



HSE

**Code of
Governance**



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Chapter 1:

Introduction and Governance Overview

1.1 Introduction

Governance refers to the systems, principles and processes by which an organisation is directed, controlled and managed.

The HSE has been given the responsibility by the Oireachtas to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public¹. Working closely with the Chief Executive Officer and with senior management, it is the Board's role to satisfy itself, on an ongoing basis, that the HSE is well run and that it is held to account for its performance. The Board is committed to ensuring that the HSE operates as a highly transparent organisation which provides high-quality information about all aspects of its performance.

How the HSE is governed is not just a concern of the Board or of the Minister for Health ("the Minister") or indeed the Government. It is also a matter of considerable interest to the public who are the HSE's most important stakeholder. This is implicitly recognised in the legislation establishing the HSE. The Health Act 2004 (as amended) ('the Health Act 2004') requires the HSE to submit a code of governance (the "**Code**"), first to the Minister for his approval, and when approved to make the Code available to members of the public.

The HSE is a very large organisation and its responsibilities are wide-ranging. It would not be possible to explain every policy, procedure, regulation and guideline which contributes to the organisation's governance within the Code. The Health Act 2004 provides however, that the Code must deal with (at least) the following matters:

- (a) the **guiding principles** that apply to the HSE as a body having legal functions relating to health and personal social services;
- (b) the **structure** of the HSE, including the roles and responsibilities of its board and the Chief Executive Officer;
- (c) the **approach** to be used by the HSE to bring about the **integration of health and personal social services**;
- (d) the **processes and guidelines** to be followed by the HSE to ensure compliance with its reporting requirements under the Health Act 2004;
- (e) the **internal controls** adopted by the HSE, including procedures relating to internal audits, risk management, public procurement and financial reporting;
- (f) the **procedures** that apply to the HSE, and to bodies funded by it to facilitate the making of and the investigation of **protected disclosures**;
- (g) the **nature and quality of service** that persons being provided with or seeking health and personal social services can expect.

The Health Act 2004 provides that the HSE shall review the Code periodically and at such times that may be specified by the Minister and shall revise the code as the HSE considers appropriate. In preparing or making any revisions to the Code the HSE shall have regard to any directions issued by the Minister under the Health Act 2004. The HSE is also obliged under the legislation, each year, in its annual report, to indicate its arrangements for implementing and maintaining adherence to the Code.

1 The Health Act 2004 (as amended) is the legislation which established the HSE, and sets out the HSE's functions, its powers and governance arrangements.

In addition to complying with the legal requirements set out above, the HSE, as a State body, must adhere to the *Code of Practice for the Governance of State Bodies* (the “**DPER Code**”) published by the Department of Public Expenditure and Reform. Drafting this Code in compliance with the DPER Code necessarily extends the core compliance obligations to which the HSE is subject under the Health Act 2004. Any derogations from the provisions of the DPER Code will be outlined in the Oversight Agreement between the Department of Health and the HSE. (See paragraph 3.3).

The HSE is also a registered charity (Registered Charity Number 20059064), and in preparing this Code account has been taken of the Charities Code of Governance, prepared by the Charities Regulator.

It should be noted that:

- The Code should be read in conjunction with the legislative provisions which govern the HSE and/or its activities. Existing legislative provisions applying to the HSE on matters that are also the subject of this Code continue to apply and, in the event of any conflict or inconsistency, the legislative provisions prevail.
- The Code should be also be read in conjunction with any directions issued by the Minister; any relevant circulars issued by government departments; and to any internal HSE circulars, policies, procedures and guidelines to which the HSE is subject in its decision making (policy, clinical and administrative). The Code includes references to such directions and/or instruments where it is thought that such will be of assistance to the reader.
- The Code is compliant with the requirements of the Department of Finance and DPER Codes and is informed by best practice in financial and public sector governance². Provisions contained in this Code, including any financial thresholds, whether referred to directly or indirectly, may be amended from time to time, or as required by law.
- The HSE is constantly reviewing its operations, policies, procedures and processes, some of which may change during the lifetime of this Code.
- This Code replaces the previous version, which was last updated in October 2015.

The Code will evolve in line with best practice in corporate governance, and will be revised periodically, in compliance with the Health Act 2004.

2 Public Financial Procedures (2012), Department of Finance ‘The Role and Responsibilities of Accounting Officers – A memorandum for Accounting Officers’ (2011), Risk Management Guidance for Government Departments and Offices (2016); Office of Government Procurement Public Procurement Guidance for Goods and Services (2019); Department of Public Expenditure and Reform Public Spending Code (2019) and the International Framework: Good Governance in the Public Sector (2014), developed jointly by the Chartered Institute of Public Finance and Accountancy (CIPFA) and the International Federation of Accountants (IFAC).

1.2 Purpose of the Code

- 1.2.1 Publication of the Code is a legal requirement under Section 35 of the Health Act 2004 and it provides a framework for the application of best practice in corporate governance by the HSE. The Code describes the systems and procedures by which the HSE is directed, controlled and managed.
- 1.2.2 The Board is the governing body of the HSE and is collectively responsible for leading and directing the HSE's activities. It must "satisfy itself that appropriate systems, procedures and practices³" are in fact in place for the internal performance and accountability of the HSE. The CEO of the HSE is obliged to "ensure that appropriate systems, procedures and practices⁴" are in place for the internal performance and accountability of the HSE.
- 1.2.3 The Code details the principles, policies, procedures, and guidelines by which the HSE directs and controls its functions and manages its business. In support of a cohesive best practice corporate governance infrastructure, it is intended to guide the Board, the CEO and all those working within the HSE and the agencies funded by the HSE, in performing their functions to the highest standards of accountability, integrity and propriety. Publishing the Code is an important element of discharging the HSE's responsibility in this regard.
- 1.2.4 The Code is not a substitute for the core documentation outlining the systems, procedures and practices that are in place for the internal performance, management and accountability of the HSE, nor is it to be taken as a legal interpretation of the Health Acts 1947-2004, or of any other enactment referred to herein. Rather, the Code is intended to assist individuals seeking to understand how the HSE is managed and controlled generally, and held to account. In this regard the Code may be of assistance to stakeholders and to other individuals or organisations as a point of reference, for example:
- individual Board members;
 - employees of the HSE;
 - patients and service users;
 - members of the public;
 - regulatory bodies;
 - civil servants and employees of other public bodies;
 - public representatives;
 - organisations or individuals providing services on behalf of the HSE, or providing services similar or ancillary to services provided by the HSE;
 - professional associations and trade unions;
 - commercial organisations contracting or seeking to contract with the HSE.
- 1.2.5 The Code has also been revised to take account of changes made by the Government to the HSE's legal structure which affect how it is governed. This Code replaces the previous document, published in October 2015, and takes effect from 9 September 2021.

3 Section 16P, Part 3B of the Health Act 2004 as amended by the HSE (Governance) Act 2019.

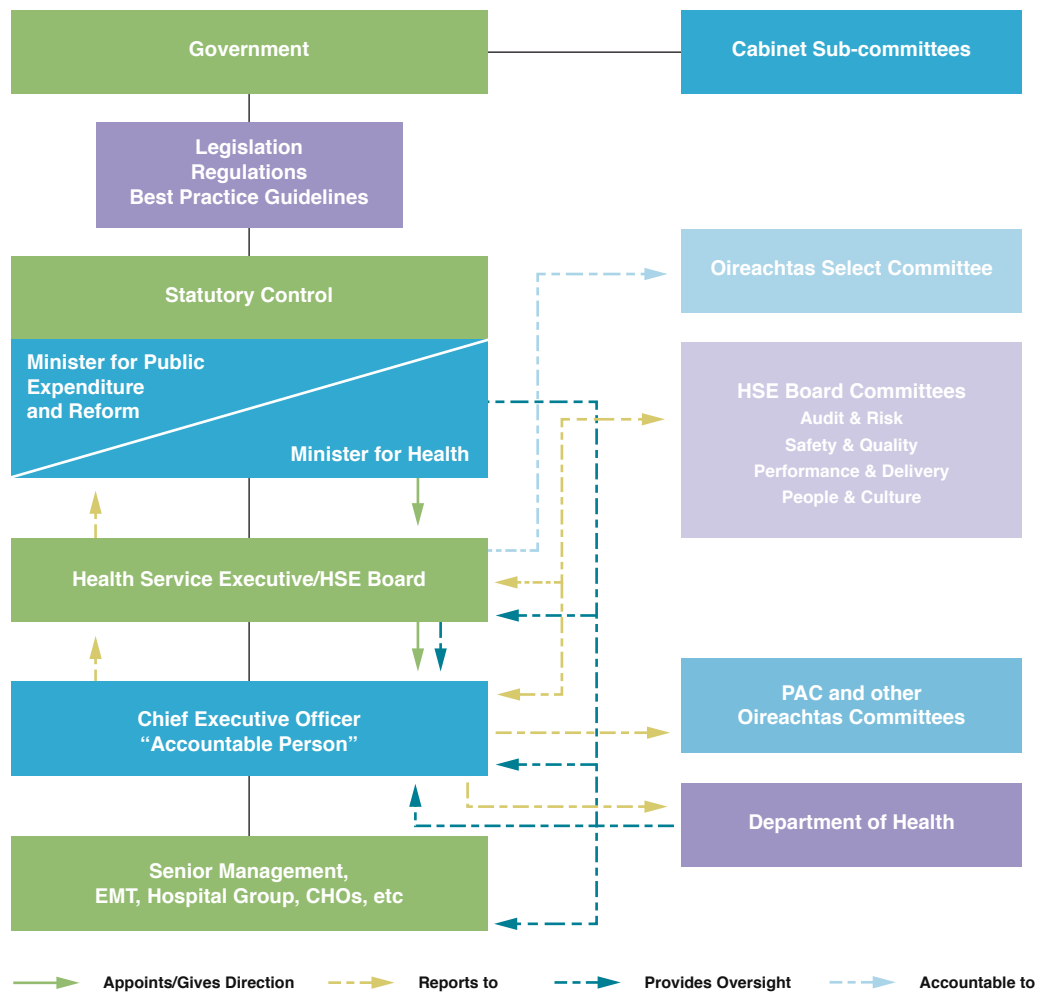
4 Section 21C, Part 4A of the Health Act 2004 as amended by the HSE (Governance) Act 2019.

1.3 Governance framework and structures

1.3.1 Governance framework in context

The Governance Framework schematic below shows the main features of the governance relationship between Government, Departments of State and the HSE.

Figure 1: Governance Framework



Adapted from "Governance Framework" as Represented in the Code of Practice for the Governance of State Bodies (2016)]

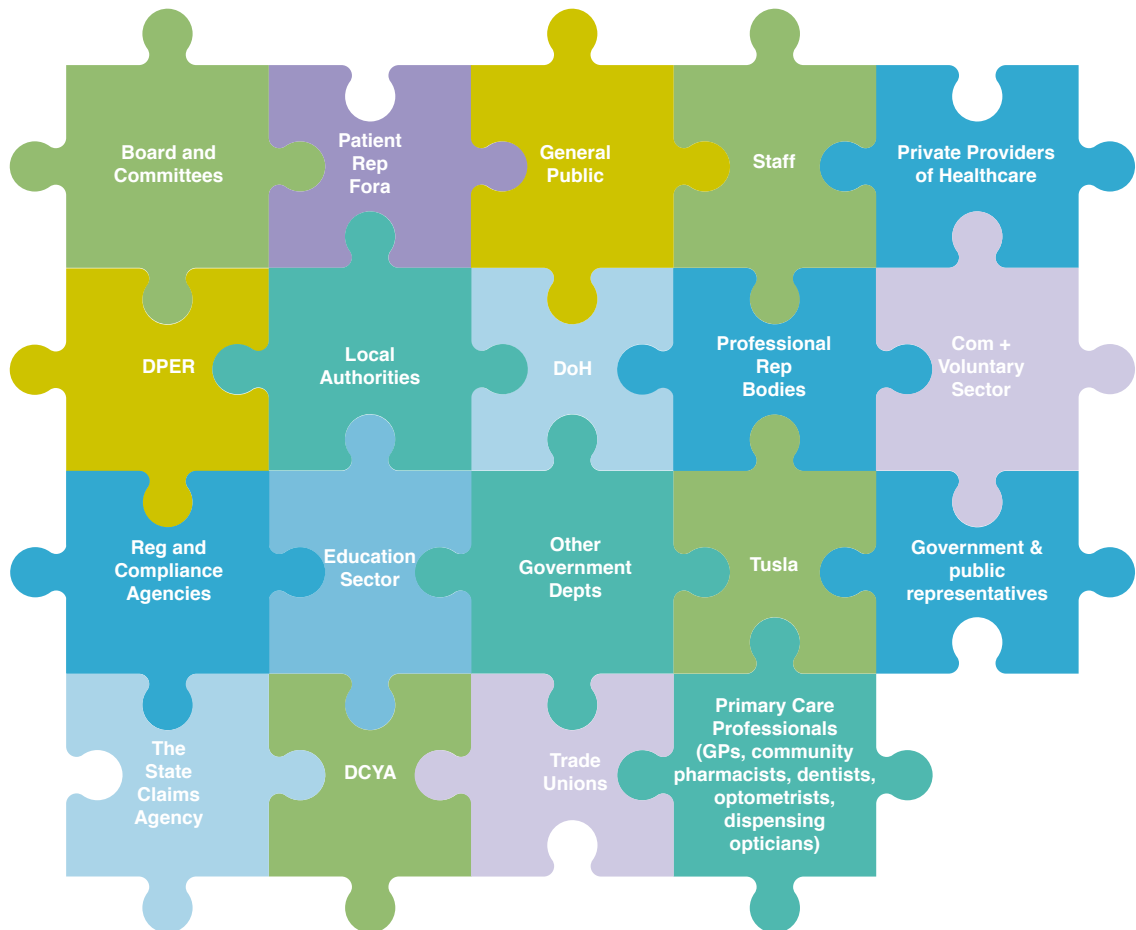
- 1.3.2 As a public body, the HSE is subject to a number of controls on the performance of its functions, as follows:
- (a) it must comply with the provisions of the Health Acts;
 - (b) it must comply with the policies (whether set out in codes, guidelines, Departmental circulars or other documents) of the Government or a Minister of Government, to the extent that those policies may affect or relate to its functions;
 - (c) it must comply with the regulatory requirements to which it is subject, e.g. standards set by the Health Information and Quality Authority (HIQA), the Charities Regulator, etc.;
 - (d) as a public body the HSE must comply with legal requirements specific to public bodies, i.e. the Public Sector Equality and Human Rights duty under the Irish Human Rights and Equality Act 2014;
 - (e) its Board, its Chief Executive Officer and its employees must comply with the provisions of the Ethics in Public Office Acts 1995 and 2001 (as amended, the **“Ethics Acts”**).

These matters are discussed in more detail in subsequent paragraphs of the Code.

1.4 Importance of stakeholders in HSE governance

- 1.4.1 As a public sector body, the HSE was established and is run for the public good, and the Board is committed to ensuring openness in the HSE's activities. Clear channels of communication and consultation will be used to engage effectively with all groups of stakeholders, including local communities or other groups about health and personal social services.
- 1.4.2 Good governance in the HSE, which is overseen by its Board, ensures that the organisation is run in a manner that takes proper account of the interests of the HSE's stakeholders, and that the intended outcomes for stakeholders are defined and achieved.
- 1.4.3 The Board of the HSE acknowledges the importance of stakeholder involvement in the design and delivery of healthcare, and is committed to the provision of public information about the services that the HSE provides, as well as its future plans.

