BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Agenda

Health Consumer Council

Venue: Property Services Meeting Room
Date and Time: Tuesday 11 July 2018 at 11:00am

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1	**Apologies**	
2	**Introductions**	
3	**Presentation** 3.1 Overview of BOPDHB Strategic Priorities and Q & A Session – Averil Boon	
4	**Minutes of Meeting** - Nil	
5	**Matters Arising** - Nil	
6	**Papers for Decision** - Nil	
7	**For Discussion** 7.1 Interest Register 7.2 Terms of Reference 7.3 Is there an alternative to the word patient	 3 8 11
8	**Papers for Noting** - Nil	
9	**General Business**	

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10	**Next Meeting** - Tuesday 8 August 2018	

ACTING IN THE SPIRIT OF SERVICE

Conflicts of Interest

> New Zealanders need to have confidence that public servants work to the highest standards of integrity in everything they do. Public servants need to exercise a high standard of judgement around the management of conflicts of interest.
>
> — **Peter Hughes, State Services Commissioner**

New Zealand is held in high regard for the standards of honesty, openness, transparency and integrity in the State services, but our reputation depends upon our ability to be impartial in our decision making, and to exercise a high standard of judgement in relation to real and perceived conflicts of interest.

In a small country like New Zealand, conflicts of interest in our working lives are natural and unavoidable. The existence of a conflict of interest does not necessarily mean that someone has done something wrong. But organisations need good policies and processes to deal with conflicts of interest appropriately and staff need to be alert to the possibility of conflicts of interest and notify any conflicts promptly.

These model standards outline the State Services Commissioner's minimum expectations for staff and organisations in the State services to support effective reporting and management of conflicts of interest. The standards should be read alongside other relevant rules and standards (for example, the Crown Entities Act 2003 and the Office of the Auditor-General's guidance).

All State services organisations should ensure that these standards are integrated into policies and processes for managing conflicts of interest within their human resource, employment relations, and operational management systems.

SCOPE OF THE STANDARDS

A conflict of interest means a conflict between a public duty and private and/or personal interests. Personal interests can be financial or relate to family, friends or associates. Conflicts of interest may be actual, potential or perceived. There are three key elements to these standards:

1. **Getting the foundations right from the start:** organisational commitment to leadership, raising awareness, and supporting staff and managers through regular communication and training.
2. **Making sure processes are robust:** ensuring systems are in place for monitoring, reporting and managing conflicts of interest.
3. **Supporting staff when issues arise:** ensuring there are channels in place for people to raise concerns about how their declared conflict(s) of interest are being managed or breaches of the conflicts of interest policy.

GETTING THE FOUNDATIONS RIGHT FROM THE START

Organisational commitment, leadership and culture

There is a range of policies and guidance which all public servants, including chief executives, need to be aware of and comply with.

Each agency will have policies to cover such situations.

Model standards:

- Organisations need regular statements from senior leadership of their expectations of people within the organisation to act honestly and ethically, and to fully and openly disclose conflicts of interest.

Appointment and engagement

Organisations need to ensure that people who are applying for a role or contract (including those applying for senior leadership roles, casual or contract staff, secondees, consultants, board members or volunteers) are alert to the possibility of conflicts of interest and disclose these prior to appointment. Organisations may need to take a potential conflict of interest into account when considering an individual's suitability for a role.

Model standards:

- Organisations ensure that candidates are alert to the possibility of conflicts of interest and its expectations that people will act honestly and ethically, and fully and openly disclose actual and potential conflicts of interest and this is formally recorded.
- Organisations have procedures to allow candidates to review and disclose potential conflicts of interest as part of the pre-selection process.
- Expectations relating to conflicts of interest are explicitly referred to and recorded in contractual agreements; individuals are required to sign that they have read and understood the expectations and accept responsibility for identifying and recording their relevant private interests.

Training and awareness

It is important that people have access to good information and training that is regularly reviewed and updated so they are clear about what to do if they think they have a conflict of interest at any stage, and fully understand their responsibility to identify and disclose it.

