The Director’s Toolkit

A resource for Victorian health service boards

Chapter 3: Conduct, ethics and fiduciary duties

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# About this Toolkit

This Toolkit is a resource to assist public health service board directors and other interested parties to better understand the role of directors of health service boards and the operating environment of the public sector health service entities they govern.

The development of the Toolkit is in response to DHHS recognising the need for a stronger emphasis on public sector health governance and enhancing the support tools available to directors of health services. Recent reports such as the *‘Targeting Zero’* review of quality and safety in the Victorian public health service have highlighted the need for greater oversight of clinical care systems across the state in the delivery of high quality, safe, person-centred care.

This accountability starts with the board.

The board of directors is held to be ultimately responsible for virtually every aspect of the health service’s activities. However, it is impractical and undesirable for a board to attempt to supervise minutia associated with the health service’s operation.

Good corporate governance requires a balance between compliance (with codes, regulations and standards) and oversight of operational and financial performance. The core purpose of good governance in health services is ensuring the delivery of high quality, safe and effective person-centred care.

Boards of high performing health services:

* understand the board’s role in governance
* discharge their legal duties
* ensure accountability to stakeholders
* understand stakeholder and management expectations
* effectively use board committees to enhance governance
* build a talented management team
* champion a productive and ethical culture
* make informed decisions
* actively contribute to strategy, and closely monitor strategic effectiveness
* ensure a disciplined approach to risk governance
* receive independent assurance
* actively engage externally on current and emerging issues relevant to their organisation and the political, social, and economic environment in which it operates.

By understanding the environment and the pressures the health service and its management face, the board can assure itself that the material risks are being identified and, most importantly, being managed. Such an approach enables the board to exercise its responsibilities in an active rather than a reactive manner and minimises ‘surprises’. The board should be alert to the red flags or risk indicators that may impact the organisation’s performance.

In preparing this Toolkit, DHHS, in its stewardship role, has not attempted to establish a model or pattern for the optimum composition and conduct of a health service board and instead has provided insight and guidance as a practical resource for health service directors.

For guidance, on the initial pages of chapters 1–14, there are a number of red flags, plus a list of pertinent questions that directors of health services may ask.

In addition, the Toolkit documents and summarises information on roles and responsibilities and consolidates statutory and policy-based elements, including those in the *Health Services Act 1988* (Vic), the *Ambulance Services Act 1986* (Vic), the *Mental Health Act 2014* (Vic), other acts, and policy and administrative documents.

Although this Toolkit sets out material of key importance to health service boards, the boards of other entities, such as, ambulance services, mental health services, aged care services, community health centres, and other private and not-for-profit entities delivering Victorian Government health services, may also find the material useful.

Historically, health service boards focussed on financial issues and chief executive performance. Quality of care was assumed, its oversight was left to clinical leaders and it tended to be poorly measured. That approach is being rewritten today, spurred by mounting evidence that organisational factors, including high-level leadership, influence quality of care.\*

**\*Source**: Bismark, Marie M, Walter, Simon J and Studdert, David M, *The role of boards in clinical governance: activities and attitudes among members of public health service boards in Victoria*, Australian Health Review, (2013), 37, p682–687. Available from the CSIRO here: <http://www.publish.csiro.au/ah/pdf/AH13125>

# Acronyms and definitions

The following acronyms and definitions were current at date of publication.

| Acronym | Full description |
| --- | --- |
| AACC | Aged Care Complaints Commissioner |
| AAQHC | Australasian Association for Quality in Health Care |
| AAS | Australian Accounting Standards and Interpretations |
| AASB | Australian Accounting Standards Board |
| ABF | Activity based funding |
| ACAS | Aged Care Assessment Services |
| AGM | Annual General Meeting |
| AHPRA | Australian Health Practitioner Regulation Agency |
| AMA | Australian Medical Association |
| ASA | *Ambulance Services Act 1986* (Vic) |
| ASIC | Australian Securities and Investments Commission |
| AV | Ambulance Victoria |
| BBCAC | Building Board Capability Advisory Committee |
| BCV | Better Care Victoria |
| BMAC | Boards Ministerial Advisory Committee  |
| CBC | Council of Board Chairs |
| CEO | Chief Executive Officer |
| CFO | Chief Finance Officer |
| COO | Chief Operations Officer |
| DHHS | Department of Health and Human Services |
| DMS | Director of Medical Services |
| DPC | Department of Premier and Cabinet |
| DPI | Declaration of Private Interests |
| DRG | Diagnosis Related Groups |
| DSM-V | Diagnostic and Statistical Manual of Mental Disorders, 5th revision. This the manual used primarily in the USA (but also widely used in Australia in addition to the ICD-10) for classification of mental disorders. |
| DTF | Department of Treasury and Finance |
| FMA | *Financial Management Act 1994* (Vic) |
| GiC | Governor in Council |
| HCC | Health Complaints Commissioner |
| HEER | Health Executive Employment and Remuneration Policy  |
| HMI | Hospital Mortality Indicator |
| HPV | Health Purchasing Victoria, trading as HealthShare Victoria |
| HSA | *Health Services Act 1988* (Vic) |
| HSMR | Hospital Standardised Mortality Ratios |
| IBAC | IndependentBroad-based and Anti-Corruption Commission |
| IHPA | Independent Hospital Pricing Authority |
| ICD-10 | International Statistical Classification of Diseases and Related Health Problems, 10th Revision. This is the disease classification used in Australia cf. DSM-VNotes: * a CM suffix refers to Clinical Modification
* an AM suffix refers to Australian Modification
* a different number instead of 10 will refer to a different revision e.g. 9th revision
 |
| KPI | Key performance indicator |
| LHN | Local hospital network |
| LOS | Length of Stay |
| LTI | Lost Time Injury |
| MHA | *Mental Health Act 2014* (Vic) |
| MHCC | Mental Health Complaints Commissioner |
| MPS | Multi Purpose Service |
| NAESG | Non Admitted Emergency Services Grant |
| NDIS | National Disability Insurance Scheme |
| NEP | National Efficient Price (as determined by IHPA) |
| NSQHS Standards | National Safety and Quality Health Service Standards |
| NWAU | National Weighted Activity Unit against which NEP is paid (national equivalent of WIES) |
| OH&S | Occupational Health and Safety |
| OHSA | *Occupational Health and Safety Act 2004* (Vic) |
| OVA | Occupational Violence and Aggression |
| PAA | *Public Administration Act 2004* (Vic) |
| PDA | *Protected Disclosures Act 2012* (Vic) |
| PFG | Policy and Funding Guidelines (updated every year) |
| PMF | Performance Monitoring Framework |
| PRISM | Program Report for Integrated Service Monitoring |
| PSRACS | Public Sector Residential Aged Care Services |
| SCV | Safer Care Victoria |
| SoP | Statement of Priorities |
| SRHS | Small Rural Health Services |
| TRP | Total remuneration package (for an executive salary) |
| VAGO | Victorian Auditor General’s Office |
| VAHI | Victorian Agency for Health Information |
| VCC | Victorian Clinical Council |
| VGRMF | Victorian Government Risk Management Framework |
| VHA | Victorian Healthcare Association |
| VIFMH | Victorian Institute of Forensic Mental Health, also known as ‘Forensicare’ |
| VMIA | Victorian Managed Insurance Authority |
| VMO | Visiting Medical Officer |
| VPSC | Victorian Public Sector Commission |
| WIES | Weighted Inlier Equivalent Separation |