Figure 2: The HSE's key stakeholders



- 1.4.4 As a large and complex organisation, the HSE must constantly adapt to the changing health and social care needs of the people that it serves. Effective stakeholder engagement requires strong and enduring relationships between HSE, at local and at national level, which must be built to endure, even in times of challenge or pressure.
- 1.4.5 The HSE's stakeholders are any person or group of people who have an interest in the services which it provides, or who receive(s) or may be affected by such services. Engagement refers to how the HSE listens to, communicates with and involves people and/or organisations.
- 1.4.6 Stakeholder engagement is the process by which the HSE builds trust and confidence, through involvement, communication, and listening to stakeholders' views and experiences. Effective engagement ensures that the HSE provides patients and/or family members with care centred around their needs.

Chapter 2:

Purpose of the HSE

2.1 Statutory object/function/powers

2.1.1 The HSE was established on 1 January 2005. The object of the HSE is described in the Health Act 2004 as follows:

“... to use the resources available to it in the most beneficial, effective, and efficient manner to improve, promote and protect the health and welfare of the public.”

2.1.2 The function of the HSE is to manage and to deliver or arrange to be delivered on its behalf, in accordance with the Health Act 2004 health and personal social services.

In so doing the HSE must:

- (a) Integrate the delivery of health and personal social services;
- (b) To the extent practicable and necessary to enable the HSE to perform its functions, facilitate the education and training of:
 - (i) Students in training to be registered medical practitioners, nurses or other health professionals; and
 - (ii) Its employees and the employees of service providers
- (c) Provide advice to the Minister for Health in relation to its functions as he or she may request.

2.1.3 In performing its functions, the HSE is required to have regard to the following:

- (a) services provided by voluntary and other bodies that are similar or ancillary to the services which the HSE is authorised to provide;
- (b) the need to cooperate with, and coordinate its activities with those of, other public bodies if the performance of their functions affects or could affect the health of the public;
- (c) the policies, (whether set out in codes, guidelines or other documents) and objectives of the Government or a Minister of Government, to the extent that those policies and objectives may affect or relate to the HSE's functions;
- (d) the resources, wherever originating, that are available to the HSE for the purpose of performing its functions;
- (e) the need to secure the most beneficial, effective and efficient use of those resources; and
- (f) any standards set by HIQA, in so far as practicable and subject to the resources of the HSE.

2.1.4 In order to perform its functions, the HSE has certain powers under the Health Act 2004, which include the following:

- (a) it may sue and be sued in its corporate name;
- (b) it may acquire, hold and dispose of land or an interest in land;
- (c) it may acquire, hold, and dispose of any other kind of property;
- (d) it may appoint persons to be its employees, and determine their duties;

- (e) it may, subject to and with the approval of the Minister, given with the consent of the Minister for Finance determine:
 - (i) employees' terms and conditions of employment (including those relating to remuneration and allowances)
 - (ii) the grades of the employees of the HSE and the numbers in each grade.
 - (f) it may engage such advisers as it considers necessary for the performance of its functions
 - (g) it may undertake, commission or collaborate in research projects on issues relating to health and personal social services. It may also collaborate in research projects involving parties from outside the State;
 - (h) it may (subject to its available resources and any directions from the Minister) enter into an arrangement with a person/service provider for the provision of a health or personal social service by the person/service provider on behalf of the HSE;
 - (i) it may (subject to its available resources and any directions from the Minister) give assistance to any person or body that provides or proposes to provide a service similar or ancillary to a service that the HSE may provide;
 - (j) it may enter into an agreement with a public body to perform a function of that public body on its behalf;
 - (k) it may enter into an agreement with a public body for that public body to perform a function on the HSE's behalf;
 - (l) it may enter into an informal arrangement with a local authority, for duties relating to the HSE's functions to be performed by an employee or employees of the local authority;
 - (m) it may enter into an informal arrangement with a local authority, for duties relating to the local authority's functions to be performed by an employee or employees of the HSE;
 - (n) it may accept gifts of money, land or other property on such trusts and conditions as may be specified by the donor, provided that they are not inconsistent with the HSE's object or functions or with any obligations imposed on it by any enactment, e.g. the Charities Acts, Taxes Consolidation Act 1997
 - (o) it may take such steps as it considers appropriate to consult with local communities or other groups about health and personal social services, including the establishment of advisory panels.
- 2.1.5 Subject to the provisions of the Health Acts or any other enactment, the HSE has *"all powers necessary or expedient for it to perform its functions."*

2.2 HSE Values/Sláintecare principles

- 2.2.1 The HSE has chosen Care, Compassion, Trust and Learning as its core Values. The Board, as governing body will ensure that these values are at the forefront of its own thinking and recognize and will set the "tone-at-the-top" of the organisation. These four Values inform everything that the HSE does and every decision that it makes; whether in its dealings with patients or at executive or board level. The HSE wants to foster a culture where all staff live these Values every day when interacting and dealing with service users, colleagues and members of the public.

CARE

- to provide care that is of the highest quality.
- to deliver evidence based best practice.
- to listen to the views and opinions of our patients and service users and consider them in how we plan and deliver our services.

COMPASSION

- to show respect, kindness, consideration and empathy in our communication and interaction with people.
- to be courteous and open in our communication with people and recognize their fundamental worth.
- to provide services with dignity and demonstrate professionalism at all times.

TRUST

- to provide services in which people have trust and confidence.
- to be open and transparent in how it provides services.
- to show honesty, integrity, consistency and accountability in its decisions and actions

LEARNING

- to foster learning, innovation and creativity.
- to support and encourage our workforce to achieve their full potential.
- to acknowledge when something is wrong, apologise for it, take corrective action and learn from it.

2.2.2 Guiding Principles: Sláintecare

The Oireachtas Committee on the Future of Healthcare was established to devise cross-party agreement on a single, long-term vision for health and social care and the direction of health policy in Ireland. The Committee's report, *Sláintecare* was published in May 2017 and has been adopted by the Government. The Sláintecare Fundamental Principles will inform future health policy in Ireland, and they are as follows:

- (a) Patient is paramount**
- (b) Timely access to health and social care**
- (c) Prevention and public health**
- (d) Free at the point of delivery**
- (e) An appropriate, accountable flexible, well-resourced workforce**
- (f) Public money and public interest**
- (g) Engagement, to build long term public and political confidence in the health services**
- (h) Accountability, through effective organisational alignment and good governance**

2.2.3 Corporate Plan 2021-2024

The Corporate Plan 2021-2024 sets out the HSE’s vision for “a healthier Ireland, with the right care, at the right time, and in the right place.” The Corporate Plan includes six objectives and five enablers, all of which are consistent with Sláintecare, as outlined in the diagram below:

Figure 3: Corporate Plan 2020-2023: Objectives and Key Enablers



The plan also places a strong focus on supporting Our People (staff and teams) by developing a culture across the organisation where staff feel valued and supported to be the best that they can be, and where staff are empowered to deliver change.

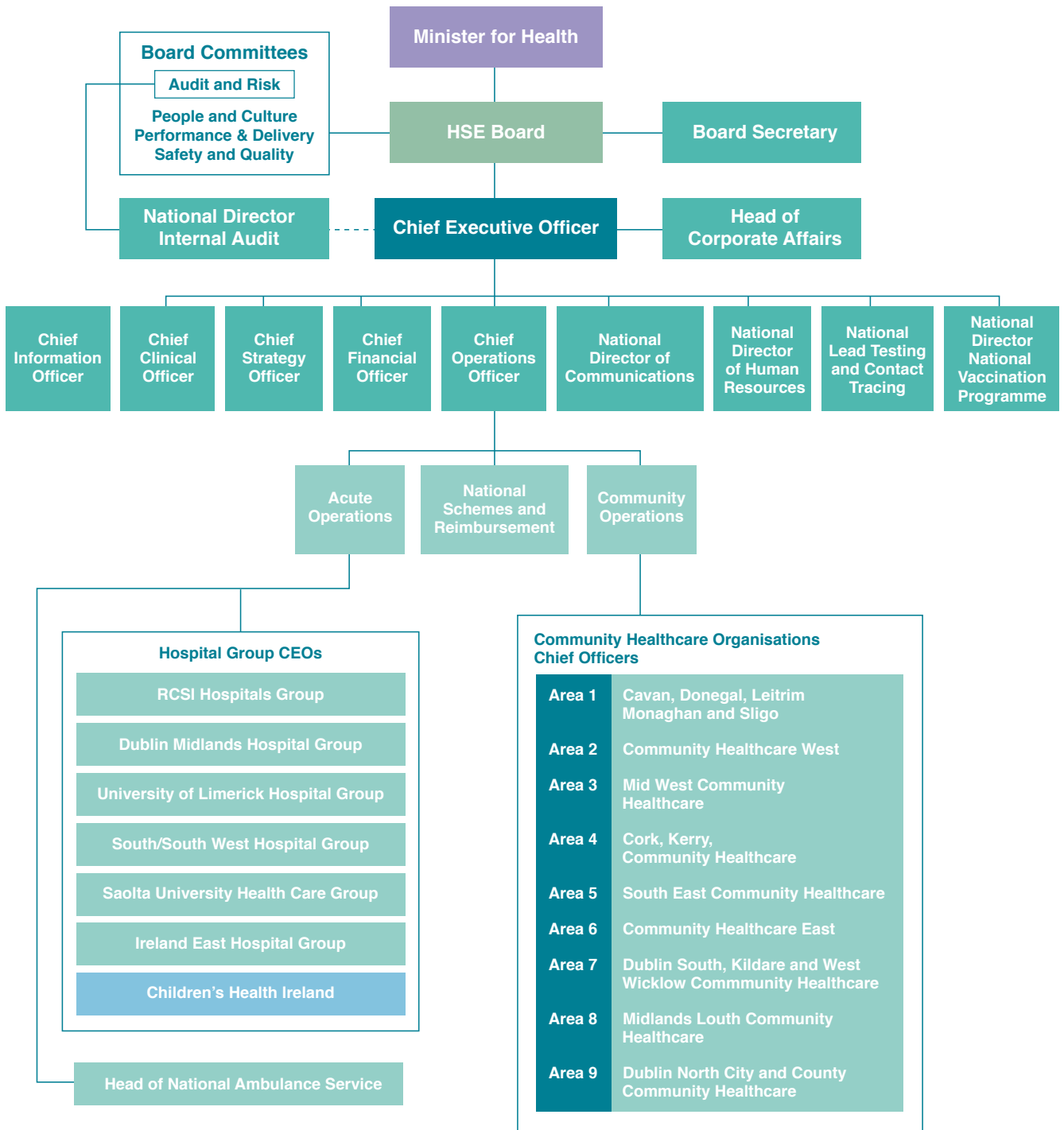
The HSE is committed to fully implementing the Corporate Plan and driving demonstrable improvements over the next three years.

2.3 HSE organisational structure

2.3.1 The Health Act 2004 was amended by the Health Service Executive (Governance) Act 2019 to provide for a revised governance model for the HSE.

- **Board:** The Board is the HSE's governing body, and the Board is accountable to the Minister.
- **Committees:** The Board is obliged to establish an audit committee and may also establish further committees to advise and assist it in relation to the performance of any of its functions.
- **Chief Executive Officer:** The Chief Executive Officer is accountable to the Board of the HSE.
- **Senior Management:** The Chief Executive Officer may delegate his functions to other employees, and to that end he or she may form a management team, the structure of which may change from time to time.

Figure 4: HSE Organisational Structure



2.4 Nature and quality of HSE service provision

The HSE provides health and personal social services to everyone living in Ireland. These services are universally accessible, although certain services are available free of charge only to specified categories of individuals.

The HSE's services are delivered in hospitals, in health facilities and in communities throughout Ireland. Private practitioners such as GPs, dentists, optometrists/dispensing opticians and community pharmacists also deliver services on behalf of the HSE, as do a large number of voluntary organisations.

The nature of the services provided by the HSE are outlined in the Health Act 1970 (as amended) and the charges that apply for availing of such services (if any) are set out in various statutory regulations made by the Minister for Health.

2.4.1 Currently, health and social care services are delivered through key service delivery infrastructure, broadly organised as follows:

- **Health and Wellbeing**

The aim of this division is to help people to live healthier and more fulfilled lives. Health and Wellbeing services cover the areas of public health, health protection, child health, health promotion and improvement, environmental health, emergency management and health intelligence. It also has an enabling role in relation to the roll out of the Healthy Ireland Framework (2013-2025) in the health services.

- **Primary Care**

The purpose of Primary Care is to ensure that the vast majority of patients and clients who require either urgent or planned care are managed within General Practice and/or other community-based settings whilst ensuring that services are safe and of the highest quality, responsive, accessible, efficient, integrated and aligned with relevant specialist services.

- **Social Care**

Social care services support and facilitate older people and people with disabilities to live independently by promoting such independence and lifestyle choice as far as possible. Services are delivered directly by the HSE or through agencies funded by the HSE which are governed through service arrangements or grant aid agreements.

- **Mental Health**

Mental Health services are organised by catchment areas, and include acute in-patient centre, residential homes, and community-based teams. Mental Health Services are provided in accordance with the Mental Health Act 2001 (the "2001 Act"). A "centre" is defined in the 2001 Act as "a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder" and an approved centre is a centre that is registered by the Mental Health Commission.

These are specialised services for Child and Adolescent Mental Health, General Adult Mental Health, and Psychiatry of Old Age. There are also a number of services which serve the whole population, including the National Forensic Mental Health Service, the National Counselling Service and the National Office for Suicide Prevention (NSOP).

- **National Ambulance Service**

The objective of the National Ambulance Service is to provide a modern, quality service that is safe, responsive and fit for purpose whilst delivering a significant reform agenda which has at its centre service improvement to ensure high quality safe care for its patients.

- **Acute Hospitals**

The publicly funded acute hospitals throughout Ireland provide all patients with equal access to safe quality inpatient and outpatient services. The hospitals collaborate with other services and with key stakeholders to deliver the best possible outcome for patients after they are discharged. Services are organised to maximise the amount of appropriate care delivered in local smaller hospitals while ensuring that highly specialised and complex care is safely provided in larger hospitals.

2.4.2 “Eligibility” for health and social services

A person’s liability to pay when availing of services provided by or on behalf of the HSE is determined by a person’s legal **“eligibility”** for such services under the Health Act 1970 (as amended).

Within the public health system, there are two categories of eligibility, namely:

- (a) **“full eligibility”** and
- (b) **“limited eligibility”**

Persons having full eligibility may (except in the case of long-term residential care) access health and personal social services free of charge and access medicines at nominal cost. Assessments for full eligibility are through the Medical Card application process. The issuing of a Medical Card to a person is confirmation that he or she has been granted full eligibility status.

Persons with limited eligibility do not have full eligibility, and so the HSE is required to levy certain charges in respect of services provided to such persons. The charges imposed by the HSE for services provided to persons with limited eligibility are in most cases substantially below the economic cost to the HSE of providing such services.

The following persons qualify for full eligibility (i.e. a Medical Card):

- (a) adult persons who, following an assessment of their financial means and/or personal circumstances are assessed as being unable to pay for services from within their own resources without undue hardship; and
- (b) dependants of such adult persons referred to above.

