reimbursement

Board members are entitled to claim an out of pocket actual expense where an expense has been incurred that is associated with their role on the Board. Board Directors are encouraged to participate in relevant Education and Training. HETI online training is encouraged. Reimbursement of actual expenses includes travel costs, meals, accommodation and other approved travel costs are facilitated via the Secretariat of the Board once approved by the Chair. Claims are to be administered via the iExpenses system and processed on production of receipts and approval of the Chair and Chief Executive.

12.4. Expenses reports

Regular reports are to be provided to the Board on expenditure from the Board cost centre and performance to budget.

13. Director Induction and Development

13.1. **General**

The Chair and the CE are expected to contribute to the induction of all new Directors of the Board. Development activities for the Board as a whole and on an individual basis will be available from time to time.

13.2. **Minimum contents of Induction Program**

13.2.1. The induction program kit will include relevant information required to ensure that the induction process for the informing Board Director/s is 'fit for purpose' i.e. that it will meet the needs of that particular incoming Board Director/s at that particular time.

13.2.2. The induction kit will include all Board policies, this Charter, By-Laws, the Compendium, relevant declarations as to interests, gifts and hospitality, and any relevant legislation or regulation.

13.2.3. If practicable, a briefing from the Chair and the CE should be arranged for the incoming Director/s.

13.3. **Capacity building/continuing education**

13.3.1. The Board will ensure that it has the collective knowledge and skills to perform its role effectively and that individual Directors have the knowledge and skills to make an effective contribution via its annual review process contained in this Charter.

13.3.2. Newly appointed Directors are encouraged, with the support of the Chair, to attend all Board committee meetings in the first 6 months of their term.

14. Dispute Resolution

14.1. **Definition**

14.1.1. A dispute is defined as two or more Directors having difficulty working together, or a situation that is unduly affecting the ability of the Director, or the Board collectively, to perform their duties in an effective, safe and efficient manner.

14.1.2. A difference of opinion in relation to a decision or issue is not a 'dispute' unless the situation meets the definition of 15.1.1.

14.2. **Obligation to avoid disputes via informal process**

Directors are required to avoid disputes where possible. Directors must act in good faith to resolve the dispute as soon as possible in the public interest. The Chair will actively guide the parties toward resolution of the dispute. The other Directors will support this process. Should a party to the dispute be the Chair, this role is undertaken by a Director nominated by the Board.

14.3. **Notice of Unresolved Dispute**

If the dispute cannot be resolved informally, the Chair will place the matter on the agenda for the next meeting. At the meeting, the Board will invoke the formal mediation process if it is satisfied that:

14.3.1. A dispute exists that cannot be resolved informally;

14.3.2. It is in the public interest to do so.

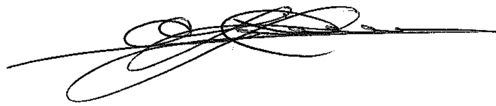
14.4. **Formal Mediation Process**

Where the Board invokes the formal mediation process:

Step	Action
1	An independent, suitably qualified mediator will be appointed who is acceptable to all parties.
2	If the parties cannot agree on a mediator, the dispute will be referred to the CE for appointment of an independent external mediator.
3	The parties will cooperate with the mediator and provide reasonable assistance. They will actively work in good faith to resolve the dispute.
4	If the dispute is resolved, unless good reason exists otherwise, the outcome will be recorded in writing by the mediator and signed by the parties, who will each receive a copy and consent to the Chair receiving a copy.
5	If the dispute cannot be resolved and is continuing to unduly affect the operation of the Board, the MOH will be contacted for advice.

14.5. **Risk**

If at any time a dispute poses a major risk to the effective operation of the LHD, the Minister and/or MOH will be notified.



Mr Adrian Lindner

Interim Chair

Date: 27 January 2024