# Key definitions used in this Toolkit

|  |  |
| --- | --- |
| Definition | Full description |
| Consumers | ‘patients’ and ‘consumers’ are terms often used to describe users of health services. In this Toolkit, ‘consumers’ has been used, unless it is part of a publication title or a quotation, as patients are not the only users of health services. |
| Directors | In this Toolkit, all board directors are referred to as directors or chairs as applicable, and the roles and responsibilities are outlined as applying to all boards. This includes members of the board of Health Purchasing Victoria, (trading as HealthShare).  |
| Enabling Acts[[1]](#footnote-1) | *Health Services Act 1988* (Vic) (**HSA**), *Mental Health Act 2014* (Vic) (**MHA**), *Ambulance Services Act 1986* (Vic) (**ASA**)(in some circumstances other acts may also be applicable). If one Enabling Act is referenced such as the HSA, the reader should presume the other Enabling Acts may also apply and should check the other Enabling Acts for clarification. |
| HLA Bill | Health Legislation Amendment (Quality and Safety) Bill 2017 was introduced into Parliament in June 2017 in response to the *Targeting Zero* report and the Government’s response, Better, Safer Care. This Bill amends the Enabling Acts for health services, in particular relating to obligations for board directors and the composition and conditions of appointment of boards. |
| HPV | Health Purchasing Victoria (HPV) is the organisation established to assist the Victorian health sector ease cost pressures through collective, strategic purchasing for all health services. From 1 January 2021 HPV trades as HealthShare Victoria. |
| Minister | In this Toolkit, Minister refers to the Victorian Ministers for Health, Ambulance Services, and Mental Health where applicable.  |
| Patient Experience Survey | Collects data from consumers of health services in Victoria and is used as a key feedback mechanism in clinical governance to identify areas for improved provision of service or management of risks. It is a critical stakeholder engagement and performance management / monitoring tool. |
| People Matter Survey | Regular survey of health service staff undertaken by health services to identify workforce engagement, participation, concerns or other feedback. It is a critical stakeholder engagement and performance management / monitoring tool. |
| Health services | The term ‘health services’ is used to refer to both the ‘public hospitals’, ‘public health services’ and multi-purpose services listed in the HSA, as well as Ambulance Victoria (ASA) and VIFMH (MHA) unless otherwise specified.  |
| Secretary | The Secretary of the DHHS. |
| Victorian Clinical Council | Victorian Clinical Council is a council of clinicians and consumers whose purpose is to provide leadership and direction to make the health system safer and provide better care to all Victorians. |

# Conduct, ethics and fiduciary duties

## Questions that directors of health services should ask

Boards and their directors are integral to the running of Victoria’s health services. Directors are representatives of the Victorian Government. How directors conduct themselves reflects on the board, the health service, DHHS and the Minister. Health service board directors are therefore expected to uphold the highest standards of integrity and conduct and act in accordance with their responsibilities and obligations.

* Do I always act in the best interests of the health service?
* How well do I understand the concept of ‘conflict of interest’?
* Are perceived, potential or actual conflicts discussed and declared regularly?
* Do I have a clear understanding of what constitutes confidential information and how it must be treated in and out of the boardroom?
* Does the board have its own code of conduct and compliance program? How often are these programs reviewed to determine if they need updating in accordance with DHHS, organisational, policy, legal and/or regulatory changes?
* Has the board’s ethics and compliance program been reviewed by outside consultants or experts for improvement opportunities?
* Does the board have an effective process in place that allows for a protected disclosure?
* Do employees receive the information required to understand the health service’s core values, code of ethics and conduct, policies, and laws and regulations related to their jobs?
* Do the executive and senior management fully inform the board about perceived, potential or actual conflicts between the health service’s values and the organisational practices of the services it operates?
* Are there processes and practices in place to promote ethical behaviour and do they align with VPSC requirements?
* How does the board manage disputes/grievances?

## Red flags

* Directors do not understand that they are public officials and what this means.
* Directors sometimes make decisions that benefit individuals and/or the local community rather than the health service.
* Obligations such as management of conflicts of interest, development of the health service’s by-laws, maintaining clinical standards of care and meeting privacy requirements are not known or well understood by directors.
* Directors do not know of or understand the VPSC’s *Director’s Code of Conduct*.
* There are an unusual number of internal and external complaints.
* The board receives no reports or information regarding protected disclosure policy.
* The board does not ask questions related to ethics or conduct.
* A board director is claiming expenses that are not reasonable.
* Directors communicate inappropriate or confidential content to the local community, the press and/or social media.
* Directors fail to meet their fiduciary duties, enshrined in law, to act in the best interest of the health service (which includes governing the health service in accordance with the Minister’s policy directives).

## Introduction to the chapter

All board directors are expected to lead by example in relation to behaviours, for example, adopting the organisation’s values, respecting confidentiality and encouraging discussion. This chapter:

* provides information and guidance in relation to the binding provisions of the PAA and VPSC’s *Director’s Code of Conduct[[2]](#footnote-2)* (applicable to all Victorian public sector directors), which includes conflicts of interest, expenses and proper use of information
* provides practical examples of how to apply the *Directors’* *Code of Conduct*
* introduces the concept of ‘fiduciary duties’, which are common law duties, and what that means for individual directors and boards collectively, especially in relation to conduct, behaviour and ethics.

Case study - accountability

Bethany is the CEO of Better Care Services (BCS). She has just attended the BCS board meeting at which the board had requested she present on a key strategic outcome - improving emergency department wait times.

The project to support this was to implement an access triaging method/algorithm. The project has not been going to plan and, although a project plan was in place, staff are disengaged with the new algorithm and continue to use the old method. Recent surveys and statistics depicted no improvement in wait times.

Bethany was honest with the board and stated the outcome was not progressing as expected or forecast. She explained some of the challenges she and her team were facing with staff uptake of the new algorithm and provided various options for the board to decide on to get the project back on track.

## The binding obligations on directors

Conduct is more than just adherence to rules and policies. Conduct should embed an ethical code into an organisation.

Every director of Victoria’s public entities are public officials and are bound by the obligations outlined in the PAA.[[3]](#footnote-3)

The PAA sets out the importance of maintaining public sector professionalism and integrity and charges the VPSC with preparing and issuing a code of conduct based on the public sector values.

The VPSC’s *Director’s* *Code of Conduct* also sets the standard of behaviour expected of directors. These behaviours are essential to how directors perform their duties, the relationships they have with each other and the relevant portfolio Minister, departmental and public entity staff, and the community. It details the expected levels of behaviour, integrity, transparency and independence of directors. These elements are integral to upholding the values of the PAA and are critical in assisting directors to fulfil their obligations and duties. The *Director’s Code of Conduct* also forms one of the key measures of director performance. Failure to follow the *Director’s Code of Conduct* will impact on an individual’s opportunity for appointment or reappointment to a public entity board.

## Public sector values

Section 7 of the PAA sets out those obligations and duties and requires public officials, including directors, to demonstrate the following seven public sector values:

1. **Responsiveness** - frank, impartial and timely advice to the Government; high quality services to the Victorian community; identification and promotion of best practice
2. **Integrity** - be open and transparent in your dealings; use power responsibly; do not place yourself in a position of conflict of interest or seek undue advantage for yourself (or others); strive to earn and sustain a high level of public trust
3. **Impartiality** - avoid bias (conscious and unconscious), discrimination, impulse or self-interest; demonstrate respect for others by acting in a professional and courteous manner
4. **Accountability** - accept responsibility for your decisions; do not engage in activities that may bring you or the entity into disrepute; work to clear objectives in a transparent manner
5. **Respect** - demonstrate respect for fellow board directors, colleagues, other public officials and members of the Victorian community by treating them fairly and objectively; ensuring freedom from discrimination, harassment and bullying; using their views to improve outcomes on an ongoing basis
6. **Leadership** - promote and support the application of the Victorian public sector values; act in accordance with the *Director’s Code of Conduct*
7. **Human rights** -public officials should respect and promote the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006* (Vic);[[4]](#footnote-4) make decisions and provide advice consistent with human rights; actively implement, promote and support human rights.