Legal provision has also been made for certain individuals to qualify for full eligibility, e.g. women deemed eligible by the Minister for Health under the Redress for Women in Certain Institutions Act 2015.

All other persons ordinarily resident in Ireland are automatically deemed as having limited eligibility status.

A person's eligibility status for services is assessed by the HSE, by the application of income thresholds which are set out in statutory regulations which may be varied by the Minister from time to time.

Where a person has been unsuccessful in their application for a Medical Card, but providing for his or her healthcare needs would, owing to the nature of his or her medical condition, cause "undue hardship," the situation can be reviewed on medical grounds. A medical officer will review such applications on request, in accordance with guidelines issued by the HSE. Accordingly, a person may, in exceptional circumstances be assessed as having full eligibility, even though their income is in excess of the applicable income thresholds.

2.4.3 **Over 70s**

Provision has been made in law for a separate assessment of persons over the age of 70 years, who may, notwithstanding the standard means assessment, qualify for full eligibility, or if not full eligibility, for access to free General Practitioner Services.

2.4.4 **Children**

It is the intention of the Minister for Health, in line with Sláintecare, to extend free General Practitioner Services to children on a phased basis. The process of extending full eligibility has already been commenced, with children under 6 years of age qualifying for full eligibility.

2.4.5 **Special Categories**

Provision may also be made for other categories of persons to qualify for a Medical Card, e.g. persons who have been affected by the drug Thalidomide, or for access to free General Practitioner Services, e.g. persons who are receipt of Carers Allowance. Legislation has also been passed for the provision of health services without charge to certain persons, e.g. for persons who have contracted hepatitis C directly or indirectly from the use of Human Immunoglobulin-Anti-D or other blood products under the Health (Amendment) Act 1996.

2.4.6 **Waiver of eligibility**

Individuals availing of acute hospital services may also choose to waive their eligibility status, by availing of acute inpatient services as a private patient. Individuals accessing services as private patients are liable for in-patient services in accordance with a schedule of private in-patient fees. Where the patient avails of private in-patient services under the terms of a private health insurance policy, these costs will be reimbursed to the HSE directly by the health insurance company.

2.4.7 **Quality of Services**

There is strong commitment to improving the quality of care across the HSE on a continuous basis. The HSE's approach to improving quality is set out in its *Framework for Improving Quality in our Health Service*.

Quality services are viewed by the HSE in terms of four quality domains, as follows:

- (1) **Person centred** – care that is respectful and responsive to individuals needs and values and partners with individuals in designing and delivering that care;
- (2) **Effective** – care that is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes
- (3) **Safe** – care that avoids, prevents and minimises harm to patients and learns from when things go wrong
- (4) **Better health and wellbeing** – care that seeks to identify and take opportunities to support patients in improving their own health and wellbeing

Figure 5: Defining quality within the Irish Healthcare System



2.5 Integration of health and personal social services

2.5.1 The Health Act 2004 requires that the HSE shall manage and deliver, or arrange to be delivered on its behalf, health and personal social services in accordance with the Health Act 2004 and also requires that the delivery of such health and personal social services shall be integrated.

2.5.2 Although the term “integrated care” is not defined in legislation the term has been defined in the Sláintecare report as:

‘Healthcare delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access and service providers can easily deliver. This is a service in which communication and information support positive decision-making, governance and accountability; where patients’ needs come first in driving safety, quality and the coordination of care.

2.5.3 The HSE is working to integrate the delivery of health and personal social services by:

- (a) the implementation of Sláintecare;
- (b) the implementation of the Corporate Plan 2020-2023;
- (c) recalibrating the entire health system to build up primary and social care capacity, which in turn will relieve some pressures on the acute hospital system and free up capacity to deal with care that can only be provided in an acute setting;
- (d) developing a strategic national centre for the HSE to complement and support the Regional Health Areas that are accountable for delivering integrated care; and
- (e) delivering on the transfer of care of patients with chronic illness and their associated complex care requirements from secondary to primary and continuing services, while also addressing the needs of an aging population close to home, enabled by Community Healthcare Networks.

2.5.4 Voluntary Sector (“Section 38” and “Section 39” bodies)

The voluntary sector comprises a wide range of organisations that vary significantly in terms of size, geographical coverage and the type of services they provide.

The HSE has entered into arrangements with a number of organisations within the voluntary sector for the provision of services on its behalf. The HSE has also entered into arrangements to provide assistance to a very large number of organisations, each of which delivers services which are similar or ancillary to those which the HSE provides.

The HSE recognises that it benefits from and relies upon the services delivered by the voluntary sector.

Chapter 3:

Governance Roles and Responsibilities

Part A: Ministerial Oversight of the HSE

The Health Act 2004 refers to “the Minister” (being the Minister for Health) throughout, rather than to the Department of Health. However, under the Irish Constitution and in law, ministers are regarded as being one and the same as the government departments of which they are in charge. As such, and unless otherwise prescribed in legislation, Department officials act in the name of the Minister (the “**Carltona Principle**”).

3.1 Role of the Minister for Health

- 3.1.1 The principal legislative provisions governing Ministers’ powers are the Ministers and Secretaries Acts 1924 to 2013 and the Public Service Management Act 1997. The Ministers and Secretaries Act 1924 provides that the Minister for Health shall be the responsible head of the Department or Departments under his/her charge and “... *shall be individually responsible to Dáil Éireann alone for the administration of the Department or Departments of which he is head ...*”.
- 3.1.2 The Department of Health is obliged under the Public Service Management Act 1997 to publish a strategy statement every three years outlining its mission and strategic goals.
- 3.1.3 The HSE is a body under the aegis of the Minister for Health. The Health Act 2004 confers certain powers on the Minister for Health in relation to the HSE, as follows:
- (a) The Minister may issue **general** written directions to the HSE or the Board:
 - (i) for any purpose relating to the Health Act 2004 or any other enactment;
 - (ii) concerning any matter or thing referred to in the Health Act 2004);
 - (iii) concerning the implementation of any policy or objective of the Minister or the Government which relates to the HSE’s functions, where the Minister is of the opinion that the HSE is not having sufficient regard to such policy or objective in the performance of its functions
 - (b) The Minister is responsible for determining and notifying the HSE of the maximum amount of net non-capital and capital expenditure that may be incurred for -
 - (i) a financial year of the HSE (generally January to December), or
 - (ii) such part of a financial year of the HSE as may be specified in the notification.
 - (c) The Minister may issue **specific** written directions to the HSE concerning the submission by the HSE of:
 - (i) its corporate plan;
 - (ii) its annual service plan; and
 - (iii) its annual capital plan.

The Minister is also responsible for the approval of the HSE's corporate plan, its annual service plan⁵, its capital plan, and its Code of Governance.

- (d) The Minister may, where he or she considers it in the public interest to do so for the performance of his or her functions (whether under the Health Act 2004 or otherwise), require the HSE to furnish him or her with such information or documents as he may specify that are in its procurement, possession and control.
- (e) The determination by the HSE of the terms and conditions of employment (including terms and conditions relating to remuneration and allowances) of employees and the grades of employees it employs and the number of employees in each grade are subject to the approval of the Minister, given with the consent of the Minister for Public Expenditure and Reform.

3.1.4 The Minister may not issue a direction to the HSE, or specify a priority or performance target, as respects:

- (i) Any function relating to the provision of treatment or a health or personal social service to any particular person;
- (ii) Any function relating to a decision concerning:
 - Whether or not a particular person is eligible for a particular health or personal social service (including the payment of a grant or allowance) OR
 - The extent to which and the manner in which a person is eligible for any such service.
- (iii) Any function of the HSE relating to a decision concerning the making or recovery of a charge for the provision of a health or personal social service by the HSE to a particular person concerning the amount of that charge.
- (iv) Any function of the HSE that has been specified in an enactment to be a function of the Chief Executive Officer relating to the functions (i) to (iii) above.

3.2 Role of the Department of Health/Minister for Health

3.2.1 The Department of Health is established under the Ministers and Secretaries Act 1924 to 2013. The role of the Department is to provide strategic leadership for the health service and to ensure that Government policies are translated into actions and implemented effectively. The Department has the responsibility for the evaluation of such policies and of the performance of the health system. In summary the role of the Department is:

- providing leadership and policy direction for the health sector to improve health outcomes;
- undertaking governance and performance oversight to ensure accountable and high-quality services;
- collaborating to achieve health priorities and contribute to wider social and economic goals;
- creating an organisational environment where, on an on-going basis, high performance is achieved, collaborative working is valued, and the knowledge and skills of staff are developed and deployed.

⁵ Amending legislation in respect of the role of the Minister in approving the corporate plan and service plan is being considered at the date of publication of this Code.

3.2.2 The Department supports the Minister and Ministers of State in their implementation of Government policy and in discharging their Governmental, parliamentary and Departmental duties.

3.2.3 The relationship between the HSE the Minister of Health and the Minister's Department is determined primarily by:

- The Health Act 2004;
- Department of Health Circulars and/or Circulars from the Department of Finance/Public Expenditure and Reform;
- The Oversight Agreement between the Department of Health and the HSE;
- The Code of Practice for the Governance of State Bodies (2016), as amended.

The Secretary General

The Minister and Secretaries Act 1924 to 2013 and the Public Service Management Act 1997 outline the statutory responsibilities of the Secretary General including the following:

- managing the business generally of the Department;
- implementing Government policies appropriate to the Department;
- monitoring Government policies that affect the Department;
- delivering outputs as determined by the Minister;
- providing policy advice to the Minister on all matters within the remit of the Department;
- preparing Statements of Strategy for submission to the Minister;
- providing progress reports to the Minister on the implementation of the Statement of Strategy;

In addition to the role of Secretary General, he/she is assigned the role of Accounting Officer for the Vote of the Office of the Minister for Health under the Comptroller and Auditor General (Amendment) Act 1993. The role of Accounting Officer is to ensure proper use of resources and the provision of cost-effective public services. The HSE receives its Exchequer funding (non-capital and capital) by way of a grant from Vote 38.

The Chief Executive Officer of the HSE is obliged under Section 21C of the Health Act 2004 to assist and provide the accounting officer with such information (including financial information and records) relating to the Accounting Officer's functions as he or she requires.

3.2.4 The DPER Code

Under the Health Act 2004, the HSE must have regard to:

" ... the policies (whether set out in codes, guidelines or other documents, or any combination thereof) and objectives of the Government or any Minister of the Government to the extent that those policies and objectives may affect or relate to the functions of the Executive ... "

The HSE must therefore comply with the DPER Code, which applies to both the internal practices of the HSE and its external relations with Government, the Minister for Health, the Minister for Public Expenditure and Reform, and the Department of Health. The HSE is required to confirm to the Minister for Health that it complies with the DPER Code in its governance practices and procedures.

“Comply or Explain”

The DPER Code provides that State bodies are required to confirm to their relevant Minister/Parent Government Department that they comply with this Code in their governance practices and procedures. However, the DPER Code makes provision for certain requirements to be applied proportionately, subject to the written agreement of the relevant Minister/Parent Department.

Where the HSE proposes to deviate from the DPER Code it is required to reach an agreement with the Minister for Health/Department of Health on the extent to which the compliance requirement might be suitably adapted.

3.3 Oversight Agreement between the Department of Health and the HSE

- 3.3.1 According to the DPER Code, the starting point for accountability is that Government Departments should have a written Oversight Agreement with State bodies under their aegis. The HSE is a body which is under the aegis of the Department of Health.
- 3.3.2 In line with the Health Act 2004 and the DPER Code the Department of Health has an oversight role in relation the HSE. The DPER Code states that any State body *“must be subject to sufficient oversight and accountability to ensure that it is performing effectively and delivering its objectives to ensure public resources are used efficiently and effectively”*. It also provides that: *“[t]he Accounting Officer of the Government Department under whose aegis the State body lies should satisfy him/her self that the requirements of this Code are being properly implemented and observed.”*
- 3.3.3 The Oversight Agreement is a written statement between the Minister for Health/Department of Health and the Health Service Executive (HSE) which sets out the terms of the relationship between the Minister/Department of Health and the HSE, and it:
 - (a) sets out the terms of the relationship between the two bodies and the respective roles and responsibilities of both parties;
 - (b) sets out structured arrangements for communications, reporting and liaison, accountability and governance between the two parties to the Agreement in order to facilitate effective oversight and accountability;
 - (c) supports the existing on-going co-operation and engagement between the Department and the HSE.

- 3.3.4 The Oversight Agreement also reflects the following:
- the legal framework of the HSE;
 - the environment in which the HSE operates (e.g. commercial, non-commercial, regulatory);
 - the purpose and responsibilities of the HSE;
 - the HSE's level of compliance with the Code;
 - details of the HSE's performance delivery; (e.g. outputs to be delivered as outlined in the HSEs annual Service Plan);
 - monitoring and reporting on conformity with Government Policy, including those areas of expenditure where prior sanction from the Department of Health and/or the Department of Public Expenditure and Reform is required.
- 3.3.5 The Oversight Agreement between the HSE and the Department of Health will be reviewed periodically.

3.4 Performance Delivery Agreement/National Service Plan

- 3.4.1 Under the DPER Code the HSE is required to agree a Performance Delivery Agreement (PDA) with the Minister/Department of Health and report to the Minister on progress against targets. The PDA acts as a performance contract between the Department of Health and the HSE in which an agreed level of performance/service is formalised, and which will ultimately result in improved efficiency and effectiveness in the delivery of health and personal social services. The PDA between the HSE and the Department of Health is represented by the HSE's National Service Plan.
- 3.4.2 Under the Health Act 2004 the HSE is obliged to prepare and adopt a service plan for the financial year (or such other period as may be determined by the Minister). In practice the preparation of this plan ("National Service Plan) is an operational matter which is attended to by the CEO and the Executive Management Team, in close consultation with the HSE Board, which must adopt it prior to submission to the Minister for Health.
- 3.4.3 The first step in preparing the National Service Plan is the "Estimates" process. Each year, based on Government direction and the economic environment, the CEO establish a process to identify the financial and human resources requirements for the following year. This typically includes:
- (a) Existing Levels of Service**
Identification of resources to support existing levels of service. This always assumes a breakeven position at year end and no change in eligibility policies.
 - (b) Service Priorities**
Identification of key priorities and key pressure areas which will either be unavoidable and therefore will require to be funded, or to not proceed with will cause significant risk for the organisation. The priority list is cross referenced with the Corporate Risk Register.

(c) **Government Policy**

Consideration of government policy in relation to public services (e.g. Public Service Agreements, McCarthy and Considine Reports 2010).

(d) **Strategic Direction of HSE**

Consideration of the Organisation's strategic direction (e.g. informed by the Corporate Plan, Sláintecare, etc) and requirements for the reconfiguration of services if required.

(e) **Service Efficiencies/Initiatives**

Identification of additional service efficiencies and value for money initiatives.