Policies and procedures for full disclosure are the foundation of good management. It is a continual process as interests and conflicts change over time. Active management by the organisation is also needed to ensure that people regularly review their own interests and fully disclose any conflicts as early as possible.

Model standards:

- There are processes in all organisations for ensuring that existing and potential staff understand and are alert to the possibility of conflicts of interest and the requirement to disclose them.
- Training on recognising and disclosing conflicts of interest is covered in induction for staff and contractors, as well as following any changes to policies or procedures, supported by regular reminders of individuals' responsibility to identify and disclose.
- Training for managers includes receiving and dealing with disclosures of conflicts of interest, knowing how and when to access professional advice and support, and handling complaints or breaches of the policy.
- There are designated people or teams that staff can talk to when they think they may have a conflict of interest.
- All conflicts of interest disclosed to an organisation are assessed and either avoided or actively managed in a timely way.

MAKING SURE PROCESSES ARE ROBUST

Roles, responsibilities and accountability

Organisations need to have in place effective conflict of interest policies and processes that support robust and timely decision-making and foster public confidence in their integrity, the integrity of officials and public decision-making.

Everyone working in the State services has a duty to put the public interest above their personal or private interests when carrying out their official duties.

Appointment and Engagement

- Do you require individuals to sign an acknowledgement accepting responsibility for disclosing interests?
- Are candidates required to disclose potential conflicts as part of pre-selection?

Ongoing Disclosure

- Do your managers encourage teams to be alert to conflicts of interest?
- Do you have designated people or teams that staff can talk to when they think they may have a conflict of interest?

Managing Conflicts

- Is there a central mechanism in place for recording conflicts of interest?
- Is there support in place to assist managers receiving and managing conflict of interest situations?

Raising Concerns

- Do you have processes in place where people can raise concerns about the management of their disclosure?
- Can people find information on how to raise a concern, such as the 'Speaking Up' standards?

Senior leaders

Those in senior roles (such as Board members or senior managers) are expected to set an example in identifying and disclosing any interests relevant to their work, given their level of influence on decisions about matters of public significance or value and their higher public profile.

Partnerships with other stakeholders

When working with other stakeholders, including contractors, consultants and service providers, organisations need to take care to communicate expectations, identify potential conflict of interest areas before the contract starts, and develop and document appropriate responses to manage risks to all parties in a potential conflict situation.

Model standards:

- Internal policies and processes designate clear roles and responsibilities and are readily available for people to access.
- Internal policies provide clear rules that define inappropriate conflicts, such as involvement in the appointment of a family member.
- There is a mechanism for recording private interests that may give rise to a conflict of interest, which is frequently updated and monitored while appropriately protecting privacy.
- The policy makes it clear that the disclosure of a private interest does not in itself resolve a conflict and measures to resolve or manage the conflict must be considered.
- When a conflict of interest is suspected to involve criminal activity, organisations will report the matter to the Police or the Serious Fraud Office.

POLICIES, PROCESSES AND CHANNELS

The main goal of identifying and managing conflicts of interest is to ensure that all operational decisions are made – and are seen to be made – legitimately, justifiably, independently and fairly.

Integrated management processes and internal controls will support timely and appropriate identification and management of any risk.

Managing conflicts

Processes for managing conflicts of interest need to be robust, understood by people in the organisation, actively managed and fit together as a whole within the organisation's framework of management policies and internal controls. Conflicts of interest need to be well managed so that public trust and confidence in the individual or the organisation is not undermined.

Assessing a situation to identify whether a conflict of interest exists and must be avoided or is able to be managed, involves weighing up the interests of the organisation, the public interest, and the legitimate interests of the individual concerned, as well as other factors such as the position the individual holds and the nature and seriousness of the conflict.

Disclosure of conflicts of interest is a continuous process as interests change and new conflicts may emerge in the course of day to day business. An example of this is where it becomes apparent before or at a meeting that an attendee has a conflict of interest with regard to an item on the agenda.