## Individual integrity and ethical conduct

Good governance is ultimately about personal and organisational integrity. Ethics is about honesty, integrity, trust, accountability, and transparency.

This is why ethical conduct is a key factor in the long-term viability and success of health service organisations.

The reputations of individual directors and executives are tarnished when a health service is seen not to have acted ethically, or has otherwise breached community standards.

## Behaviours expected of the board and the individual

The *Director’s Code of Conduct* enhances and expands upon these values and outlines the expected behaviour of the board and individual directors. [[5]](#footnote-5)

Responsibilities of the board

**Leadership and stewardship** – the board safeguards and oversees the management of the health service, focusing largely on strategic issues, risk management and engagement with stakeholders. The board does not get involved in implementation and operations; this is the remit of the CEO and executive team.

**Board authority and delegation** – the board clearly defines matters that are reserved for board discussion and approval, ensuring that any necessary delegations to management or sub-committees are documented, communicated and in place. The board is accountable for the actions of its delegates/sub-committees.

**Best interests of the public entity** – the board acts consistently with the functions and objectives of the health service, such as its SoP and any other similar documents.

**Risk management and financial responsibility** – the board oversees the management of risk so as to ensure that the health service is financially viable. This includes ensuring a robust financial management system is in place. The board informs the portfolio department and Minister of known major risks to the effective operation of the health service.

**Conflicts of interests and duty** – the board manages actual, potential and perceived conflicts of interest with directors restricting their involvement in a matter, stepping down from their position or relinquishing their private interest where applicable.

Responsibilities of individual directors

**Duties of the chair** – presiding over meetings and ensuring policies, processes and behaviours are upheld.

**Leadership and stewardship** – lead by example and promote public sector values through their own behaviours.

**Complying with establishing legislation and board policies** – comply with all relevant legislation, regulations, by-laws, policies and procedures that apply to the health service. This includes the Victorian Government’s and Minister’s policies and priorities.

**Care, diligence and skill** – exercise powers with reasonable care, due diligence and skill; ensuring that only relevant information is sought and considered.

**Best interests of the public entity** – the health service always comes first. Directors must act in the best interests of the health service and must not allow personal and/or professional interests/relationships to influence their judgement.

**Proper use of position** – directors use their position to promote the best interests of the health service. Directors must not seek advantage for themselves and/or others or cause detriment to the health service.

**Proper use of information** – all information provided to directors is only used only for the purpose it was intended. Directors do not use information (e.g. privileged or commercially sensitive) to obtain an advantage for themselves and/or others or cause detriment to the health service. Confidentiality is respected at all times and information is not ‘leaked’.

**Standing for election** – directors notify the board of any intention to stand for any election (state, federal or local level), which is promptly relayed to DHHS.

**Fairness and impartiality** – directors behave in a manner that is free from favouritism, self-interest, bullying and/or intimidation in all dealings.

**Financial responsibility** – directors exercise care in relation to public funds and comply with the Standing Directions of the Minister for Finance and the rules of the Financial Management Compliance Framework.

**Honesty and integrity** – directors act with honesty and integrity and comply with all laws, policies and generally accepted standards of behaviour.

**Conflicts of interest and duty** – directors avoid actual, potential and perceived conflicts of interest. If a conflict arises, they declare and manage the conflict in accordance with the guiding policies and processes in place

##  ‘Walking the talk’

‘Walking the talk’ is about embedding the principles within the *Director’s Code of Conduct* throughout the organisation*.*

When overseeing the implementation of the *Director’s Code of Conduct*, directors must ensure it is effectively communicated by management. The board should make certain that the *Director’s Code of Conduct* is taken seriously throughout the organisation, and breaches will give rise to disciplinary measures (both internally and externally).

Merely issuing the *Director’s Code of Conduct* does not ensure it will be observed. To add value, it must extend beyond a compliance focus and strive to cultivate and maintain an organisation that focuses on positive moral behaviour while simultaneously striving to prevent ethical lapses.

The *Director’s Code of Conduct* will continually evolve with the changing environment, which includes adapting to changes in laws and regulations, the operational environment, public opinion and the focus on acceptable organisational behaviour. Those health services developing or revising their internal code of ethics and conduct should consult frequently with DHHS and VPSC.

## Conflicts of interest

The duty to declare interest and avoid conflicts of interest is a fiduciary duty.

### What is a conflict of interest?

A conflict of interest is where a director has interests that could influence, or be seen to influence, their decisions or actions in the performance of their duties.

Conflicts of interest and duty may be actual, potential or perceived.

### Why does it matter?

Conflicts of interest are frequently referenced in public sector governance and public settings due to the trust and confidence reposed on the director. Public sector agencies like health services have significant investment and faith placed in them by the public. Avoiding, and where this is not possible, declaring and managing a conflict is critical for the public to maintain their trust and confidence in the health service as an entity. For this reason, no decision maker in the entity – be they the board, the CEO or even a low level procurement officer, can have a conflict of interest regarding the decision being made.

For directors and senior management, this duty is more onerous, where the duty to broader to avoid any conflict that would cause a reasonable person to doubt if you put the health service interests first.

Fiduciary duties are further discussed later in this chapter.

### Actual conflict of interest

There is a conflict between a director’s public duties to the health service and private interests or other public duties.

**Case study 1: Nurses R Us**

John is a board director of Better Health Service. He is also a director of ‘Nurses R Us’, a specialist employment agency that provides nurses to health services.

The health service has a high nurse turnover and urgently requires nurses to fill those vacant full time positions. Permanently filling the roles will take a number of months due to the length of the advertising, shortlisting and hiring processes. During the interim period, the health service must hire agency nurses.

John suggests the health service use ‘Nurses R Us’. The board believes they can trust the agency as it is more of a known quantity because they know and trust John. The board agrees with John’s recommendation and enters into an agreement with ‘Nurses R Us’.

This is an **actual conflict** as a decision has been made that directly benefits John’s private interests.

### Potential conflict of interest

A director has interests that **could** conflict with their duties.

This type of conflict also encompasses circumstances where it is foreseeable a conflict may arise in future.

Case study 2: Tendering

Janice is the chair of the Better Care Service board; she is also a director of a large construction company. The health service has been having infrastructure issues for several years and requires refurbishment. The board has decided to tender for the refurbishment works.

The chair has a **potential conflict** of interest and needs to be cautious when discussing and/or making decisions with respect to the refurbishment of the hospital.

### Perceived conflict of interest

The public or a third party **could form the view** that a director’s interests could influence their decisions or actions, now or in the future.

Case study 3: Family benefits

Rose is a former board chair of Better Care Services (BCS) and her family is well known in the community. Her daughter, Jasmine, is interested in applying for a director role on the board of BCS. Rose arranges for the current BCS chair to have a coffee meeting with Jasmine in the local coffee shop and give her an insight into what the board does and the appointments process.

Jasmine subsequently applies for a director role, goes through the appropriate due process, and is appointed to the board by Governor-in-Council on the recommendation of the Minister.

This is a **perceived conflict of interest**. The public knows Steven’s family, including Jasmine, and seeing her sit down with the current chair, and subsequently being placed on the board, is **likely to cause a reasonable bystander/outsider to believe the** appointments **process has been influenced**.

### Conflict of duty

A conflict of duty arises when a person is required to fulfil two or more roles that may actually, potentially or be perceived to be in conflict with each other. For example, a director may hold a director position on a health service and also hold a position as a member of another public board. A conflict of duty may also arise through a director having official duties to other Commonwealth and local government bodies, community and professional associations or non-governmental organisations.