3.4.4 The indicative timeframes in preparing the National Service Plan are set out in the table below:

Milestone	Timeline
Performance and Delivery (P&D) Committee agree key planning milestones	Early June
National Directors discuss and agree approach, assumptions and timelines for service planning	End June
Guidance notes on development of NSP (including process for Estimates) issued by Chief Strategy Officer	End June
On-going interaction between HSE and Department of Health line divisions on identifying specific priorities	July – end process
Return of first draft NSP submissions to Corporate Planning	Mid-August
First draft NSP to CEO and Executive Management Team	Early September
First draft NSP to P&D Committee	Mid-September
Budget Day	1 st week in October
Letter of Determination (LoD) received	Within 21 days of Budget
NSP draft updated based on LoD and funding	Mid-October – early November
Final NSP considered by EMT	Early November
Final NSP considered by P&D Committee	Early November
Final NSP adopted by HSE Board and submitted to Minister	Mid-November (within 21 days of receipt of LoD)

3.4.5 The National Service Plan must:

- Indicate the type and volume of health and personal social services to be provided
- Indicate any capital plans proposed
- Contain an estimate of the number of employees of the Executive for the period
- Contain any other information specified by the Minister
- Comply with directions issued by the Minister under Section 10
- Accord with the policies and objectives of the Minister and the Government
- Have regard to the approved Corporate Plan in operation at the time.

3.4.6 The adoption of the National Service Plan is a reserved function of the HSE Board. Once the National Service Plan has been adopted by the Board it is submitted to the Minister for approval. The Minister may issue a wide range of directions in respect of the form and manner of the National Service Plan and may direct that it be amended. The Minister may refuse to approve the National Service Plan unless it is amended by the HSE in accordance with the Minister's directions.

PART B: Board as governing authority of the HSE

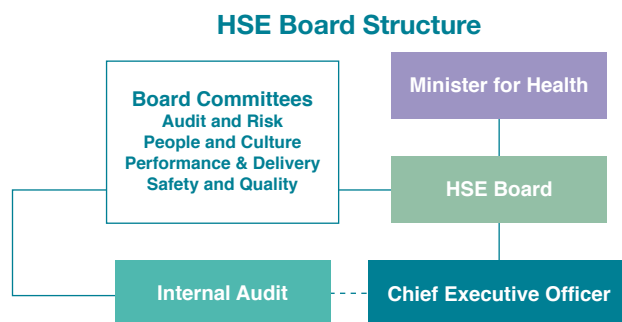
3.5 Role of HSE Board

3.5.1 The HSE Board is collectively responsible for leading and directing the HSE's activities. While the Board may delegate particular functions to the Chief Executive Officer, the exercise of the power of delegation does not absolve the Board from the duty to supervise and be accountable for the discharge of the delegated functions.

3.5.2 The Board was established under Part 3B of the Health Act 2004 ⁶ The Board is the governing body of the HSE with authority, in the name of the HSE, to perform its functions.

3.5.3 Consistent with the DPER Code, the role of the Board in relation to the HSE, the Minister and can be represented graphically as follows:

Figure 6: Board of the Health Service Executive



6 As inserted by the Health Service Executive (Governance) Act 2019.

3.5.4 In accordance with the Health Act 2004 the Board has been assigned a number of key functions as follows:

(a) It is required to satisfy itself that appropriate systems, procedures and practices are in place -

- (i) to achieve the HSE's objectives;
- (ii) for the internal performance and accountability in respect of the HSE's: -
 - (A) performance of its functions,
 - (B) achieving its objectives in accordance with the corporate plan,
 - (C) delivery of health services in accordance with the Health Act;

and

- (iii) in order to enable compliance with the policies (whether set out in codes, guidelines, or other documents, or any combination thereof) of the Government or a Minister of the Government to the extent that those policies may affect or relate to the functions of the HSE

and

(b) establish and implement arrangements for the management of the performance of the Chief Executive Officer.

3.5.5 The Board fulfils key functions in respect of the HSE, including:

- the adoption of the HSE's corporate plan with appropriate objectives, indicators and targets against which performance can be measured;
- reviewing and guiding strategic direction and major plans of action;
- risk management policies and procedures;
- approval of annual service plans and budgets;
- setting performance objectives;
- monitoring implementation, and evaluating the HSE's performance;
- overseeing major capital expenditure and investment decisions; and
- approval of the HSE's annual accounts and annual reports.

3.5.6 The Board must ensure that the HSE's Corporate Plan and its strategic planning are aligned to Sláintecare and to the Department of Health's Statement of Strategy, to the extent relevant, and should also be consistent with the HSE's statutory mandate.

3.5.7 The Board must act on a fully informed and ethical basis, in good faith, with due diligence and care, and in the best interest of the HSE, having due regard to its legal responsibilities and the objectives set by Government.

3.5.8 The Board promotes the development of the capacity of the HSE including the capability of its leadership and staff.

3.5.9 The Board is responsible for holding the CEO and senior management to account for the effective performance of their responsibilities.

3.5.10 Consistent with the Health Act 2004 the Board also exercises the following responsibilities in respect of the HSE in accordance with the DPER Code:

- **Leadership:**

The Board's role is to provide leadership and direction of the HSE within a framework of prudent and effective controls which enables risk to be assessed and managed. The Board agrees the HSE's strategic aims with the Minister and his or her Department, to the extent relevant, and ensures optimal use of resources to meet the HSE's objectives.

- **Ethical Standards:**

The Board has a key role in setting the ethical tone of the HSE, not only by its own actions but also in overseeing the internal performance management and accountability of the HSE, and its Chief Executive Officer. This clearly visible commitment to high ethical standards is in the long-term interests of the HSE and a key means to sustain public trust and credibility. It is important that the Board sets the correct 'tone from the top'. The Board should lead by example and ensure that good standards of governance and ethical behaviours permeate all levels of the HSE.

- **Compliance:**

The Board should review the controls and procedures adopted by the HSE to provide itself with reasonable assurance that such controls and procedures are adequate to secure compliance by the HSE with its statutory and governance obligations.

- **Collective Responsibility:**

The collective responsibility and authority of the Board must be safeguarded. All Board members will be afforded the opportunity to fully contribute to Board deliberations, and where necessary to provide constructive challenge, while excessive influence on Board decision-making by one or more individual members will be guarded against.

- **Oversight Role:**

The Board must be provided with all necessary information to enable it to perform its duties to a high standard. The Board of the HSE should take all necessary steps to make themselves aware of any relevant information and access all information as necessary.

While the Board of the HSE has established an Audit and Risk Committee to assist with its consideration of issues relating to audit, governance and risk management, the Board maintains responsibility for and makes the final decisions on all of these areas.

- **Advice to Minister:**

The Health Act stipulates that the **Board** inform the Minister in writing of **any matter** which the Board considers requires the Minister's attention.

- **Directions from Minister:**

The Health Act 2004 provides that **the Chairperson** of the Board informs the Minister of the measures taken by the HSE or the Board (as applicable) to comply with a direction issued by the Minister under section 10(7) of the Health Act 2004 and such information shall be furnished to the Minister within such period as specified by the Minister

3.5.11 **Decision making, oversight and control**

The Board has established the following mechanisms to ensure that it exercises appropriate decision-making, oversight and control of the HSE's functions:

(a) **Delegation Policy Framework and Governance Arrangements**

The HSE's Delegation Policy Framework and Governance Arrangements lists the functions that have been delegated by the Board to the Chief Executive Officer, and by the Chief Executive Officer in turn to his or her Executive Management Team. Provision is also made in law for employees to whom functions have been delegated or sub-delegated to further sub-delegate those functions.

(b) **Reserved functions**

The Board has a formal schedule of matters specifically reserved to it for decision (its **"reserved functions"**) to ensure that the direction and control of the HSE is firmly in its hands (some of these matters may also require Ministerial approval). The reserved functions of the Board are listed in the Delegation Order issued to the Chief Executive Officer.

(c) **Executive management**

The Board, through the Chief Executive Officer is responsible for holding senior management to account for the effective performance of their responsibilities. It is the responsibility of the Chief Executive Officer and his or her senior management team to ensure that the Board is provided with all necessary information to enable it to perform its functions. The Chief Executive Officer must also provide assurance to the Board that the functions which it has delegated to him are being appropriately discharged.

(d) **Establishment of committees**

The Board is empowered under Section 16T of the Health Act 2004 to establish committees, consisting in whole or in part of persons who are members of the Board, to assist and advise it in relation to the performance of any of its functions (See paragraph 3.6.11(f), below). In addition to this general power, the Board is specifically required to establish an audit committee in accordance with Section 40H of the Health Act 2004.

Within the organisational structure, five committees have been established by the Board to provide more detailed oversight of specific areas as defined in the respective committee's terms of reference. The Board may elect to establish any further committees it deems necessary (see paragraph 3.9 for further information on Committees of the Board).

(e) **Approval of certain policies**

The Board may decide to review and approve certain policies, which in the opinion of the Board may have a material impact on the manner in which the HSE performs any of its functions.

(f) **Corporate performance reports**

Corporate performance reports, including reports on budget and human resources are presented at each Board meeting

3.6 Role of the Chairperson

3.6.1 In accordance with the DPER Code, the Chairperson shall be responsible for leadership of the Board and ensuring its effectiveness on all aspects of its role.

3.6.2 The Chairperson shall display high standards of integrity and probity and set expectations regarding culture, values, and behaviours for the State body and for the tone of discussions at Board level.

3.6.3 Specific DPER Code Provisions

- **Board's Agenda:** The Chairperson is responsible for the effective management of the Board's agenda and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.
- **Openness and Debate:** Essential to the effective functioning of the Board is dialogue between the Board members, and with management which is both constructive and challenging. The Chairperson should promote a culture of openness and debate by facilitating the effective contribution of key management and all Board members.
- **Timely Information:** The Chairperson shall work with the CEO to ensure that the Board receive accurate, timely and clear information. The Chairperson should ensure effective communication with all relevant stakeholders.
- **Board Skills:** Where a Chairperson is of the view that specific skills are required on the Board, he/she should advise the relevant Minister of this view for his/her consideration sufficiently in advance of a time when Board vacancies are due to arise. This is in order to seek to ensure that the process undertaken under the publication: *Guidelines for Appointments to State Boards* identifies candidates with those skills and so that the Minister may take the Chairperson's views into consideration when making appointments from qualified candidates from the stateboards.ie process.
- **Information Flows:** Under the direction of the Chairperson, the responsibilities of the Secretary of the Board include ensuring good information flows within the Board and its committees and between senior management and Board members. See paragraph 3.10, below.
- **Report to the Minister:** The Chairperson will furnish, as part of or in conjunction with the annual report and annual financial statements of the HSE, a comprehensive report to the Minister for Health.
- **Statement on Internal Control:** The Chairperson's report to the Minister regarding the system of internal control should be included in the annual report of the State body.
- **Oireachtas Committee:** The Chairperson and in his or her absence, the Deputy Chairperson may be required to appear before an Oireachtas Committee to discuss the approach they will take to their role as Chairperson and their views regarding the HSE and the contribution of the Board in question to its governance.

3.7 Role of the Deputy Chairperson ⁷

- 3.7.1 The role of the Deputy Chairperson is not specifically described in the Health Act 2004, other than that a distinction is made between “ordinary members” of the Board and the Chairperson and the Deputy Chairperson who are “members”, but not “ordinary members” of the Board. Accordingly, under the current legislation (unless or until amended) the Deputy Chairperson may not be counted as an “ordinary member” for the purposes of a quorum for a meeting of the Board, at which the Chairman is present.
- 3.7.2 Where the Chairperson is not present at a Board meeting, or if the office of Chairperson is vacant, the Deputy Chairperson is required, if present to be the Chairperson of the Board meeting.

3.8 Role of Board Members

- 3.8.1 The Board is collectively responsible for achieving the HSE’s object and, among other responsibilities, for overseeing the delivery of health and personal social services as outlined in the Health Acts 1947 to 2019. The Board members are mandated to bring **independent** judgement to bear on issues of strategy, performance, resources, key appointments, and standards of conduct.
- 3.8.2 Statutory, Fiduciary and Ethical Duties

All Board members have a duty to act in accordance with the Health Act 2004, and/or to perform their functions in accordance with such obligations as may be conferred on the Board by any other enactment.

Board members have a fiduciary duty to the HSE (i.e. the duty to act in good faith and in the best interests of the HSE), which include the following:

- (i) to act in good faith in what the Board member considers to be the interest of the HSE;
- (ii) to act honestly and responsibly in relation to the conduct of the affairs of the HSE;
- (iii) to act as trustees under the Charities Act 2009 in relation to the HSE’s status as a charitable organisation;
- (iv) to act in accordance with the Health Act 2004 and to exercise the Board’s functions and powers only for the purposes allowed by law;
- (v) not to benefit from or use the HSE’s property, information or opportunities for his or her own benefit;
- (vi) not to agree to restrict the Board’s or any Board member’s power to exercise an independent judgment;
- (vii) to avoid any conflict between the Board member’s duties to the HSE and the Board member’s other interests unless the Board member is released from his or her duty to the Board in relation to the matter concerned;
- (viii) to exercise the care, skill and diligence which would be reasonably expected of a person in the same position with similar knowledge and experience as a Board member.

⁷ Amending legislation is being worked upon at the date of release of this Code of Governance which, if enacted, will enable the Deputy Chairperson to be counted in the quorum for the Board.

- 3.8.3 Board members may, if they consider it necessary in the furtherance of their duties, arrange to obtain professional advice at the reasonable expense of the HSE.

3.9 Role of Board Committees

- 3.9.1 Section 16T of the Health Act 2004 confers powers on the Board to establish committees to advise it in relation to the performance of its functions. The HSE is also required to establish an audit committee under Section 40H of the Health Act 2004. The following Committees have been established by the Board:

- (a) **The Audit and Risk Committee;**
- (b) **Performance and Delivery Committee;**
- (c) **Safety and Quality Committee;**
- (d) **People and Culture Committee.**

The terms of reference for the Board Committees are published on the HSE's website and are subject to periodic review.

3.10 Role of the Secretary to the Board

- 3.10.1 The Secretary to the Board is regarded as the HSE's champion of governance, and the Board must be satisfied that the person appointed to the role has the skills and the administrative capacity required to discharge the duties of the role.
- 3.10.2 The role of the Secretary is to provide advice and guidance to Board members in relation to their obligations under appropriate legislation and regulations, to act as the corporate governance officer, and to organise, administer and take minutes of Board meetings.
- 3.10.3 The Board Secretary should be fully familiar with the Health Acts 1947-2019, and any other legislation relevant to the Board's decision making, and the particular requirements of parliamentary accountability including the Oireachtas Committees and the Public Accounts Committee, general Government accounting conventions and general public service conventions.

3.10.4 The Board Secretary has the following obligations in relation to the Board and its Committees:

- assist the Chairperson in providing accurate and timely information;
- organise and administer Board and Board Committee meetings;
- properly notify members in advance;
- prepare, following consultation with the Chairperson, the agenda and collate supporting papers;
- prepare minutes that note the sense of Board and Committee meetings, set out action points with assigned responsibilities and note the unresolved matters to be brought forward to subsequent Board agendas until resolved;
- apprise members of legal changes that affect their duties (including their duties as trustees of a registered charity) and responsibilities;
- apprise members of material changes to corporate governance standards and best practice, with suitable recommendations for change, if appropriate;
- arrange for the validation and discharge of members' remuneration and expenses;
- ensure that all statutory records pertaining to the Board are maintained, and statutory reporting by the Board is carried out in accordance with the provisions of the Health Act 2004 and any other applicable legislation;
- compile Board members' returns under the Ethics in Public Office Acts 1995 to 2001;
- maintain an appropriate register and comply with the European Union (Anti-Money Laundering Ownership of Corporate Entities) Regulations 2019.
- make recommendations on suitable training opportunities that may benefit Board members;
- ensure appropriate governance arrangements are in place for those joining and leaving the Board.