Model standards:

- There are policies and processes in place for disclosing, recording and responding to conflicts of interest. Policies and processes reflect the organisation's particular functions, context and statutory requirements.
- There is a process for managing conflicts of interest which includes what constitutes a conflict, options for managing it (including considering whether or not an individual should continue to be involved with work in the potential area of conflict), who makes decisions, and potential consequences of non-compliance.
- There are clear and documented responsibilities and actions for managers receiving, assessing, managing and monitoring disclosed conflicts of interest.
- There are support mechanisms for assisting managers in reviewing and improving their skills in identifying and avoiding or managing conflicts.
- The arrangements for dealing with conflicts are clearly recorded in formal documents to enable the organisation concerned to demonstrate, if necessary, that a specific conflict has been appropriately identified and managed.
- Decision-making processes at all stages can be audited and justified.

Monitoring and evaluating

Organisations' ability to understand the nature of conflicts of interest in their operational environments relies on their ability to identify particular at-risk areas for potential conflict of interest situations, track and monitor any risks, and learn from them.

Centralised tracking and monitoring requires that managers, supervisors and other designated people to whom conflicts of interest are made are able to log and provide auditable details.

Model standards:

- All conflicts of interest are centrally recorded and organisations have designated people responsible for tracking, monitoring and reporting to senior leadership.
- Conflicts of interest are included in organisation's risk management programmes and reporting, including any internal or external risk and assurance committees.
- There are training and systems in place to enable centralised tracking, monitoring, auditing practices and continuous improvement of policies and processes.
- The conflict of interest register is regularly reviewed, updated and included as part of the organisation's audit programme.
- Monitoring agencies regularly review Crown entities' conflict of interest policies, procedures and registers.

SUPPORTING STAFF WHEN ISSUES ARISE

Raising concerns

It is important that people have a channel to make a complaint about how the organisation is managing their declared conflict(s) of interest.

People must also be able to raise concerns about wrongdoing, including suspected impropriety in relation to disclosure/non-disclosure of interests or the management of declared interests.

The State Service Commissioner's model standards for organisations to support staff on speaking up in relation to concerns about wrongdoing can be found here.

Model standards:

- Internal policies and processes include mechanisms to allow individuals to raise concerns about how the organisation is managing their declared interest.
- All concerns raised about management of declared interests are assessed, recorded and acted on in a timely way.
- There is appropriate separation of duties and well defined roles that underpin organisations' processes in relation to concerns raised by individuals.

USEFUL LINKS

- Office of the Auditor-General's guidance
- Crown Entities Act 2004 (sections 31 and 62)
- SSC's Board Appointment and Induction Guidelines

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

BOP Health Consumer Council
Draft Terms of Reference 2018
(to be reviewed by Council once appointed)

Purpose:	The Bay of Plenty Health Consumer Council (BOPHCC) will be a voice for the consumers of the health system and the people of the Bay of Plenty District Health Board (BOPDHB). The BOPHCC will work collaboratively with the BOPDHB as an advisory body to advance their vision of "Enabling communities to achieve good health, independence and access to quality services".
Functions:	The BOP Health Consumer Council will: • Enable meaningful consumer participation across the Bay of Plenty • Identify and advise on issues requiring consumer and community participation, including input into the development of health service priorities and strategic direction • Participate, review and advise on reports, developments and initiatives relating to provision of health services • Ensure regular communication and networking with the community and relevant consumer groups • Link with special interest groups as required, for specific issues and/or problem solving • Maintain an overview of consumer engagement activity across the BOPDHB for transparency benefits • Challenge planned services for any omission or disadvantage to those in most need, should it occur • Adhere to the BOPDHB's policies and protocols. For the avoidance of doubt, the BOPHCC will NOT: • Provide clinical evaluation of health services • Be involved in the BOPDHB's contracting processes • Be held accountable for decisions made by BOPDHB's management and/or governance whether compatible with BOPHCC's views or not • Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust BOPDHB processes exist • Represent any specific consumer interest group or organisation nor enter into communication with a clear conflict of interest.
Level of Influence	The BOPHCC has the authority to give advice and make recommendations to the BOPDHB senior management and the Board according to the levels of impact shown in the BOPDHB Consumer Engagement Framework – 2016.
Secretariat	Secretariat support provided, in collaboration with the BOPDHB Programme Manager, Quality & Patient Safety will convene the BOPHCC
Membership:	The BOPHCC will comprise ten to twelve consumer representatives. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible health care and services from the BOPDHB.