Conflict of duty scenarios are especially common in regional and rural settings due to the smaller size of communities. It is not always possible to avoid a situation where a conflict of duty exists, particularly in small communities, or some specialist industries. However, it is vital that these situations are managed appropriately to ensure the public interest is protected.

Could a decision be doubted due to the perceived, potential or real influences on the decision maker (the director, board or other party)?

The following table provides numerous examples to assist in identifying conflicts of interest and duty.

|  |  |  |
| --- | --- | --- |
|  | **Conflict of interest** | **Conflict of duty** |
| **Financial** | **Non-financial** |
| **Actual** | Director is a partner in a business tendering for a contract with the health service. | Director’s former partner owns a business tendering for a contract with the health service. | Director is also a union representative. The board is discussing upcoming enterprise bargaining agreement negotiations. |
| **Potential** | Director owns shares in a start-up company which intends to provide services in the same sector as the health service. | Director’s friend is a senior employee of the health service and is likely to be considered for the CEO role (chosen by the board) in the future. | Director is also on the local council. The board is considering a building program which requires planning permission. |
| **Perceived** | Director was widely known in the community as a partner in a local firm which is a key contractor to the health service but has divested her stake in the business. | Director’s cousin (who the director has little contact with) is active in a community group that is advocating strongly against proposed changes to the health service. | Director is also the local mayor; there are no current conflicts, but a perception of conflicted duties may arise in future. |

Table 3.1 - Identifying conflicts

### Statutory disclosure provisions regarding conflicts of interest and duty

While the *Director’s Code of Conduct* provides information on conflicts of interest and duty, the Enabling Acts[[6]](#footnote-6) (e.g. the HSA) containsdisclosure provisions, which require directors:

* disclose any direct or indirect pecuniary interest in a matter being considered by the board
* record the declaration in the minutes of the meeting
* with a conflict must not be present during deliberations and must not vote on the matter.

In practice, this requires directors to be diligent in declaring conflicts. In some cases, a conflict may not be apparent until further discussion or information is devolved. A director must declare a conflict of interest as soon as they become aware.

Where possible, conflicts should be declared and discussion held with the chair (and potentially other directors) to determine how the conflict should be managed going forward.

### Identifying a conflict of interest

Directors should proactively review board agenda items prior to any meeting to identify any interest they have relating to those items or that might arise in discussion.

All directors should declare **any interest**, regardless of whether they think there is a conflict (or not).

The director with the interest cannot be the one to determine whether that interest creates a conflict (or not).

In some instances, this may require that board papers relating to that agenda item are not provided to a director with a known interest or conflict (actual or otherwise). In all circumstances of this nature, the chair should discuss the interest with the relevant director before withholding information to determine if there is a conflict, the materiality of the conflict and if it can be managed.

Directors should also declare any interests at the start of the board meeting and as they arise in discussion, regardless of whether these were on issues on the agenda or whether that director had already disclosed the interest to the chair. The director should not wait for the chair to identify the director’s interest, rather, the director should proactively disclose the interest to the board.

Do I have a conflict?

* Does this further the health service’s goals or mine?
* What assessment would a reasonable person make of this regardless of my belief?
* Could my involvement in this matter cast doubt on my, the board’s or the health service’s integrity?
* If I saw someone else doing this, would I suspect they had a personal interest they were putting before the health service?
* If I did participate in this action or decision, would I be happy if the public became aware of my involvement and any association or connection?
* How would I feel if my actions were covered by the media? Would this embarrass me, the health service, DHHS and/or the Minister?
* Would I have to choose who to be loyal to?

All directors should be aware of any actual, potential or perceived conflicts of interest and practice the ethos of ‘entity first’.

In most cases, particularly if the interest is one that the board was not previously aware of, the board should discuss whether the interest creates a conflict or not. This discussion should be led by the chair (or deputy chair if the chair is the party with the interest). The board should have a clear procedure for such discussions, which should include time for the board to consider the conflict of interest without the potentially conflicted director present.

### What about a “positive” conflict of interest?

A ‘positive conflict’ is where both the conflicted party and the health service benefit from the conflict of interest. On its face, a positive conflict will often appear to be win-win for both parties, however, the question a director must always ask is whether this decision would have been made but for that director’s influence.

Positive conflicts must be avoided, however, directors can provide their services and/or use their contacts for the benefit of the health service provided a *quid pro quo* is not expected (or not perceived to be expected).

Examples of positive interests – still conflicts!

1. Providing contracting services to the health service at a discount – note the reasonable bystander, including the parties that didn’t win the contractor, would reasonably believe that that director undercut them due to misusing insider information

2. Encouraging the health service to ‘partner’ on particular projects that the director’s company or charity is involved in – again from the outsider point of view, there would be many charities that would benefit from using the pull and influence of a health service for their fundraising or marketing.

### What to do if you have an interest? Disclose!

Sometimes an interest is unavoidable, even if it presents a conflict of interest.

If a director has identified that they have a conflict of interest and/or duty, they must declare this and discuss it with the board chair and other directors to determine **if**, and how, it can be managed.

Declarations must be recorded in the minutes of the meeting and the conflicted director must not be present during deliberations and must not vote on the matter.[[7]](#footnote-7)

A conflict of interest may not necessarily disqualify a person from serving on a board, however full disclosure is a legal and ethical requirement. The matter should be resolved in favour of the health service rather than the individual director.

Obligations in relation to conflicts of interest for health service board directors are also detailed in the PAA as well as the health service’s and DHHS’ relevant conflict of interest policy.[[8]](#footnote-8)

Obligations with respect to conflicts of interest are also outlined in Victorian Government policy, for example a Declaration of Private Interest (DPI) form must be completed by all applicants when applying for health service board positions[[9]](#footnote-9) and be updated annually for the health service’s records.

The DPI provides the applicant with a formal opportunity to disclose pecuniary interests or other private interests that could reasonably raise an expectation or a real or perceived conflict of interest, or could have a material interference with the proper performance of a director’s duties.

Board applicants with a background in financial management are also required to disclose if they have engaged in consultancy work with professional financial services organisations providing audit, tax and advisory services to Victorian health services. Furthermore, applicants who have provided other high-level advice or management services to any Victorian health services must disclose details of their involvement.

#### Absenting from decision making

Any director can request the disclosing director to absent themselves from the discussion on the conflict, noting that the conflicted director may also need to answer questions from the board before leaving or on return to help the board understand the nature of the conflict. Indeed, the disclosing director can request to be absent. This request should always be complied with (i.e. the disclosing director should leave the discussion) to enable the board to determine:

* if the director is able to participate in the matter for decision and if so, to what extent the director is able to participate in the matter for decision (e.g. full participation, can listen but cannot contribute, can be part of the discussion but cannot vote, etc), OR
* if the director’s participation would cause the decision to be tainted due to that director’s conflict of interest.

### What if the conflict cannot be managed?

Sometimes a conflict is unavoidable but also cannot be managed by merely absenting oneself from the particular discussion or topic. Examples of this include:

* Where the director has become an employee of the health service or other closely related service provider / contractor
* Where the director has a relationship with an employee or contractor of the health service
* Where the conflict arises far too often to make it practical to continue serving on the board
* Where the director becomes involved in a political party or advocacy group that has a particular interest in what or how this specific health service performs its role
* Where the director has clients or patients that are positions that could influence decision making or quality of care
* Where the director has become involved in some form of dispute (legal or otherwise) with the health service and/or its employees.

This is not an exhaustive list, but demonstrative of the sort of situations where the conflict cannot be merely avoided or managed. In these cases, a leave of absence could be sought (until the conflict is resolved) otherwise resignation will be required.