All members have direct access to the Board Secretary in relation to Board business.

3.10.5 **HSE Seal**

The Board Secretary is responsible for the care and use of the seal of the HSE, which must be authenticated:

- (i) by the signature of two members of the Board, or
- (ii) by the signature of both a member of the Board and an employee of the HSE authorised by the Board to authenticate the seal.

3.10.6 The Secretary of the Board is authorised by the Board to authenticate the HSE seal. A protocol for the use of the HSE's seal is maintained by the Board Secretary.

3.11 Delegation Policy Framework

- 3.11.1 A broad range of functions have been vested in the HSE by the Oireachtas, which are exercisable by the Board on behalf of the HSE. The manner in which such functions are exercised may impact both individuals and the public generally. Although the Board may delegate the HSE's functions to the Chief Executive Officer, it must still satisfy itself that the functions which it has delegated are being exercised in accordance with the Health Act 2004, in accordance with good corporate governance, and in accordance with any directions that the Board may have been given by the Minister in relation to the exercise of those functions.
- 3.11.2 The Health Act 2004 provides for a formal system of delegations in accordance with Sections 16P and 21D.
- 3.11.3 An effective framework of delegation is critical to the lawfulness of a comprehensive system of delegations, by ensuring clarity around the delegations. In order to be effective, the framework must:
- act as a reference point for the source of the authority for the delegations;
 - accord with the parent legislation under which the delegations are made;
 - identify the circulars, policies, protocols and guidelines underpinning the system of delegations;
 - be clear, consistent and understandable to those affected by the delegations, while providing sufficient information to understand how the system of delegations operates.
- 3.11.4 The key delegation schedules are as follows:
- delegation by the Board to the Chief Executive Officer;
 - delegation by the Chief Executive Officer to individual members of the Executive Management Team;
 - sub-delegation by individual members of the Executive Management Team to National Directors;
 - sub-delegation by National Directors to senior service managers, e.g. Hospital Group CEOs, Community Health Organisation Chief Officers, Assistant National Directors (e.g. Head of PCRS), etc.;
 - Sub-delegation by senior service managers/Assistant National Directors to other appropriate employees in respect of certain specified functions.
- 3.11.5 The Board is entitled to exercise any function that is vested in the HSE which it has not delegated to the Chief Executive Officer or any function which it has delegated to the CEO, once it has revoked that delegation by notice in writing to the CEO.

Both the Board and the CEO have been conferred with legal authority to delegate their functions. However, the Board may also issue directions in writing to the Chief Executive Officer in relation to his powers of delegation, with which he or she is obliged to comply.

3.12 Delegations by the Board and reserved functions

- 3.12.1 The Board may delegate any of the HSE's functions in writing to the Chief Executive Officer. In order to enable the effective management of the administration of the HSE, the Board has delegated a wide range of functions to the Chief Executive Officer. The Chief Executive Officer is accountable to the Board for the performance of his functions and any functions delegated to him or her by the Board.
- 3.12.2 Any delegation of functions from the Board to the Chief Executive Officer, or any revocation of such delegation(s) must be notified to the Minister for Health in writing. Board delegations to the Chief Executive Officer remain in force until they are revoked by the Board, which must be done by notice in writing to the Chief Executive Officer.
- 3.12.3 The Board is the governing body of the HSE with authority, in the name of the HSE, to perform the functions of the HSE. Any function which is not delegated, and which the Board reserves to itself the right to exercise, is called a reserved function. The following functions are reserved functions of the Board:
- (a) **Performance:** the Board shall satisfy itself that appropriate systems, procedures and practices are in place to achieve the HSE's object, and for the internal performance management and accountability of the HSE in relation to specified matters;
 - (b) **Plans:** the Board shall adopt (and approve any amendments to) the HSE's Corporate Plan and shall adopt (and approve any amendments to) the HSE's Service Plan, and shall adopt (and approve any amendments to) the Capital Plan and Capital Investment Framework, and shall approve the submission of any superannuation schemes prior to their submission to the Minister for Health. Any amendments made to the aforesaid Plans and superannuation scheme require the prior approval of the Minister.
 - (c) **Codes:** the Board shall adopt the HSE's Code of Governance and all subsequent updates, and the Board shall approve any Code of Conduct and all subsequent updates to be issued for the guidance of members of a committee of the Board but who are not members of the Board, employees, advisers, or employees of advisors.
 - (d) **Annual Report:** the Board shall adopt the HSE's annual report prior to it being submitted to the Minister for Health.
 - (e) **Ongoing approvals:** the Board shall approve changes to the corporate structure of the HSE, it shall approve all contracts in excess of specified monetary thresholds, it shall approve appointments to the Audit Committee, the appointment of external auditors (other than the Comptroller and Auditor General), and the creation and appointment of members to Committees of the Board and the dissolution of Board Committees.
 - (f) **Chief Executive Officer:** The Board shall appoint the Chief Executive Officer, who shall be accountable to the Board for the effective and efficient management of the HSE and for the performance of his or her functions. The Board shall also be responsible for designating and approving a panel of employees suitable to be acting Chief Executive Officer when the chief executive is absent from duty or otherwise unable to perform the functions of the role.
 - (g) **Financial matters:** The Board shall approve the HSE's bank arrangements, including the opening of all new bank accounts. The Board shall approve acceptance of gifts to the HSE in excess of €100,000 and shall approve arms-length acquisitions of land and property where the transaction value exceeds €2m exclusive of VAT and service charges.

3.12.4 Ultimately the Board remains accountable to the Minister for the performance of all its functions, whether delegated or reserved.

3.12.5 Delegations and Sub-Delegation by the Chief Executive Officer

The Chief Executive Officer may delegate any of his functions (described in Section 21C as including his functions under the Health Act 2004 or any other enactment) to an employee of the HSE, which employee must be specified by “name, grade, position, or otherwise.”

The Chief Executive Officer may also authorise an employee to whom functions have been delegated, to sub-delegate any or all of the functions which he or she has delegated to the employee.

The delegation of a function by the Chief Executive Officer, or a function sub-delegated by an employee to another employee, does not preclude either of them from performing that function personally.

The CEO, or a person who has sub-delegated a function of the CEO may also:

- vary a delegation (or sub-delegation) of a function, including by modifying the geographical area to which the delegation relates;
- revoke a delegation (or sub-delegation); or
- without revoking the delegation (or sub-delegation), revoke any authority for the employee to sub-delegate the delegated function.

Where the authority to delegate or sub-delegate a function has been varied, each employee to whom the function was delegated or sub-delegated must be informed of its variation or revocation.

Section 76(4) of the Health Act 2004 provides that any act or thing done by the Chief Executive Officer pursuant to a delegation by the Board to him has the same force and effect as if done by the Board. Similarly, section 76(5) provides that any act or thing done by an employee of the HSE pursuant to a delegation or a sub-delegation has the same force and effect as if done by the Chief Executive Officer as provided for in s76 (4) of the Health Act 2004.

3.12.6 Authorisations and Warrants

In order to fulfil certain statutory functions, e.g. environmental health officers in connection with food safety, the appointment of contractors (pharmacists, dentists, etc.) reimbursed as part of the Primary Care Reimbursement Scheme, the Chief Executive Officer is required to issue warrants of appointment.

3.13 Legal effect of delegation of CEO’s functions

3.13.1 Section 76(2) of the Health Act 2004 provides that where any function of the Chief Executive Officer is delegated by him or her to an employee of the HSE, (or is in turn sub-delegated by that employee to another employee), then references in any provision that Act, or any other enactment that regulates the manner in which that function is to be performed, are to be construed as including references to the employee to whom the function is delegated (or subdelegated).

PART C: Management of the HSE

3.14 Management and leadership capacity

The management and leadership capacity of the HSE's executive is an important responsibility of the Board. The HSE needs effective leadership both at executive and at clinical level.

Leadership and organisational capability will be strengthened by the participation of people with many different types of backgrounds, reflecting the structure and diversity of the communities and of the health and social care workforce.

3.15 Role of the Chief Executive Officer

3.15.1 The function of the Chief Executive Officer as set out in the Health Act 2004 is described as follows:

- (a) to carry on and manage, and control generally, the administration and business of the Executive and perform such other functions as are conferred on him or her by or under this Act or any other enactment.
- (b) to ensure that appropriate systems, process and practices are in place -
 - (i) to achieve the HSE's object,
 - (ii) for the internal performance management and accountability of the HSE in respect of:
 - (I) the performance of its functions
 - (II) achieving objectives in accordance with the HSE's corporate plan;

and

 - (III) delivery of health and personal social services in accordance with this Act;

and

 - (IV) in order to enable compliance with the policies (whether set out in codes, guidelines or other documents, or any combination thereof) of the Government or a Minister of the Government to the extent that those policies may affect or relate to the functions of the HSE.
- (c) to provide the Board with such information (including financial information) relating to the performance of his or her functions and the implementation of the policies of the HSE as the Board may require, and
- (d) to assist and provide the accounting officer (the Secretary General of the Department of Health) with such information, including financial information and records relating to the accounting officer's functions within such period as the accounting officer may require.

3.15.2 The CEO has the responsibility of ensuring that the day-to-day running of the HSE and its performance is in accordance with the strategic goals that the Board has determined.

3.15.3 The roles of the CEO and of the Board are distinct. There is a clear division of responsibilities between the Board's role as the governing body of the HSE as already described, and the executive responsibility for carrying on and running the administration of HSE. The CEO's executive role may be described under the following broad headings:

(a) **Delivery against service plan**

The CEO is responsible for ensuring that the level of health and personal social services committed to in the annual Service Plan are delivered.

(b) **Strategy**

The CEO is responsible for implementing HSE policy in consultation with and as determined by the Board. He or she will direct strategy towards achieving the HSE's statutory objectives.

(c) **Communication**

The CEO plays a key role in ensuring effective communication with staff and other stakeholders. The CEO also provides the Board with adequate impartial information to enable the Board to make effective decision, on a timely basis.

(d) **Ethics and values**

The CEO should promote the HSE's cultures, values and behaviours through both the CEO's own example and the day-to-day working environment of the organisation. He or she should ensure that the standards of performance are accepted and understood by management and all other employees.

(e) **Risk management**

The CEO should put in place operational planning and financial control systems, consistent with legislation and with any strategies determined by the Board and ensure that there is adequate oversight of these areas, and also adequate oversight of the HSE's Integrated Risk Management Policy (2017).

(f) **Administration**

The CEO is the "accountable person" for the HSE's budget. The CEO is also accountable to the Board for the running and the administration generally of the HSE to enable compliance with the policies (whether set out in codes, guidelines or other documents or any combination thereof) and objectives of the Government or any Minister of the Government to the extent that those policies and objectives may affect or relate to the functions of the HSE.

(g) **Finance**

The CEO must monitor closely the HSE's adherence to service plan and its adherence to the approved budget. Under the Health Act 2004 the onus is on the CEO to take necessary steps to ensure that the HSE does not exceed its budget and the CEO is directly accountable to the Minister for any such budget overspends.

Under the Health Act 2004 the CEO is accountable to committees of the House of the Oireachtas and is obliged on request to appear before the Public Accounts Committee.

- 3.15.4 The distinction in roles is emphasised by the fact that the Chief Executive Officer may not serve as a member of the Board or as a member of any Committee established by the Board. However, the Chief Executive Officer may attend meetings, in accordance with procedures established by the Board or a Board Committee and will be entitled to speak at and advise such meetings.

3.16 Role of the Executive Management Team

Executive Management Team

- 3.16.1 Executive accountability rests ultimately with the Chief Executive Officer. The Chief Executive Officer is however supported by a wider team of senior management, collectively referred to as the Executive Management Team (EMT).
- 3.16.2 The EMT comprises such members as may be nominated by the Chief Executive Officer from time to time. The EMT meets on a regular basis, at such intervals as may be determined by the Chief Executive Officer
- 3.16.3 The EMT, led by the Chief Executive Officer is responsible for executive decision making in the HSE and the CEO has delegated certain of his functions to EMT members in accordance with Part 4A Section 21D of the Health Act 2004 (as inserted by Section 10 of the Health Service Executive (Governance) Act 2019).
- 3.16.4 The performance of the functions delegated by the Chief Executive Officer to EMT members must be undertaken in accordance with the objectives of the Government or any Minister of the Government (to the extent that those policies and objectives may affect or relate to the functions of the HSE) and in accordance with all relevant policies, protocols, clinical and care standards, directions, circulars, codes of practice and guidelines and documents of a similar nature specified by the Board or that has issued or may issue from time to time by the HSE or any Government Department (to the extent that such Departmental policies, protocols, etc., may affect or relate to the functions and objectives of the HSE).
- 3.16.5 The responsibilities of the EMT are as follows:
- (a) to act as the senior executive decision-making forum for the Chief Executive Officer;
 - (b) to ensure the financial sustainability of the HSE by exercising responsibility over its budget;
 - (c) to monitor the performance of services against core financial and operational objectives;
 - (d) to oversee quality and risk and to support the delivery of the HSE's objects through the effective management of corporate risk;
 - (e) to monitor the HSE's activities, outputs and outcomes by reference to the National Service Plan;
 - (f) to ensure that the HSE activities are fully aligned to its statutory objects, to its values and to the objectives of the Board;
 - (g) to ensure that the HSE delivers on the roll-out of Sláintecare in conjunction with the Sláintecare Programme Office;
 - (h) to make decisions or (in relation to functions reserved to the Board) recommendations regarding the affairs of the HSE;

- (i) to develop and oversee the HSE’s strategic communications strategy;
- (j) to take responsibility for relationship management with the HSE’s internal and external stakeholders.

3.17 Role of Voluntary (“Section 38” and “Section 39”) bodies

3.17.1 Voluntary service providers have a long history of providing health and personal social services in Ireland. Their services are in many cases closely integrated with the services provided directly by the HSE.

3.17.2 Many of the organisations operating within the voluntary sector are vital to the effective delivery of health and personal social services. For example, the voluntary hospitals provide almost 30% of all acute in-patient hospital beds. Organisations providing intellectual disability services account for approximately two-thirds of the services that are currently available. A list of bodies funded by the HSE under Section 38 and Section 39 of the Health Act can be accessed on the HSE’s website.

3.17.3 The Health Act 2004 sets out the legal framework for public funding of health and personal social care in Ireland. It provides that the HSE shall manage and deliver, or arrange to be delivered on its behalf, health and personal social services to the public.

3.17.4 The HSE funds public hospitals and certain social care services directly under its authority and is also the channel for state funding to voluntary organisations and other organisations that provide health and personal social care services. These funding streams are described in Sections 38 and 39 of the Health Act 2004):

- Section 38 allows the HSE to “*enter...into an arrangement with a person for the provision of a health or personal social service by that person on behalf of the Executive*”.
- Section 39 makes similar provision for the HSE to “*give assistance to any person or body that provides or proposes to provide a service similar or ancillary to a service that the Executive may provide*”.

3.17.5 In addition to prescribing how such bodies are funded, Section 7(5) of the Health Act 2004 states that in performing its functions, the HSE shall have regard to services provided by voluntary and other bodies that are similar or ancillary to services that it is authorised to provide. The role of voluntary bodies is an important consideration for the HSE in the configuration of overall health and personal social services in Ireland.