	Members will be selected to cover a range of areas e.g. Māori health, women's health, child health, long term conditions, mental health, and disability. Although appointed to reflect the consumer voice in a particular area of interest, an individual member will not be regarded as a representative of any specific organisation or community, nor an 'expert'. One BOPHCC member will be appointed from the Consumer Health Liaison Group Membership composition will include the following principles: • Reflect the requirements of the Bay of Plenty Health Services Plan • Reflect the population that uses health services • Recognise the need to address inequalities and disparities in health outcomes • Act to recognise BOPDHB responsibilities under the Treaty of Waitangi. When selecting members, consideration must be given to maintaining a demographic balance that reflects the population; Speciality, ethnic, rural/urban, east/west geography. The BOPHCC may co–opt other people from time to time for a specific purpose. Inaugural members will be appointed for a one or two-year terms to stagger end of term dates, and thereafter appointments will be for a two year term commencing in June each year. Members may be reappointed for no more than three terms. Members will be provided with training and support by the BOPDHB to undertake their role successfully. Remuneration shall be paid based on the BOPDHB Consumer engagement payment and reimbursement of expenses guidelines. All members who reasonably believe they may have an actual or potential conflict of interest is to disclose their interest to the chair immediately they become aware of it. Any conflict in interest will be recorded. Membership may be terminated or full dissolution of the BOPHCC may be undertaken by the Chief Executive Officer (CEO) of BOPDHB in consultation with the chair of BOPHCC. Termination will be requested within three months from when performance is found to be seriously unacceptable. Members who fail to attend three consecutive meetings without an apology will be asked by the chair to step down from the BOPHCC.
Chairperson	The inaugural chair will be appointed by the BOPDHB CEO (or delegate) for a term of one year. Thereafter the chair will be appointed by the CEO following consultation with BOPHCC members.
Meetings:	A minimum of ten meetings per year will be held February to November. Should more meeting time be required, this will be treated as an 'out-of-session' consultation. The Secretariat will provide administrative support.

	A quorum will be half the current membership, including the chair or delegate. Others may attend as invited persons to facilitate the business on hand by invitation of the chair. Minutes and agendas will be circulated at least a week prior to each meeting, with any reading material attached. Meetings will be up to two hours, held at an agreed time, to enable all members to participate. Meetings will be published on the BOPDHB website and be open to staff and the public. On occasion when there are issues of confidentiality or other risks, meetings may be closed in full or part at the discretion of the chair.
Reporting:	The BOPHCC will report and make recommendations to CEO quarterly or more often when requested. Relevant information is then reported to the Board by the CEO. Reports and minutes will be placed on the BOPDHB website once approved by members. Minutes of those parts of any meeting held in "public" shall be made available to any member of the public, consumer group, community etc. on request to the chair.
Terms of Reference Review:	Members will review the Terms of Reference (TOR) bi-annually and make any recommendations for change to the CEO. BOPHCC TOR will be reviewed and confirmed by CEO biannually.

BAY OF PLENTY
DISTRICT HEALTH BOARD
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Is there an alternative to the use of the word Patient?

SUBMITTED TO:

HCC Meeting: 11 July 2018

Compiled by: Lorraine Wilson, Programme Manager, Quality & Patient Safety

Submitted by: Debbie Brown, Manager, Quality & Patient Safety / Acting General Counsel

Endorsed by: Helen Mason, Chief Executive

RECOMMENDATION:

That the Board considers the paper and accepts that the word patient has its place and will be used however where the opportunity arises to use another term ie person, it will be taken.

BACKGROUND:

At the April 2018 Board meeting a query was raised as to whether it was possible to consider not using the word patient. Whilst this can be a goal, further thought needs to be given to this. The attached paper is provided to allow some thinking and context around the question “Is there an alternative to the use of the word Patient?”

Is there an alternative to the word Patient?

Use of the word 'patient' was hotly debated across many developed countries during the 1990s (see numerous journal articles, eg BJM *Do we need a new word for patients?* and *Do we need a new word for patients? What's in a name after all?* (1999). A summing up on the academic discourse of that time can be found in Tallis (1999) and his argument – paraphrased here – led researchers to turn their focus to instead ask people what they wanted.