### Will resignation resolve all conflicts? Not always!

In general, a conflict that cannot be managed can be resolved by the director resigning. However, there are certain circumstances where the director’s resignation will be insufficient to manage the conflict. In these situations, the board and health service will need to continue to manage the conflict despite the resignation.

This is sometimes referred to as ‘ineffective resignation’[[10]](#footnote-10), in that the duty will continue to prevent the fiduciary making a profit from the knowledge received due to their position.

**Case study: When resignation is not enough**

Caleb is a director of Better Care Services (BCS) and has been an executive at other health services in the past, enabling him to provide excellent experience about health system operational matters for the board.

BCS is given notice by their current CEO of her intention to resign and the board begins its recruitment process. As part of their strategic planning day, BCS consider the sort of expertise and experience they would like the next CEO to have. Caleb realises his experiences and expertise are a really good fit for what this board needs – it is win, win!

So as to not have a conflict, Caleb resigns from the board and then, after it is publicly advertised, applies for the CEO role.

Conflict management:

In this case, the resignation was not enough to resolve the conflict. BCS cannot employ Caleb as the CEO, despite his resignation.

Why?

Caleb’s role on the board will have provided him an unfair advantage. This is both in terms of having access to information others would not have, as well as influencing the sort of attributes the board was seeking.

## Confidentiality

Confidentiality is a fiduciary duty that continues even after you are no longer a director

Whilst informal communication between board directors is encouraged, boardroom confidentially must be respected at all times. Discussion of board issues outside of the boardroom such as within the community (i.e. at social gatherings) should not occur, including discussion of the views of other board directors, confidential information, any issues under discussion, and decisions made. It is the responsibility of directors to conduct themselves appropriately to avoid ‘gossip’ and ‘faction building’ with respect to board dynamics.

It is important to note the difference between ‘leaking’ confidential information and the protection offered under the [*Protected Disclosure Act*](http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/LTObject_Store/LTObjSt4.nsf/d1a8d8a9bed958efca25761600042ef5/912fa900f9e65fb4ca257761002dd0b7/%24FILE/01-36a021.pdf) *2012* (Vic).[[11]](#footnote-11)

The[*Protected Disclosure Act*](http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/LTObject_Store/LTObjSt4.nsf/d1a8d8a9bed958efca25761600042ef5/912fa900f9e65fb4ca257761002dd0b7/%24FILE/01-36a021.pdf) *2012* encourages and facilitates the disclosures of improper conduct by public offices, public bodies and other persons, and detrimental action taken in reprisal for a person making a disclosure pursuant to the Act.[[12]](#footnote-12)

There are no circumstances under which directors can leak information internally or externally.[[13]](#footnote-13) The VPSC has a quick reference guide[[14]](#footnote-14) and coordinator to assist directors in making protected disclosures if/where the director believes improper conduct has occurred.

### Informal communications outside board meetings

Informal communication is one of the most effective ways of sharing information, building knowledge and fostering constructive working relationships. For this reason, boards that communicate regularly with each other and management are typically strong decision-makers.

Board directors must have a united voice when it comes to discussing any relevant and non-confidential matters outside of the boardroom. While the boardroom is a place of robust discussion and challenge, outside the meeting, the board must maintain a unified position, with consistent and clear messages conveyed. Private discussions regarding disagreements or decisions that did not go a certain way only result in a lack of board integrity, dysfunction and potential factions within the board.

The difference between informal discussions and confidentiality

In practice, directors must understand the difference between having valuable informal discussions and ‘leaking’ confidential information.

Informal discussions outside the boardroom can occur in private settings and in the context of sharing information or discussing relevant issues. This does not mean ‘gossiping’ or ‘faction building’ between directors who are unhappy with board decisions or individual directors.

Private settings do not include private conversations at social or community events.

### What if a director believes the decision being made is wrong?

In general, decisions at the board are made by consensus decision making, however there are times when an issue might be polarising enough for some board members that a unanimous consensus or compromise cannot be agreed to. In these cases, the board will vote on the matter and whether it passes will depend on the health services by-laws for such decisions (usually a simple majority is all that is required).

The decision itself is to be noted in the minutes and, if it is of particular importance to the dissenting director(s), then the way those directors voted can be included also (i.e. for or against the proposal). However, it is not usual for the reasons for the dissent to be recorded, particularly if the board minutes are distributed wider than the board. The reason for this is that giving further air to the dissenting viewpoints will undermine the unity and solidarity of the board and potentially harm the confidence the public has in the board. This is not a case of ‘hiding’ the truth, rather, it is a product of group decision making.

‘Board solidarity’ refers to the proper keeping of confidence by board directors, giving the view to outsiders that the board is a united front regardless of any vigorous debate and/or disagreement behind the scenes.

DHHS has prepared a model conduct charter to assist boards with conflict resolution[[15]](#footnote-15). When putting a Conduct Charter in place, it is recommended the board consider how to pass resolutions where there is disagreement and how to manage the dignity and concerns of the dissenting director(s).

A board director who feels so strongly about a decision that they resign is still prohibited from airing their views about the decision they disagreed with. If the director has a legitimate concern regarding reportable conduct (e.g. fraud, quality and safety, etc.) then the director, as discussed above, ought to report that concern via the appropriate channels (e.g. DHHS or IBAC), not through leaks or gossip.

More information on this is discussed in **Chapter 8:** Productive meetings.

## Director expenses

Directors must exercise judgement in relation to reimbursement of expenses associated with fulfilling their responsibilities.

While a director of a board is entitled to be paid reasonable expenses incurred in holding office as a director of the board, there is a level of subjectivity around what is considered reasonable. When considering whether an expense is reasonable, directors must ensure that they adopt an approach that considers:

* was the cost incurred for something that was necessary for me to fulfil my role as director of the entity?
* would the public, DHHS staff member or Minister consider the expense reasonable, such as buying expensive gifts for staff directors or staying in 5-star hotels when travelling to Melbourne for a training course?

Additionally, the VPSC provides guidance for public sector employees regarding gifts and hospitality[[16]](#footnote-16) and the *Appointment and Remuneration Guidelines* also provide guidance on reimbursement of expenses as well as permitting additional payments to directors for committee work undertaken. These payments are made at the discretion of the Minister.[[17]](#footnote-17)

All expense reimbursements require either board and/or health service approval.

### Travel expenses

The Australian Taxation Office’s Taxation Determination (TD 2016/13)[[18]](#footnote-18) provides guidance on reasonable amounts for the payment of travel expenses when these are incurred for business purposes. Although this public ruling by the Commissioner of Taxation is not prescriptive, it is recommended that all organisations use these determinations as guidance. Additionally, referring and adhering to the above determination could be beneficial to ensure fair and equitable treatment of staff and strengthen the positive public perception of the health service.

Case study: Reasonable expenses

A director is travelling less than two hours for a forum commencing at 11am and concluding at 1:30pm. The director chooses to travel the night before and stay in accommodation close to the location of the forum. The location of the forum is located a 5 minute walk from the train station.

Accommodation before or after a part-day event

In this circumstance, accommodation before or after the event, would not be reasonable, as the event commences at a time where the director would not need to travel an unreasonable time or distance in order to arrive at the event on time.

However, if the forum was:

* a full day event;
* required extended travel (more than 350km in one day with no relief driver); and/or
* accompanied a formal dinner or function at the conclusion of the day,

then these factors would be considered in determining if accommodation is reasonable.

Petrol and parking

The location has been designed to specifically accommodate train travel (being a 5 minute walk from the station). If the cost of a train fare is around the same as parking and petrol then it might be reasonable to claim the petrol and parking fees. If these fees are significantly higher, a director would need to query whether it is reasonable to drive rather than take the train. If the director intends on doing something else at that location, that is still not a reasonable basis to claim the petrol and parking fees from the health service.