3.17.6 Section 38 bodies

The term “**Section 38 body**” has become associated with bodies that are funded by the HSE in accordance with Section 38 of the Health Act 2004. Subject to available resources, and any directions issued by the Minister, the HSE is entitled to enter an arrangement under Section 38 such terms and conditions as it considers appropriate.

A Section 38 body is subject to certain obligations under the Health Act 2004) and is obliged to:

- keep, in such form as the HSE requires and in accordance with any general direction issued by the Minister, all proper and usual accounts and records of income received, and expenditure incurred by it;
- submit such accounts annually for examination;
- supply a copy of its audited accounts and the auditor's certificate and report on the accounts to the HSE within such period as the HSE may specify.

The HSE currently funds 16 acute hospitals and 23 other organisations (in the areas of disability, older persons, mental health, social inclusion, etc.) in accordance with the provisions of Section 38 of the Health Act 2004 (as amended). Each of these bodies is subject to the terms of a Service Arrangement, which is a written contract.

The HSE may also arrange for the provision of a health or personal social service in accordance with Section 38 by seeking and accepting a tender for the provision of such services.

3.17.7 Section 39 Bodies

The term "**Section 39 body**" has become associated with bodies that are funded by the HSE in accordance with Section 39 of the Health Act 2004). Subject to any directions issued by the Minister, the HSE is entitled to give assistance to such bodies, on such terms and conditions as it sees fit to impose. Assistance under Section 39, can be provided by the HSE in a number of ways, as follows:

- by contributing to the expenses incurred by the person or body;
- by permitting the use by the person or body of HSE premises, and/or making alterations and repairs and/or supplying furniture and fittings for such premises;
- by providing premises (with all requisite furniture and fittings) for use by the person or body.

Assistance may be provided to a person under Section 39, whether or not the person is a service provider.

3.17.8 Service Arrangements and other governance documentation

The HSE may enter into arrangements with certain bodies or persons in accordance with Section 38 or Section 39 of the Health Act 2004, on such terms and conditions as it considers appropriate. In practice the HSE requires such bodies or persons to execute a written agreement (a "Service Arrangement" or a "Grant Aid Agreement"), which is a legal contract outlining the terms and conditions under which funding is made available.

Chapter 4:

Board Effectiveness and Operation

4.1 Assessing Board effectiveness

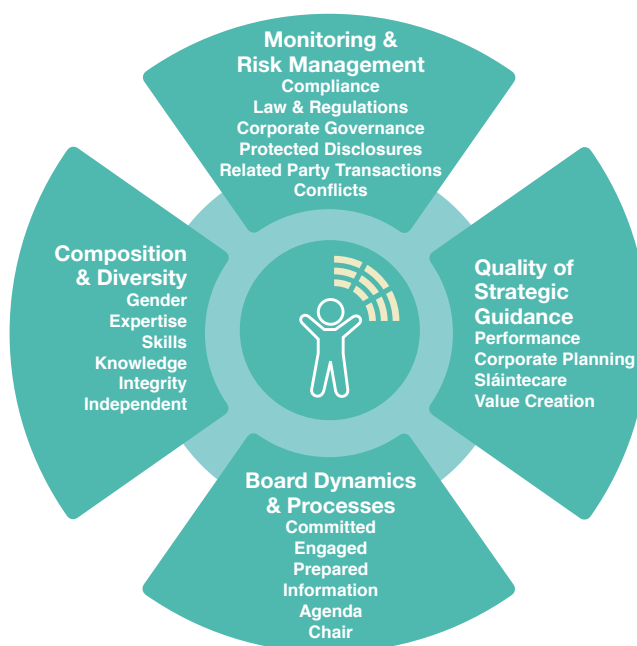
4.1.1 Subject to the statutory requirements as provided for in section 16N of the Health Act 2004, the members of the Board of the HSE are selected by the Minister from among persons, who in the opinion of the Minister, have sufficient expertise and experience relating to matters connected with the functions of the HSE to enable them to make a substantial contribution to the effective and efficient performance of those functions.

In appointing members of a committee of the Board, the Board shall have regard to the knowledge and experience necessary for the proper and effective and efficient discharge of the functions of the committee.

4.1.2 The Chairperson will undertake a formal and rigorous annual evaluation of the Board's performance and that of its committees and individual members.

Figure 7: Board Evaluation (OECD)

The “Four Dimensions” of Board Evaluations



Supporting Principles

- The Board (and individual members) will receive formal induction on joining the Board and should regularly update and refresh their skills and knowledge.
- The Board will be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties.
- The Board (and individual members) must allocate sufficient time to discharge their responsibilities effectively.
- The Board should undertake a self-assessment annual evaluation of its own performance and that of its Board committees. Evaluation of the Board should consider the balance of skills, experience, independence and knowledge of the State body on the Board, its diversity, including gender, how the Board works together as a unit, and other factors relevant to its effectiveness.
- The Chairperson will act on the results of the performance evaluation by addressing the weaknesses identified through the self-assessment evaluation.
- Skill gaps present on the Board should be brought to the attention of the Minister by the Chairperson of the Board sufficiently in advance of a time when Board vacancies are due to arise.

4.2 Membership and tenure of the Board

4.2.1 The Board consists of the following members:

- (a) a Chairperson;
- (b) a Deputy Chairperson;
- (c) ten Ordinary Members.

4.2.2 The Chairperson and the Deputy Chairperson and the Ordinary Members are appointed by the Minister from among persons, who, in the opinion of the Minister, have sufficient experience and expertise relating to matters connected to the functions of the HSE to make a substantial contribution to the effective and efficient performance of those functions.

4.2.3 The composition of the Board is also set out in legislation as follows:

- at least two of the persons on the Board shall have experience of, or experience in, advocacy in relation to matters affecting patients;
- at least two of the persons on the Board shall be persons who are practising or have practised as a member of a health profession (as defined), whether in or outside the State;
- at least one of the persons on the Board shall be a person with experience of, or expertise in, financial matters;
- amongst the members of the Board there should, in so far as is practicable, be an equitable balance between men and women.

In making appointments to the Board, the HSE is committed to implementation of the Annex on Gender Balance, Diversity and Inclusion, incorporated into the DPER Code in September 2020, which provides, inter alia:

- for the achievement of a minimum 40% representation of each gender in the membership of the HSE's Board;
- for appointments to the HSE to be made against objective criteria with due regard for the benefits of diversity on the Board;
- for the preparation of a comprehensive report to the Minister for Health to include:
 - (i) the gender balance of appointments made to the HSE Board in the previous year (if applicable);
 - (ii) where the Board stands vis-à-vis the 40% gender balance requirement;
 - (iii) the key elements of the Board's approach to the promotion of diversity and inclusion and the progress being made in this area.

The Annual Report of the HSE will also give an account of the approach being adopted in regard to the promotion of diversity and inclusion, including with regard to gender, in the specific context of the organisation; and on the progress and achievements in this regard.

4.2.4 Tenure of Office

Provision has been made from amongst the ordinary members of the Board first appointed under Section 16N of the Health Act 2004 for Ordinary Members to hold office for variable periods, as follows:

- (i) five Ordinary Members will hold office for a period of three years from the date of appointment; and
- (ii) five Ordinary Members will hold office for a period of five years from the date of appointment; and

In the case of all subsequent appointments, Board Members' tenure of office is as follows:

- (a) The Chairperson shall hold office for a period not exceeding five years from the date of appointment, as the Minister shall determine.
- (b) The Deputy Chairperson shall hold office for a period not exceeding five years from the date of appointment, as the Minister shall determine.
- (c) The Ordinary Members shall hold office for a period not exceeding five years from the date of appointment, as the Minister shall determine.

Members whose terms of office have expired by effluxion of time will be eligible for reappointment but may not hold office for more than two consecutive terms, and in any event may not serve for a period of more than ten years. In accordance with the DPER Code, it is recommended that any period of appointment should (notwithstanding the 10-year statutory cap) be renewed only for such further period as to ensure a maximum period of **eight** years' service as a Board member in total.

4.2.5 Resignation of Board Members

A Board member may resign from office by letter sent to the Minister, and his or her resignation will take effect from the later of: (a) the date specified in the letter, or (b) the date of receipt of the letter by the Minister.

4.2.6 Removal of Board members

The Minister may at any time remove a Member of the Board from office, if he or she is of the opinion that:

- (a) The member has become incapable through ill-health of performing his or her functions;
- (b) The member has committed “stated misbehaviour”;
- (c) The member’s removal is necessary for the effective and efficient performance by the Board of its functions;
- (d) The member has breached certain provisions of the Ethics legislation; or
- (e) The member has not complied with a code of conduct drawn up under the Ethics legislation that refers to the member.

Provision is also made for Board members to cease to be qualified to hold office in prescribed circumstances, e.g. bankruptcy or on conviction of any indictable criminal offence.

4.3 Board induction

4.3.1 Each Board member must receive a comprehensive induction upon appointment to the Board of the HSE. This includes providing the Board member with key documents relating to the operation of the Board and its Committees, corporate plans and policies and procedures relevant to their role. Training must also be provided on Board members’ legal responsibilities and other relevant areas for the performance of the role.

4.3.2 Professional advice/legal advice

The Board may take independent professional advice where it judges it necessary to discharge its duty. Consistent with the DPER Code, the Board may, in a Board resolution, lay down formal procedures whereby Board members, in the furtherance of their duties, may take independent professional advice, if necessary, at the reasonable expense of the HSE where they judge it necessary to discharge their responsibilities as Board members.

4.3.3 The Secretary of the Board is also responsible for the formal induction of new Board members and organising mentoring for Board members where required. All Board members have access to the advice and services of the Board Secretary, who is responsible to the Board for ensuring that Board procedures are complied with.

4.3.4 Meetings

- (a) In accordance with paragraph 2B(5) of Schedule 2 of the Health Act 2004 the Board may, subject to the provisions of that Act regulate its procedure by rules of otherwise.
- (b) Meetings of the Board should take place as are necessary for the performance of its functions, but in any case, not less than one meeting in each of 11 months of a calendar year. The time and date of Board meetings are fixed by the Chairman and notified to Board members by the Board Secretary. Relevant materials are distributed to Board members in advance of the meeting so that members have the opportunity to review the material.
- (c) The quorum for a meeting of the Board shall be seven ordinary members of the Board and;
 - (i) The Chairperson, Deputy Chairperson, or
 - (ii) a member chosen from amongst the members present to chair the meeting (i.e. 8 ordinary members, with one member acting as the Chairperson).

- (d) Board members are not permitted to give a proxy to another Board Member (or to any other person) to vote in his or her place at a Board meeting.
- (e) Board members should make every effort to attend in person at Board meetings. The attendance of each Board Member at Board meetings, and the manner of their attendance (e.g. in person or by telephone, videoconference, etc.) is reported in the Annual Report.
- (f) In accordance with Section 29 of the Civil Law and Criminal Law (Miscellaneous Provisions) Act 2020 and regulations made thereto (S.I. 532/2020) meetings of the HSE (including meetings of the HSE Board) may consist of a meeting or conference between some or all of the Board members who are not in one place, but each of whom is able (directly or by means of electronic communications technology) to speak to each of the others and to be heard by the others. Any decision made, vote taken, or any other act done by means of such meeting or conference shall be as good and effectual as a decision made, vote taken, or other act done by the Board members concerned would have been if such had been made, taken or done by those members in a meeting of them held in person. Board members must undertake to ensure privacy during such meetings or conferences.
- (g) A Board member is not counted in the quorum on an item in respect of which he or she is not entitled to take a decision.
- (h) The Chairperson of the Board shall preside at all meetings of the Board at which he or she is present and in the absence of the Chairperson, the Deputy Chairperson shall preside at the meeting. If the Chairperson of the Board is not present, or the Deputy Chairperson is not present, and/or the office of the Chairperson is vacant, the members of the Board who are present shall elect one of their number to preside at the meeting.
- (i) Each member of the Board present at a meeting of the Board shall have a vote.
- (j) Every question at a meeting of the Board shall be determined by a majority of the votes of the members present and voting on the question and, in the case of an equal division of votes, the Chairperson or other member presiding at the meeting shall have a second or casting vote. Decisions of the Board shall be recorded in the minutes.
- (k) The Board should have in place a procedure for recording the concerns of Board members that cannot be resolved.
- (l) Should any Board member require independent legal advice before voting on any question, this can be arranged through the Board Secretary. See also paragraph [4.3.2] on professional advice.
- (m) The Chairperson may at any reasonable time call a meeting of the Board.
- (n) Any 8 or more Board members may call a meeting of the Board if the Chairperson refuses to call a meeting of the Board after a request, signed by no fewer than eight members of the Board, or without refusing to call one within 7 days after being presented with such a requisition.
- (o) Until such time as the Board resolves otherwise, the meetings of the Board will be held in private.
- (p) Papers may be tabled at a Board meeting with the Chairperson's permission (or, in his or her absence, the permission of the Deputy Chairperson).

4.3.5 Procedure for obtaining Board approval between Board Meetings

- (1) The Chairperson shall decide when an issue is of a sufficiently urgent nature to warrant the taking of a decision by the Board by written request in the interval between meetings of the Board.
- (2) The request for a decision shall be communicated to Board members by e-mail and shall:
 - (a) Indicate the Chairperson's agreement that the decision be taken by written procedure;
 - (b) State the nature of the decision requested;
 - (c) Provide information on the urgent nature of the decision;
 - (d) Provide detailed information to enable the members of the Board to take the decision;
 - (e) Set out a final deadline for members of the Board to seek additional information or clarification on the issue to be decided;
 - (f) Set out a final deadline and procedures for members of the Board to inform the Board Secretary of their decisions.
- (3) In the event that any member of the Board seeks additional clarification or information on the issue to be decided, a copy of such additional clarification or information will be sent to all members of the Board.
- (4) A decision will be deemed to be taken by the Board when more than half of the members of the Board are in agreement on the issue to be decided. The decision of the Board will be communicated by the Board Secretary to all members of the Board by email as soon as it practicable after the decision has been taken.
- (5) Decisions taken by written procedure between meetings of the Board will be recorded in the minutes of the subsequent Board meeting.
- (6) These procedures for taking decisions between meetings of the Board do not interfere with the rights of the Chairperson or Board members to call a meeting of the Board as set out in Schedule 2 to the Health Act 2004.

4.3.6 Minutes of meetings

Minutes of the proceedings of a meeting of the Board will be drawn up by the Board Secretary, will be verified by the Board members and will be signed by the Chairperson at the subsequent meeting.

Any discussion on the minutes, except as to their accuracy, shall be deemed out of order and the Chairperson will rule accordingly. Questions will only be permitted on matters arising out of the minutes.

The Board Secretary will record names of Board members present and absent, and apologies for absence, at a meeting of the Board in the minutes of the meeting.

When minutes of proceedings have been adopted and confirmed by the Board, it will not be in order for any member of the Board to question their accuracy nor seek their amendment at subsequent meetings. The minutes of Board meetings are available to view on the HSE website once they have been approved for publication.