Tallis argued that we shouldn't change something if it's not necessary to change it because change takes time, effort and resources. [Falkland's maxim: When it is not *necessary* to change, it is necessary *not* to change.] So if we were to proceed we would need to be confident that all three of these conditions were met:

1. The word has undesirable connotations that produce negative interactions between healthcare workers and those who seek healthcare services
2. There is an alternative word that would serve better
3. The change in terminology would bring about an improvement

To each of these points Tallis argued as follows:

1. Undesirable connotations:

The word 'patient' is tainted etymologically; Latin root 'patiens' or 'one who suffers' implies passivity and obedience, however most people are not schooled in etymology and so this is no reason to dismiss its use. It could also be argued that the modern day meaning of patient as in 'to be patient' is still problematic as we imagine people being patient while they wait passively for healthcare. If these things were so bad why has the term persisted even now?

2. An alternative?

There is no obvious alternative (and this has been tested repeatedly even in the years since Tallis). Alternatives include:

- Client – seen as having a similar imbalance between a professional (eg lawyer) and person seeking their services
- Health seeker – seen as absurd when applying this to, for example, 'ambulatory health seeker'.
- Customer (and similar eg consumer, user) - connotation of shopper/retailer seen as not sensitive enough to the vulnerabilities of person seeking help; all lose something essential about someone who is often uncomfortable, vulnerable, worried or frightened.

Compassion and a relationship of trust might seem paternalistic/materialistic but

> ". . . the distinctiveness of [the term] patient reminds us of the vulnerability of the ill person and the often harrowing responsibilities of the doctor or nurse; something frequently forgotten in the consumerist world picture. So while the term patient may be steeped in the abuses of the past, is also captures what is positive about the special relationship between health workers and ill people." Tallis (1999)

3. An improvement?

Even if a case for change could be argued, and a good alternative could be found, would this be an improvement? Tallis suggested that introducing new terms such as 'consumer' might have a negative effect where notions of health as a business over-ride empathy and compassion (seen as threats to productivity because of the additional time they take). He noted in 1999 that the logical next step would be to ask people what they actually think about the word 'patient' and the alternatives.

This work was subsequently carried out by many during the following years. Overwhelmingly people preferred the word 'patient'; see for example Deber et al (2005), wherein numerous studies are also cited. At the very least people found the word 'patient' the least objectionable compared to all others presented.

This work through the 2000s settled the debate for the majority and in effect repositioned both the word 'patient' and actual patients more powerfully. The focus has moved away from changing terminology to changing mind sets, particularly the mind sets of healthcare providers.

> "I appreciate why some people want to discard the term "patient" and replace it with something else, but I would respectfully suggest that the term of art is not the problem. Participatory medicine is going to require a societal shift in how we interact with each other if we are to achieve definable goals". Scott (2010)

Summary

Programmes of work continue to elevate both the term 'patient' and actual patients; for example patient centred care, patient experience (including patient stories), patient rights, and patient safety. There is strong argument that an acceptance of the word patient and a focus on continuing to reframe it in ways that most benefits those who use and provide healthcare is the better way to go.

The term 'consumer' is widely accepted and rightly most used where the context for the use of that term is the public; and past or future patients and/or their whānau. However the term 'patient' holds a special and distinct recognition of the vulnerabilities, both physical as well as psychological, that face actual patients and these distinctions are immediately understood by groups across all disciplines and by the public.

To this end BOPDHB enjoins national and international use of the term preferred by people, reclaims the term in powerful ways, and which would be very problematic and expensive to change, especially when there is no consensus about the need to change, or what might be better.

References

Deber et al (2005) Patient, client, or consumer: what do people want to be called? Health Expect 2005 Dec 8(4): 345 – 351)

Scott EMD (2010) The term "patient" may describe me…but it does not define me. J Participat Med. 2010 Dec 29; 2:e22.

R Tallis (1999) Leave well enough alone BMJ Jun26; 318(7200) pp 1756 – 1758