NB: those working in or with easy access to the venue, parking would not be reimbursable. Those directors have elected to drive within a space that has ample public transport.

### Reasonable expenses test and examples

Reimbursable expenses must be:

* for the benefit of the health service
* modest, appropriate and reasonable
* ensure value for money
* supported by the appropriate approvals and supporting documentation.

As the case study below depicts, in assessing 'reasonableness', directors must consider their unique circumstances. For example, if a director has a mobility impairment (or other special consideration), which makes it unreasonable for them to take a train then it might be reasonable to reimburse petrol (at the prescribed rate)[[19]](#footnote-19) and parking (at a set rate – i.e. they cannot park somewhere more expensive and bill it back, as that would not be reasonable).

A health service should not pay the cost for convenience rather than reasonableness (this is similar to the question of the particular grade of room that can be reimbursed from a hotel).

Overall the decision is for the board as to what is reasonable in the circumstance. Reasonable does not include non-training/board related convenience in these circumstances.

## Director’s duties

In addition to their duties under the HSA, PAA and the *Director’s Code of Conduct*, directors also have a range of statutory and fiduciary duties they must adhere to. A director’s statutory duties are outlined in the next chapter. The most significant of these are the **fiduciary duties**.

### What is a fiduciary?

A fiduciary is a person who has a clear legal or ethical relationship of trust with another party or parties.

Within the fiduciary relationship, one person in a position of vulnerability, justifiably vests confidence, good faith, reliance, and trust in another whose aid, advice or protection is sought. In such a relationship, good conscience requires the fiduciary to act at all times for the sole benefit and interest of the vulnerable person.[[20]](#footnote-20)

“[A fiduciary] is someone who has undertaken to act for and on behalf of another in a particular matter in circumstances which give rise to a relationship of trust and confidence.”

-Lord Millett, *Mothew (t/a Stapley & Co) v Bristol & West Building Society* [1996] EWCA Civ 533.

### What are a fiduciary’s duties?

Fiduciary duties are prophylactic duties imposed on directors under the equitable doctrines within common law[[21]](#footnote-21) (as opposed to statute or legislation). A fiduciary duty is considered the highest standard of duty and is hinged on the concepts of acting in good faith, for a proper purpose and in the best interests of the entity (to which the duty is owed, in this case, the health service).

The fiduciary status of directors reflects the position of trust and confidence[[22]](#footnote-22) held by directors with respect to the health service. Fiduciary duties are some of the oldest principles in law and are designed to

“…shut out the inducements to perpetrate a wrong, rather than to rely on mere remedial justice after a wrong has been committed…”[[23]](#footnote-23)

The duties are generally set out as follows:

* the duty to **act in good faith**
* the duty to **act in the best interests of the health service** as a whole
* the duty to not **misuse your position or information** obtained as a result of your position
* the duty of **care and diligence**
* the duty to **avoid conflicts of interest**
* the duty to **avoid insolvency**
* the duty to **retain discretion**.

Directors are regarded as having these duties owed to the health service and their importance should not be understated and cannot be compromised.

Various duties are discussed below, as well as how they are applied in practice. It should be noticeable that there is overlap between the duties, with the overall principle being described by Justices’ Gaudron and McHugh in the High Court of Australia,

*“In this country, fiduciary obligations arise because a person has come under an obligation to act in another’s interests. As a result, equity imposes on a fiduciary [e.g. the director of a health service] proscriptive obligations – not to obtain any unauthorized benefit from the relationship and not to be in a position of conflict. If these obligations are breached, the fiduciary must account for any profits and make good any losses arising from the breach…”[[24]](#footnote-24)*

In other words, fiduciary duties are preventive measures to ensure trust reposed in the director (by the health service) is not overcome by the temptation of the director’s self-interest.

What does ‘acting in good faith’ look like in practice?

* Directors must ensure that they are aware of the motivations, rationale and basis of their decisions.
* Remove personal agendas to focus on the best interests of the health service, even if the collective decision goes against their personal views.
* Ask questions. Staying silent in meetings, for fear or favour, is not acceptable.
* Boards must encourage an open culture, where bad news can be raised without fear of repercussions.

### The duty to act in good faith

It is a duty of loyalty that is owed by each director individually and is assessed subjectively. The duty is directed at the intention, motive and beliefs of the director and whether each made the interests of the health service their principal consideration.

The duty requires directors to exercise their powers only for the purpose which they were granted and permits decisions to be invalidated if their motivating purpose is one which is beyond those which the power can be legitimately exercised.

### The duty to act in the best interests of the health service as a whole

This requires directors to primarily consult and act in accordance with the interests of the health service itself. Personal or third party interests are secondary to the interests of the health service.

Behaviours that will assist directors with respect to meeting this duty include, but are not limited to:

* acting honestly and on the basis of genuine beliefs
* putting personal interests aside
* demonstrating accountability for their actions
* accepting responsibility for their decisions
* respecting confidentiality
* abstaining from activities that may bring the director or the public entity into disrepute.

Not all breaches of a fiduciary duty are without good faith or dishonest. Breaches of duty are characterised by the director either placing their own interest before the health service (with or without the director gaining some advantage) or the director compromising the health service’s best interest with the director’s self-interest.

Example: breach of duty without a lack of good faith or dishonesty

Stacey, a director of Better Care Services (BCS), purchased a property knowing that BCS is also going to open a new clinic across the road which would raise the value of Stacey’s future property. She checks the law and notices that she does not need to tell the vendor of the land – it is a real bargain.

As a director, Stacey is prevented by her fiduciary duties from being able to purchase the property because she knows the BCS is about to open a new clinic across the road. If Stacey decides to purchase that property despite her duty not to, she would be forced to disgorge her profits to BCS and there may be other consequences (such as being disqualified as a director by ASIC for breach of fiduciary duty).

### What does acting in good faith mean in practice?

Acting in good faith requires that a director has made all reasonable attempts to make decisions that are in the best interest of the organisation. This means that a director:

* **must not make decisions based on personal agendas or motivations**. When faced with a decision or action for the health service, personal motives such as ‘saving face’ or political, ambitious motivations are not the key drivers for the decision.
* **must act on information they know or ought to have known**. This is a critical for directors to understand because it comes with legal obligations. Directors must be able to demonstrate all reasonable attempts were made to make themselves fully aware of any relevant information upon which they made a decision. This standard has significant implications for the duty of care and diligence also (discussed later in this chapter).

**No actual benefit is required for a breach of fiduciary duty**

**Example 1: Patient records - misuse of position**

Jan, a director at BCS, notices her neighbour being admitted via the urgent care centre. She is curious as to if this is related to local pollution or not so she looks at her neighbour’s patient record. The admission is unrelated and Jan does nothing with the information and shares it with no one.

Even without using the information for any benefit, Jan has breached both confidentiality of the patient’s record and has grossly misused her position as director. It will not matter if the director uses the information to his/her advantage – a breach of fiduciary duty does not require a benefit to be conferred.

**Example 2:** **Mate’s rates – conflict of interest**

BCS puts out a tender for some minor capital works. No local companies apply but two large, outside companies lodge submissions for the tender. After seeing the best offer, Caleb (a director on the board) knows that his brother’s company ‘Local Build Co’ could undercut that rate and still make a profit. After all, Local Build Co built the Caleb’s pergola at a great rate. After confirming with his brother, Caleb offers the board Local Build Co services for “mate’s rates”.

This is a breach of Caleb’s fiduciary duty to the board. While the profit margin for Local Build Co would be much less than it would normally achieve (i.e. the benefit is very small), the abuse of position (and the conflict of interest) prevents the fiduciary (Caleb) from taking part.