Chapter 5:

Codes of Conduct

5.1 Code of conduct for Members of the Board and HSE employees

- 5.1.1 Part 6 of the Health Act 2004 deals with standards and disqualifications. It provides that a person shall maintain proper standards of integrity, conduct and concern for the public interest while performing functions under the Health Act 2004 or any other enactment as:
- (a) a member of the Board or a Committee of the Board, including the Audit Committee;
 - (b) the Chief Executive Officer;
 - (c) an employee of the HSE;
 - (d) a person engaged by the HSE as an adviser and any employees of that adviser.
- 5.1.2 For the purpose of ensuring that the individuals referred to above maintain proper standards of integrity, conduct and concern for the public interest, the Board is required to issue codes of conduct for the guidance of such individuals, and may issue different codes in respect of different classes of persons.
- 5.1.3 In May 2018 the Department of Health published a document entitled *Supporting a Culture of Safety, Quality and Kindness: A Code of Conduct for Health and Social Service Providers* (the **“DoH Code of Conduct”**). Board Members and all HSE staff are expected to comply with the DoH Code of Conduct.

5.2 Conduct of Board members who serve on Board committees

- 5.2.1 Board Members who serve on HSE Committees must also comply with the DoH Code of Conduct, and with such other codes of conduct for the guidance of Board Committee members in accordance with Section 25 of the Health Act 2004.

5.3 Conflicts of interest policy

- 5.3.1 The HSE defines a conflict of interest as a situation or situations in which financial or other personal considerations may compromise or have the appearance of compromising, an individual's ability to make objective decisions in the course of their job responsibilities within the HSE or as a member of the HSE Board, or of a Committee appointed by the HSE Board. In discharging their role, individual employees and Board Members have a duty to put the interests of the HSE before their own personal interests.
- 5.3.2 If an employee is concerned that a conflict of interest exists or has any question about whether an outside activity might potentially constitute a conflict of interest he or she should contact the Finance Division of the HSE. In the case of Board members, or members of a Committee appointed by the Board having such concerns, contact should be made with the Board Secretary.

5.4 Disclosure of interest policy

5.4.1 Periodic disclosure of interest: On appointment and annually thereafter, each Board Member is required to furnish the Board Secretary with a statement in writing of:

- (a) the interests of the Board Member;
- (b) the interests, of which the Board member has actual knowledge, of his or her spouse or civil partner, child, or child of his/her spouse or civil partner;

which could materially influence the Board Member in, or in relation to, the performance of his/her official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the Board Member, or the spouse or civil partner or child, a substantial benefit.

5.4.2 Disclosure of interest relevant to a matter which arises: In addition to the periodic statements of interest required above, Board Members are required to furnish a statement of interest at the time where an official function falls to be performed by the Board Member and he/she has actual knowledge that he/she, or a connected person as defined in the Ethics Acts, has a material interest in a matter to which the function relates.

5.4.3 Doubt: If a Board member has a doubt as to whether an interest should be disclosed pursuant to this Code, he/she should consult with the Chairperson of the Board and/or the Board Secretary.

5.4.4 Confidential Register: Details of interests disclosed by Board Members are kept by the Board Secretary in a special confidential register.

5.4.5 Chairperson's Interests: Where a matter relating to the interests of the Chairperson arises at a Board meeting, the Deputy Chairperson will chair the portion of the meeting dealing with that matter. The Chairperson should absent himself/herself when the Board is deliberating or deciding on a matter in which the Chairperson or his/her connected person has an interest.

5.4.6 Documents withheld: Board or HSE documents on any deliberations regarding any matter in which a member of the Board has disclosed a material interest will not be made available to the Board member concerned.

5.4.7 Early return of documents: As it is recognised that the interests of a Board member and persons connected with him/her can change at short notice, a Board member should, in cases where he/she receives documents relating to his/her interests or of those connected with him/her, return the documents to the Board Secretary at the earliest opportunity.

5.4.8 Absent: A Board member should absent himself/herself when the Board is deliberating or deciding on matters in which that Board member (other than in his/her capacity as a member of the Board) has declared a material interest. In such cases the Board will consider whether a separate record (to which the Board member would not have access) should be maintained.

5.4.9 Uncertainty: Where a question arises as to whether or not an interest declared by a Board member is a material interest, the Chairperson of the Board will determine the question as to whether the provisions of this Code apply.

5.5 Ethics in Public Office provisions

- 5.5.1 Holders of designated directorships and positions of employment in public bodies prescribed for purposes of the Ethics Acts and are required to furnish annual statement of registrable interests to the Standards in Public Office Commission and to the 'relevant authority for the position' (see below).
- 5.5.2 Board Members and the Chairperson are Designated Directorships for the purposes of these requirements. The form to be completed for Designated Directorships by Board Members and the Chairperson is available from the Board Secretary.
- 5.5.3 The term "interest" encompasses any interest held by spouse or civil partner, child or child of spouse where the office holder has actual knowledge of the interest and the interest could materially influence the office holder's performance in his/her functions.
- 5.5.4 Annual statements should cover the period from 1 Jan to 31 December or from date of appointment if appointed during the year and should be furnished not later than 31 January in the following year.
- 5.5.5 Summary of matters to be declared
- Occupational income in excess of €2,600.00 per annum other than from designated person's current position within the organisation;
 - Shareholding worth in excess of €13,000.00 or shareholdings of more than 5% of the issued capital of a company held at any time during the Statement period;
 - Directorships or shadow directorships of any company;
 - Interests in land (excluding designated person's private home) exceeding €13,000.00 including contracts and options to purchase;
 - Travel, accommodation, meals, etc., supplied free of charge or at a reduced price (subject to some exceptions e.g. the performance of the functions of the person as a holder of a designated directorship);
 - Other remunerated positions held as a political or public affairs lobbyist, consultant or advisor;
 - Public service contracts for values exceeding €6,500.00 (cumulative);
 - Gifts, property and services with commercial value exceeding €650.00 (excluding gifts for purely personal reasons);
 - Contracts with the State;
 - Other interests which a person may wish to declare; and

It is the duty of each Board member to declare to the Secretary any matter relating to him or her that is required to be included on the Register.

5.5.6 Senior office holders – additional requirements

Every position of employment in respect of which the maximum salary is not less than the maximum salary of a Grade VIII Officer (as contained in the Department of Health consolidated salary scales) is a “designated person” under the Act. Board members, although not remunerated at this level, are also subject to these provisions, and the following protocol applies to Board members:

Where an employee or Board member has to carry out a particular function and has actual knowledge that he/she or a connected person has a material interest in a matter to which this function relates that person must take specific actions as follows:

- In the case of an employee furnish a written statement of facts to the Chief Executive Officer and to the Head of Corporate Affairs.
- in the case of the Chief Executive Officer or a Board member furnish a written statement of facts to the other Board Members and to the Board Secretary.
- do not perform function unless there are compelling reasons to do so.
- if required to do so, furnish a written statement of such compelling reasons before or, if that is not possible, as soon as possible after such performance.
- the employee or Board member, as the case may be, must furnish that statement to the Chief Executive Officer (in the case of an employee) or to other Board members of the HSE, to the Board Secretary and to the Standards Commission (in the case of the CEO or a Board member).

5.6 Confidentiality provisions

5.6.1 Section 26 of the Health Act 2004 prohibits unauthorized disclosure of confidential information. It provides that an employee or a Board member shall not disclose confidential information obtained by him or her while performing functions as:

- a member of the HSE Board or a committee of the HSE Board
- the CEO or any other employee of the HSE
- a person engaged by the HSE as an adviser or an employee of any person engaged as an adviser
- a person appointed by the Minister to conduct an independent review in relation to the Board

Unless he or she is required by law, or duly authorized by the HSE, or in the case of a person conducting an independent review in relation to the Board, the Minister.

A person who contravenes the provision of Section 26 will be guilty of an offence.

The section is not contravened by disclosing confidential information if:

- (a) the disclosure is made to the board; or the disclosure is made to the Minister by or on behalf of the HSE;
- (b) the disclosure is made by a person appointed by the Minister to conduct an independent review in relation to the Board;
- (c) the disclosure made is a protected disclosure.

- 5.6.2 Reports, documents and briefings issued to members in relation to Board matters must be treated as confidential until such time as the Board has had an opportunity to discuss and make decisions on their contents including their distribution outside the Board membership. When a Board member resigns or when his or her term of office is at an end all equipment, documentation, notes memoranda must be returned to the Secretary of the Board.

5.7 Protected disclosures

Protected disclosures under the Health Acts

- 5.7.1 Part 9A of the Health Act 2004 deals with Protected Disclosures of Information concerning "Relevant Bodies," which bodies include the following:
- (a) the HSE;
 - (b) a body providing a service on behalf of the HSE under Section 38 of the Health Act 2004;
 - (c) a body or person receiving or who has received assistance under Section 39 of the Health Act 2004);
 - (d) a body established under the Health (Corporate Bodies) Act 1961 (as amended).
- 5.7.2 Where an employee of a Relevant Body, makes, in good faith, a disclosure to an authorised person, and the employee has reasonable grounds for believing that it will show one or more of the following:
- (a) that the health or welfare of a person who is receiving a health or personal social service in accordance with this Act has been, is or is likely to be at risk;
 - (b) that the actions of any person employed by or acting on behalf of the relevant body has posed, is posing or is likely to pose a risk to the health or welfare of the public;
 - (c) that the relevant body or a person employed by or acting on behalf of the relevant body failed, is failing or is likely to fail to comply with any legal obligation to which the relevant body or person is subject in the performance of the relevant body's or person's functions;
 - (d) that the conduct of the relevant body or of a person employed by or acting on behalf of the relevant body has led, is leading or is likely to lead to a misuse or substantial waste of public funds;
 - (e) that evidence of any matter falling within any of the paragraphs (a) to (d) above is being or is likely to be deliberately concealed or destroyed;
 - (f) the disclosure shall be a protected disclosure under the Health Act 2004.
- 5.7.3 Similar provisions also exist for employees working in designated centres under the auspices of HIQA and the Mental Health Commission and/or the Inspector of Mental Health Services. Employees who disclose that:
- (a) any person employed or running such services has posed, is posing or may pose a risk to the health and welfare of a patient/resident;
 - (b) any person employed or running such services has failed, is failing or is likely to fail to comply with regulations, or any other statutory obligation; or
 - (c) that evidence of any such matters is being or is likely to be deliberately concealed or destroyed shall be a protected disclosure.

5.7.4 An employee who makes, in good faith, a disclosure to a professional regulatory body which that person has reasonable grounds for believing will show that the action of any regulated person has posed, is posing, or is likely to pose a risk to the health or welfare of the public shall be a protected disclosure.

5.7.5 Disclosures under the Health Act 2004 must be made to the “Authorised Person” who is responsible for considering the matter and for arranging an investigation in accordance with HSE procedures. The Authorised Person may, depending in the nature of the protected disclosure, refer the matter or any part of it to the appropriate regulatory body, or if there is reason to believe that a criminal offence has been committed, to An Garda Síochána.

5.7.6 Protected Disclosures Act 2014

The HSE is also subject to the provisions of the Protected Disclosures Act 2014, which defines the term as a “*disclosure of information ... which, in the reasonable belief of the worker ... tends to show one or more relevant wrongdoings ... which came to the attention of the worker ... in connection with the worker’s employment.*”

Relevant wrongdoings under the Protected Disclosures Act are defined as follows:

- (a) the commission of an offence;
- (b) the failure of a person to comply with any legal obligation, other than one arising under the worker’s contract of employment or other contract whereby the worker undertakes to do or perform personally any work or services;
- (c) a miscarriage of justice;
- (d) a danger to the health and safety of any individual;
- (e) damage to the environment;
- (f) an unlawful or otherwise improper use of funds or resources of a public body, or of other public money;
- (g) an act or omission by or on behalf of a public body that is oppressive, discriminatory or grossly negligent or constitutes gross mismanagement; or
- (h) information tending to show any matter falling within any of the preceding paragraphs (a) to (g) has been, is being, or is likely to be concealed or destroyed.

Protected disclosures under the 2014 Act can also be made to the HSE Authorised Person, who can be contacted as follows:

Office of the Authorised Person

An Clochar, College Street, Ballyshannon, Co. Donegal

Tel 071-9834561

Email: protected.disclosures@hse.ie

5.7.7 Role of the Board in Protected Disclosures

The Board, with the assistance and input of the Audit and Risk Committee provides oversight and advice concerning adherence to the protected disclosure legislation and the operation of protected disclosure policies and process. The Audit and Risk Committee receives reports from the HSE of concerns raised under the Protected Disclosures of Information in the Workplace Policy and ensures that appropriate action is taken in order to maintain the highest standards of probity and honesty throughout the health services.

The HSE has published a policy on protected disclosures, which sets out the process by which a worker can make a disclosure, what will happen when a disclosure is made and what the HSE will do to protect a discloser.

The Board is committed to the following:

- facilitating the disclosure of wrongdoing;
- encouraging workers to make protected disclosures at the earliest possible opportunity;
- providing workers with guidance as to how to make protected disclosures;
- assisting, supporting and protecting workers who make protected disclosures;
- protecting a worker's identity in a manner consistent with the requirements of the 2014 Act and taking action where those requirements have been breached;
- assessing any disclosure made, conducting an investigation, where warranted, and addressing all findings that require attention;
- providing that workers are not to be penalised for reporting relevant wrongdoings; and
- taking appropriate action against workers who make disclosures without a reasonable belief in the truth of the disclosure.

While the Board maintains an oversight role, day-to-day responsibility for these procedures is delegated to the Chief Executive Officer.

The Protected Disclosures Act 2014 also requires public bodies to publish an annual report setting out the number of protected disclosures made the previous year, and the actions that were taken.

5.7.8 Confidential Recipient

The confidential recipient is a person who can act as a voice for vulnerable older people and people with a disability. The Confidential Recipient is appointed by the HSE and reports to the Chief Executive Officer, but is independent of the HSE in respect of their role, which is to:

- listen to persons raising concerns or complaints, provide advice about such concerns or complaints, and send them to the right place;
- make sure the HSE or a funded agency looks into such concerns or complaints within 15 days, and in the right way;

Anyone can use the service to report a concern or make a complaint if they are:

- concerned about an adult with a disability or an older person in a HSE, or a HSE-funded residential care service, day service or home support service;
- a resident in one of these services and they need confidential help and advice

The confidential recipient deals with the following concerns:

- abuse;
- negligence;
- mistreatment;
- poor care practices.

Concerns of this nature may also be relayed directly to the HSE through the *Your Service Your Say* complaints process. If the matter is referred to the Confidential Recipient, the person's identity will remain confidential, if requested, unless disclosure of the person's identity is required by law.

5.8 National Independent Review Panel (NIRP)

5.8.1 The National Independent Review Panel (NIRP) has been established by the HSE to undertake reviews of serious cases within the disability services across the HSE and services funded by the HSE. The Chairperson of the Panel reports to the Chairperson of the Quality and Safety Committee, while having an administrative relationship to the HSE's National Director for Quality Assurance and Verification. The NIRP reviews the circumstances surrounding such cases and presents reports to the HSE on its findings and recommendations relating to service improvement. In addition, the Review Panel produces an annual report and aggregate analysis of the cases investigated, to ensure that the learning from such cases can be disseminated across health and social care services nationally.

5.8.2 The NIRP mission statement is as follows:

The NIRP is committed to promote learning and best practice by reviewing serious cases in a professional timely manner, with a view to assisting the disability system/social care sector to improve its services and prevent similar situations occurring in the future.