### Duty to not misuse position or information

Directors must not improperly use their position or information they receive as a result of their position to gain an advantage for themselves or someone else or cause detriment to the health service. This includes seeking gifts or favours, which casts doubt on the director’s independence.

It is this duty at common law that prevents a person in a superior position (like a director or supervisor) from using their position to coerce another into cooperating or not refusing behaviour they might otherwise refuse. This is normally considered within the context of misusing the position to obtain access to some pecuniary benefit (such as a bribe) or abuse of power. However, it is useful to consider this duty also in light of the conduct a director must demonstrate – abuse of power is not only an issue regarding integrity of decisions, it can also extend to bullying and harassment.

There are many more specific parts of the law that have developed to manage the power imbalance that can occur between a person in a powerful position vis-à-vis another party; for example, a board director and a staff member of the health service. The board is ultimately the employer of the CEO, and thus, the supervisor of every staff member’s employer. While the board does not take part in employment decisions, the power imbalance can be intimidating for a member of staff. As such, the duty to not misuse one’s position extends beyond financial gains. It places a duty on board directors and on the chairperson in particular, to behave in a manner that is fit and proper.

Statutes, OH&S policies and other laws (such as the ‘undue influence’ doctrine in contract law) have arisen to protect employees from such power imbalances, particularly in the workplace. Nevertheless, directors must keep the power imbalance in mind in all interactions with staff.

More information on topics like bullying and harassment are in the next chapter, **Statutory Duties**.

An offence is committed under both statute and common law if it is shown the conduct was undertaken with the intention of gaining an advantage. It is not necessary to establish the advantage was actually obtained – the intention alone is enough to amount to a breach of this duty. Nor does it save the case if a benefit is also conferred on the health service – recall from earlier in this chapter, a positive conflict is still a conflict.

A key principle of fiduciary duties is that **no benefit need be demonstrated for a breach** to occur.

### Duty of care and diligence

Directors and other officers must exercise their duties with care and diligence. Whether they have done so or not is an objective test. A director must exercise powers with the degree of care and diligence a reasonable person would:

* as a director or committee member of an entity in that entity’s circumstances
* if they held the same office and had the same responsibilities.

This duty recognises that a higher standard is required of the chair of a health service as compared with a director of a corner shop business, however a high base level of care and diligence is required of all directors.

Matters to consider include the director’s position and responsibilities with the health service, the health service’s circumstances, any special expertise of the director, the director’s ability to ascertain all relevant information, make reasonable enquiries and understand the financial, strategic and other implications of decisions.

Tips to assist with demonstrating care and diligence include:

* understanding and monitoring operations (including systems and controls)
* understanding and questioning proposals put before the board
* participating and making further inquiries as necessary
* understanding and monitoring the financial position of the health service
* reasonable attempts made to understand the situation.

Care and diligence should also be applied with respect to confidential information (as expressed above). Directors are obligated under the *Director’s Code of Conduct* to ensure that private information remains confidential. This applies to any information - financial, personal, commercial or otherwise - discussed by the board.

Care must be taken to ensure that all confidential information is clearly identified as such and that protocols, including discussions with DHHS and staff, are undertaken with the appropriate levels of professionalism, integrity and confidentiality.

#### **Do I need to know everything?**

No. This comes back to the idea of reasonableness. **A director need not account for risks that are far-fetched and fanciful.** Nor does a director need to account for risks that he/she has enquired about and been satisfied with the expert advice (a director is entitled to rely on expert advice). Basically, a director needs to know what is going on and if there is something that a person with that director’s skills would want to know more about, that director must to make reasonable enquiries the answers for which provide the director with assurance.

Reasonable enquires does not mean burdening the executive by extensively probing every single thing that crosses the director’s path. For example, there is no need to account for the risk of crocodiles eating your patients (unless that has happened at your service before) because that is not reasonable or foreseeable. It is beyond what a reasonable person would be alerted to.

Nevertheless, the 2011 Federal Court case of *ASIC v Healy* (the Centro Case[[25]](#footnote-25)) highlighted the directors’ responsibilities in relation to a company’s financial statements. The judgement outlined that directors cannot *simply* rely on specialist advice (e.g. from external auditors) or advice from others (e.g. management) in discharging their duties. The general principles covered by the judgement could be applied to health services regarding endorsement of financial statements.

The main lessons from the Centro case are this:

* All directors must have a minimum level of financial literacy (this could also be extended to a minimum level of literacy in other key governance matters, such as, for health services, clinical governance)
* Directors cannot passively rely on advice from experts – they must, at a minimum, put their mind to it (which includes genuinely reading the material)
* If there are circumstances that might put a reasonable person on alert (in the Centro case it was the instability of the debt markets, for health services it would be quality and safety) then the director must make the effort to be satisfied.

This means, as a director, you cannot simply say ‘we have a great CEO’ or ‘we have great staff’ and walk away. You likely do have both, but you still must put your mind to actively consider the material presented to you. This should not translate to berating or interrogating the CEO, but it will mean a director cannot just sit back and accept what is said, even by experts. A director that says ‘that could never happen to us’ or ‘our CEO takes care of all that’ is likely not fulfilling this key duty of care and diligence.

#### **Am I better off not knowing anything?**

At law, “knowledge” can be actual or constructive. Actual means, as it sounds, that you *actually* knew. Constructive knowledge refers to knowledge that can be inferred from other circumstances that you knew OR that a reasonable person, in your position, making reasonable enquiries, would have found out. It is the idea that if you presented the situation to a stranger on the street with similar skills, experience and qualifications as you – would that stranger be put on alert that they should better understand this?

This is where the idea of **wilful blindness** comes in – have you shut your eyes to the obvious and thus wilfully or recklessly refused to make the sort of enquires a reasonable person in your position would have made? If so, then you have breached the duty of care and diligence in a manner that is not only a breach, but a dishonest or bad faith breach.

The reason for this development in the law is clear: it is not in the interests of any entity to have a director that can merely close their eyes to any danger or just avoid going to board meetings, in order to avoid liability. Similarly, you cannot just get drunk or skip meetings in order to avoid knowledge. Justice Gibbs in the High Court of Australia described this protective element of the law as:

*“…It would not be just that a person who [could recognise] the facts could escape liability because his own moral obtuseness prevented him from recognizing an impropriety that would have been apparent to an ordinary man.”[[26]](#footnote-26)*

Wilful Blindness

The simplest example of wilful blindness is the hit-and-run. If you hit a person with your car but it is too dark to see, you know you hit something. And you know that it was big and could be a person.

Your choices are:

* go check it out (and thus call for help) or to drive away;
* hoping that if you don’t see it, you don’t know for sure you hit someone.

The law would say you ought to have known (because you should have checked) and treat that incident as a hit-and-run, not merely a mistake.

Key lesson: the law treats a hit-and-run more harshly than merely hitting a person with the car due to the active decision not to seek knowledge of what happened when a reasonable person would have been alerted.

### Duty to avoid insolvency

An organisation is considered to be insolvent if it is unable to pay its debts as and when they fall due.

This essentially means, before a new debt is incurred, directors should consider whether it is reasonable to think the organisation may be, or may become, insolvent as a result of incurring the new debt. Directors have a duty to ensure the health service can do this and there is potential for liability for directors if:

* they are on the board at the time the debt is incurred
* the organisation is insolvent or will become insolvent by that debt
* there are reasonable grounds for suspecting the organisation is or will become insolvent, and the director/committee member knew (or should have known) this
* the director/committee member fails to prevent the organisation from incurring the debt.

Pursuant to the Enabling Acts, board directors of health services are not to be held personally liable for anything done or omitted to be done, in good faith when carrying out their duties. Instead, any liability resulting from an act or omission is attached to the health service.

## Code of Ethics – An internal health service guide

In addition to the *Director’s Code of Conduct*, health services should put in place their own code of ethics that:

* spells out an organisation’s values and principles
* reflects and shapes the organisation’s culture
* makes transparent the value framework within which the organisation operates.

This internal ethics framework helps provide support and guidance to the health service for ethical decision-making by enabling the important aspects of various situations be highlighted and evaluated. Further, the code of ethics compliments the *Director’s Code of Conduct* and addresses:

* the practices necessary to maintain confidence in the health service’s integrity
* the practices necessary to take into account the health service’s legal obligations and the reasonable expectations of stakeholders
* the responsibility and accountability of individuals for reporting and investigating reports of unethical practices
* the organisation’s processes with respect to bribes and unethical payments
* the organisation’s processes for handling conflicts.

Whilst not required under the Enabling Acts, the development and implementation of an effective code of ethics aligns with best practice governance and generates real benefits, including:

* increasing the integrity of financial reports and information
* minimising the incidence and encouraging the reporting of fraud and other organisational misconduct
* creating confidence that unethical behaviour will be reported and addressed
* producing a working environment that fosters pride, responsibility and a sense of both purpose and value.

### Who can health service directors and/or staff make protected disclosures to?

Protected Disclosure Coordinator

Victorian Public Sector Commission

3 Treasury Place

Melbourne VIC 3002

Telephone: (03) 9651 0835

Email: protected.disclosure@vpsc.vic.gov.au

Independent Broad-based Anti-corruption Commission (IBAC)

GPO Box 24234

Melbourne, VIC 3001

or

Level 1, North Tower

459 Collins Street

Melbourne Vic 3000

Telephone: 1300 735 135

Website: [www.ibac.vic.gov.au](http://www.ibac.vic.gov.au)

## Useful references

* *Public Administration Act 2004* (Vic) available from [www.legislation.vic.gov.au](http://www.legislation.vic.gov.au)
* VPSC, *Public Sector Values*. Available from: <http://vpsc.vic.gov.au/ethics-behaviours-culture/public-sector-values/>.
* VPSC, *Director’s Code of Conduct*: Available from: <http://vpsc.vic.gov.au/resources/code-of-conduct-for-directors/>.
* VPSC, *Protected Disclosures Guide* <https://vpsc.vic.gov.au/about-vpsc/protected-disclosures-procedures/>
* Independent Broad-based Anti-corruption Commission (IBAC) website [www.ibac.vic.gov.au](http://www.ibac.vic.gov.au)
* *Charter of Human Rights and Responsibilities Act 2006* (Vic). Available from: <https://www.humanrightscommission.vic.gov.au/human-rights/the-charter>
* R Meagher, D Heydon and M Leeming, *Meager, Gummow & Lehane’s Equity: Doctrines and Remedies*, (2002), 4th ed, LexisNexis Butterworths.
* Governance Institute of Australia’s resources and guidance on public sector governance and legal duties [www.governanceinstitute.com.au/knowledge-resources/public-sector-governance](http://www.governanceinstitute.com.au/knowledge-resources/public-sector-governance)
* ASIC’s Corporate Governance guidance and resources <https://asic.gov.au/regulatory-resources/corporate-governance/>
* ASIC’s guidance on conflicts of interest [www.asic.gov.au/regulatory-resources/corporate-governance/managing-conflicts/](http://www.asic.gov.au/regulatory-resources/corporate-governance/managing-conflicts/)
* Justice Connect’s resources on Governance and legal duties of office holders [www.nfplaw.org.au/governance](http://www.nfplaw.org.au/governance)
1. Please note, these acts may have been amended and/or updated after this Toolkit was published. When reviewing, please review the most recent version. [↑](#footnote-ref-1)
2. Available from: <http://vpsc.vic.gov.au/resources/code-of-conduct-for-directors/> [↑](#footnote-ref-2)
3. Please see sections 4 and 5 of the Public Administration Act 2004 (Vic) for the definitions of ‘public entity‘ and ‘public official’. [↑](#footnote-ref-3)
4. Available from <https://www.humanrightscommission.vic.gov.au/human-rights/the-charter> [↑](#footnote-ref-4)
5. For a full description of the expected behaviours please review the *Director’s Code of Conduct* in full, available from: <http://vpsc.vic.gov.au/resources/code-of-conduct-for-directors/> [↑](#footnote-ref-5)
6. See, for e.g., HSA sections. 65W and 134I; ASA section 20; MHA section.364. [↑](#footnote-ref-6)
7. See **Appendix 6** for an example of meeting minutes. [↑](#footnote-ref-7)
8. Refer to the [www.vpsc.vic.gov.au](http://www.vpsc.vic.gov.au) for guidance on management of conflicts of interest. Example policy documents that align with Victorian public sector requirements pertaining to conflicts of interest can be found from: <http://vpsc.vic.gov.au/ethics-behaviours-culture/conflict-of-interest/>. [↑](#footnote-ref-8)
9. Available from: <http://vpsc.vic.gov.au/resources/conflict-of-interest-guidance-for-organisations/> [↑](#footnote-ref-9)
10. See R Meagher, D Heydon and M Leeming, *Meager, Gummow & Lehane’s Equity: Doctrines and Remedies*, LexisNexis Butterworths, 4th ed, (2002), 176-8 [5-090]-[5-100]. [↑](#footnote-ref-10)
11. Protection was formally offered under the *Whistleblowers Protection Act 2001* (Vic). This Act has now been repealed. [↑](#footnote-ref-11)
12. See section 4 of the PDA for an explanation of what a protected disclosure is. [↑](#footnote-ref-12)
13. Available from: <http://www.ibac.vic.gov.au/>. [↑](#footnote-ref-13)
14. Available here: <https://vpsc.vic.gov.au/about-vpsc/protected-disclosures-procedures/> [↑](#footnote-ref-14)
15. Available from: <https://www2.health.vic.gov.au/hospitals-and-health-services/boards-and-governance/education-resources-for-boards/directors-conduct-and-workplace-culture> [↑](#footnote-ref-15)
16. Available from: <http://vpsc.vic.gov.au/resources/gifts-benefits-and-hospitality-resource-suite/>. [↑](#footnote-ref-16)
17. Available from: <http://www.dpc.vic.gov.au/index.php/policies/governance/appointment-and-remuneration-guidelines>. [↑](#footnote-ref-17)
18. Available from: <https://www.ato.gov.au/law/view/document?DocID=TXD/TD201613/NAT/ATO/00001&PiT=99991231235958>. [↑](#footnote-ref-18)
19. Available from: <https://www.ato.gov.au/business/fuel-schemes/fuel-tax-credits---business/rates---business/>. [↑](#footnote-ref-19)
20. *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41. [↑](#footnote-ref-20)
21. Legal principles that have been developed through the court system over time. [↑](#footnote-ref-21)
22. *Boardman v Phipps* [1967] 2 AC 46. [↑](#footnote-ref-22)
23. Story, Joseph, *Commentaries on Equity Jurisprudence (as Administered in England and America*), Vol 1, Cambridge Press, Boston (1836), p.261, §258. [↑](#footnote-ref-23)
24. *Breen v Williams* (1996) 186 CLR 71 [113]. [↑](#footnote-ref-24)
25. *Australian Securities and Investments Commission (ASIC) v Healey & Ors* [2011] FCA 717. [↑](#footnote-ref-25)
26. *Consul Development Pty Ltd v DPC Estates Pty Ltd* (1975) 132 CLR 373, [176]-[177]. [↑](#footnote-ref-26)