5.9 Gifts/benefits and hospitality policy

5.9.1 Gifts/Benefits

Board members and employees of the HSE should not receive directly or indirectly any benefits of any kind (gift, gratuity, favour, etc.) from a third party which might reasonably be interpreted as being of such a nature that it could affect their impartiality in dealing with the donor or their personal judgement and integrity. Any benefits received should be of nominal value. All gifts and benefits received must be disclosed by employees to their line managers, or in the case of Board Members to the Chairman and to the Board Secretary.

5.9.2 Hospitality

Board members and employees should not accept hospitality of any kind from a third party which might reasonably be seen to compromise their personal judgement or integrity. Every care must be taken to ensure that any acceptance of hospitality does not influence, or is not perceived as likely to influence, the discharging of employees functions, or the functioning of the HSE Board. Any hospitality received should be of nominal value.

Chapter 6:

Internal Controls Environment

6.1 Financial reporting

6.1.1 The HSE is required to have robust financial management systems in place, and an effective system of internal control over the use of its financial resources. This includes an obligation to ensure that the HSE has appropriate, efficient and effective procedures in place in relation to financial reporting.

6.1.2 There are also a number of corporate governance requirements in this area that arise from the application of the DPER Code. The HSE must ensure that its accounting policies, annual financial statements, annual report and corporate governance assurances comply with the Health Act 2004 and with the DPER Code.

6.1.3 Health Act 2004 and DPER Code

The HSE is subject to particular obligations under the Health Act 2004 and under the DPER Code including the following:

- It must establish an audit committee, to be appointed by the HSE's Board to advise the Board and the Chief Executive Officer on financial matters relating to their functions.
- It must keep all proper and usual accounts of all money received or expended by it.
- It must, in respect of each financial year, prepare annual financial statements of income and expenditure in the manner prescribed by the Minister.
- it must ensure that the net non-capital and net capital expenditure which has been allocated by the Minister under Section 30A(1) and Section 33B(1) respectively, is not exceeded.
- if the CEO forms the opinion that an action undertaken by the HSE will, or that a proposed action by the HSE would, if made, result in
 - (i) the HSE's non-capital expenditure for a financial year, or part of a financial year being exceeded; or
 - (ii) the HSE's capital expenditure for a financial year being exceeded,then the CEO must notify the Minister for Health.
- if the HSE exceeds its non-capital allocation in any given year, the amount of any excess must be charged by the HSE to its income and expenditure account for the next financial year. A budget surplus may, with the Minister's consent, also be credited to its income and expenditure account for the next financial year.

6.1.4 Functions of the Board in relation to financial reporting requirements.

The Board must be satisfied that the annual accounts of the HSE give a true and fair view of the income, expenditure, assets, liabilities and capital at the year's end. The accounts also include the Business and Financial Reporting requirements set out in the DPER Code.

The HSE's accounts are adopted by the Board and submitted to the Comptroller and Auditor General (C&AG) for audit not later than three months after the end of the financial year to which the accounts relate. Within one month of the C&AG issuing an audit certificate for the accounts, the accounts are submitted to the Minister. They are then sent to the Library of the Houses of the Oireachtas (deemed being laid before the Houses of the Oireachtas) within two months after being submitted to the Minister.

The HSE's annual report, submitted to the Minister by the Chairperson of the Board must set out what has been achieved during the previous year with reference to the Service Plan for that year. The annual report will include:

- (a) a general statement of the health and personal social services provided during the preceding year by or on behalf of the HSE whether provided in accordance with an agreement under section 8 of the Health Act 2004 (public authorities) or an arrangement under section 38 of the Health Act 2004 (service providers) and of the activities undertaken by the HSE in that year;
- (b) a report on the implementation of the corporate plan in the year;
- (c) a report on the implementation of the service plan in the year;
- (d) a report on the implementation of the capital plans in the year;
- (e) an indication of the HSE's arrangements for implementing and maintaining adherence to its Code of Governance;
- (f) the report required by section 55 of the Health Act 2004 (complaints),
- (g) such other information as the HSE considers appropriate or as the Minister may specify; and
- (h) all other key reporting requirements as set out in the DPER Code.

6.1.5 National Financial Regulations

The National Financial Regulations (NFRs) outline at a high level the framework within which the internal financial control system of the Health Service Executive (HSE) operates. These regulations have been prepared to meet best practice requirements and to meet specific requirements of:

- Irish and EU statutory provisions
- Department of Health/DPER, and Government policies, circulars and guidelines

The National Financial Regulations are updated periodically and published on the HSE's website. It is the responsibility of all budget holders, managers and staff in the delivery of day-to-day operations and corporate activities that the NFRs are fully complied with.

6.2 **Statement on Internal Control and Management Controls Handbook**

- 6.2.1 The system of internal control seeks to ensure that the HSE's assets are safeguarded, transactions are authorised and properly recorded, and that material errors and irregularities are either prevented or detected in a timely manner. The system of internal control is also designed to ensure appropriate protocols and policies are in place and operating effectively in the context of clinical and patient safety
- 6.2.2 The **Statement of Internal Control** is an annual statement which sets out the HSE's approach to and responsibility for risk management, internal controls and governance. The Board has ultimate responsibility for ensuring that effective systems of internal control are instituted and implemented. The Board is required to confirm annually to the Minister for Health that the HSE has an appropriate system of internal and financial control in place.

- 6.2.3 The HSE **Management Controls Handbook** sets out the overall framework for risk and control within the organisation and supports managers in facilitating improved management and internal control within their area of responsibility. The Handbook outlines the legislative and policy framework within which managers must perform their functions. The Handbook also sets out the internal control environment, being the integration of activities, plans, attitudes, policies and efforts of staff working together to provide reasonable assurance that the HSE achieves its objectives. It is the responsibility of management to establish and foster a control environment which is economic, efficient and effective and caring and which ensures:
- activities are conducted efficiently and in compliance with the HSE's objectives, policies, plans and procedures;
 - that HSE assets are safeguarded and properly accounted for;
 - the reliability and integrity of HSE financial and operational systems and controls;
 - the provision of relevant and reliable corporate and operational management information;
 - Compliance with legislation, regulations and directives.
- 6.2.4 All managers should read the Management Controls Handbook to ensure that they fully understand their duties and obligations as managers.

6.3 Expenses

- 6.3.1 Allowances for expenses, if any, are payable by the Board and the members of Committees of the Board by the HSE. The Board Secretary will arrange for Board Members to be reimbursed in accordance with public sector norms.
- 6.3.2 All aspects of travel and subsistence allowances will be in accordance with the HSE's own policies and procedures which take cognisance of current public sector rate circulars and guidelines as issued by the Department of Finance and Public Expenditure and Reform.

6.4 Remuneration

6.4.1 Board Fees

In accordance with Part 3B of the Health Act 2004 the Minister for Health, with the consent of the Minister for Public Expenditure and Reform may determine the remuneration, if any, payable to Board Members and Members of Committees.

In accordance with the "One Person One Salary" Principle it is a requirement that public servants who may be appointed to the board of a public body do not receive remuneration in the form of Board fees. The Board Secretary will ensure that the fees paid under this Part are in accordance with the rates authorised by the Minister.

6.4.2 CEO Remuneration

In accordance with Part 4A of the Health Act 2004 the chief executive officer of the HSE shall hold office upon and subject to such terms and conditions (including terms and conditions relating to remuneration, allowances, and superannuation) as may be determined by the Board with the approval of the Minister, given with the consent of the Minister for Public Expenditure and Reform.

6.4.3 Employee Remuneration

In accordance with Part 5 of the Health Act 2004, the HSE shall, with the approval of the Minister, given with the consent of the Minister for Public Expenditure and Reform, determine the terms and conditions of employment, including terms and conditions relating to remuneration and allowances of employees of the HSE.

The consolidated salary scales applicable to employees of the HSE are published and maintained by the Department of Health, and available on the Department's and the HSE website.

6.5 Public procurement

6.5.1 It is the responsibility of the Board, with the assistance of the Audit and Risk Committee, to satisfy itself that the requirements for public procurement are adhered to and to be fully conversant with the current value thresholds for the application of EU and national procurement rules.

6.5.2 The Board should satisfy itself that procurement policies and procedures have been developed and published to all staff. It should also ensure that procedures are in place to detect non-compliance with procurement procedures. The HSE maintains a contracts database/listing for all contracts/payments in excess of €25,000 with monitoring systems in place to flag non-competitive procurement. Non-competitive procurement is reported in the Chairperson's comprehensive report to the Minister.

6.5.3 Procedures

The Board will ensure that competitive tendering should be standard procedure in the procurement process of the HSE. The Chief Executive Officer, and ultimately the Board, will ensure that there is an appropriate focus on good practice in purchasing and that procedures are in place to ensure compliance with procurement policy and guidelines.

6.5.4 Legal Obligations

EU Directives and national regulations impose legal obligations on public bodies in regard to advertising and the use of objective tendering procedures for awarding contracts above certain value thresholds. Even in the case of procurement which might not be subject to the full scope of EU Directives, such as certain 'non-priority' services or service concessions, the EU Commission and the Court of Justice of the European Union has determined that EU Treaty principles should be observed.

6.5.5 Corporate Procurement Plan

The Office of Government Procurement Policy framework requires that all non-commercial State bodies complete a Corporate Procurement Plan. This plan is underpinned by analysis of expenditure on procurement and the procurement and purchasing structures in the organisation. The plan should set practical and strategic aims, objectives for improved procurement outcomes and appropriate measures to achieve these aims should be implemented.

6.5.6 The Board Chairperson should affirm adherence to the relevant procurement policy and procedures and the development and implementation of the Corporate Procurement Plan in the HSE's annual report.

6.6 Acquisition/disposal of assets

- 6.6.1 The HSE has developed a Property Protocol, which sets out the procedure to be followed when the HSE:
- (a) acquires or disposes of any interest in property (whether freehold or leasehold); or
 - (b) enters into any arrangement which diminishes or alters its interest in its property (“property” to include land and/or buildings).

- 6.6.2 With respect to any proposed transaction in relation to property or an interest in property, the designated employee must first consider whether the transaction would be a:
- **Category 1 Transaction**, in excess of €2 million exclusive of VAT and any Service Charge, in which case the transaction will require Board approval.
 - **Category 2 Transaction**, equal to or less than €2 million exclusive of VAT and any Service Charge (See Section 2.2 below). The National Director of Commercial & Support Services may approve Category 2 transactions with the delegated authority of the Chief Executive Officer.

For the purposes of this Protocol, the value of a lease is calculated by multiplying the annual rental costs by the duration in years of the lease.

- 6.6.3 Under section 40I(3)(d) of the Health Act 2004 the Audit Committee of the HSE has, among other roles, a specified role in advising the Board on the appropriateness, effectiveness and efficiency of the HSE's procedures relating to the acquisition, holding and disposal of assets. HSE Board approval is required for all transactions that
- (a) are over €2m in value;
 - (b) are above market value acquisitions, or below market value disposals;
 - (c) disposals of over €150,000 in value where an auction or competitive bidding process has not been used, before negotiations start, and again before disposal of the asset.
 - (d) Where an auction or competitive tendering process takes place and the highest bid is not the bid accepted.
- 6.6.4 Matters to be considered in the acquisition and disposal of any property or interest in property.
- (a) whether the contemplated transaction falls within the ambit of any function reserved to the HSE's Board, the Chief Executive Officer, or to such officer as the Chief Executive Officer may have subdelegated. These are “reserved” functions.
 - (b) the desirability of the HSE retaining, for the benefit of the healthcare system, of properties that it currently owns or leases.
 - (c) how the HSE might best secure and realise the value of its Capital investment in property owned by Third Parties upon the disposal of such properties. e.g. where HSE provides Capital assistance to Third Party organisations which facilitates the improvement of property held by those organisations or facilitates the purchase of property by them. Regard must be had to National Financial Regulations which provide in greater detail the legal documentation required to ensure that HSE recoups the value of its Capital investments upon disposal of third-party assets part funded by the HSE.

- (d) any general or specific written directions that may be issued by the Minister that may be relevant to the proposed transaction under Section 10 of the Health Act 2004.
- (e) whether the proposed transaction is consistent with the terms of the Minister's sanction of the HSE's Corporate Plan and Service Plan (including the capital plan) for the relevant financial year.
- (f) whether the proposed transaction would involve capital expenditure in excess of the level allocated in the Capital Plan which is approved by the Minister with the consent of the Minister of Finance. If so, before entering into any such transaction, the Chief Executive Officer is required to inform the Minister in accordance with Section 34A of the Health Act 2004.
- (g) if the transaction would require the HSE Seal to be applied to any document, the Protocol for the Use of the HSE Seal must be utilised. In general, where the HSE is acquiring or disposing of any property or interest in property or agreeing to a variation of its entitlements the document recording such acquisition, disposal or alteration must be sealed by HSE.
- (h) the HSE should have regard to paragraph 8.24 and paragraph 8.34 of the DPER Code, dealing with Acquisition of Land, Buildings or other Material Assets and disposal of State assets, respectively.

6.6.5 Disposals of assets to members of the HSE's Board, or employees of the HSE, or their connected persons will also require Board approval. Any instance where a property interest is acquired from a member of staff should be noted on the relevant property transaction documentation.

6.7 Tax compliance

6.7.1 The Annual Report of the HSE includes a statement confirming compliance with its obligations under tax law.

6.7.2 Arrangements are in place and integrated with the HSE's procurement and financial procedures to ensure that all individuals or organisations who receive payment for the provision of services have a valid tax clearance certificate. Controls in this regard include:

- the provision of a tax clearance certificate when tendering for a contract;
- payments in excess of €10,000 demand reference to a valid certificate.

The HSE shall ensure that in relation to payments to contractors, consultants and similar type payments all Tax Clearance and RCT requirements as set out in Circulars relating to Public Sector Contracts are adhered to.

6.7.3 The HSE has a dedicated in-house tax team resourced by qualified tax professionals. The HSE is committed to meeting its obligations in respect of its compliance with taxation laws.

6.8 Internal Audit

- 6.8.1 The Mission of Internal Audit is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.
- 6.8.2 The role of internal audit is: *“to provide an independent, objective assurance and consulting activity designed to add value and improve an organisation’s operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes”* (The Institute of Internal Auditors).”
- 6.8.3 The HSE’s Internal Audit Division is responsible for ensuring that a comprehensive programme of audit work is carried out annually throughout the HSE. The purpose of this work is to provide assurance that controls and procedures are operated in accordance with best practice and with the appropriate regulations and to make recommendations for the improvement of such controls and procedures. The HSE Audit Committee, to whom the Division reports, monitors the work of the Division. In addition, the Division reports at the highest level in the HSE. The scope of Internal Audit covers all systems and activities throughout the HSE, and bodies totally or partially funded by the HSE.
- 6.8.4 The Division comprises four units:
- (a) **Internal Audit Operations** – this is the main part of the work of the Division and entails the completion of a programme of internal audits.
 - (b) **ICT Audit** – this comprises of a number of ICT audits conducted mainly by external specialist ICT auditors contracted to work for the Division.
 - (c) **Special Projects & Investigations** – this work is conducted by a small team in the Division together with, if required, specialist forensic accounting contractors.
 - (d) **Healthcare Audit** – this team provides assurance to the HSE that the services it provides meet statutory obligations and are delivered in accordance with best practice.
- 6.8.5 Audit and Risk Committee

The Health Act 2004 recognises that the Audit Committee has a role in oversight and advice in risk management. Accordingly the Audit Committee has adopted the title of “Audit and Risk Committee” to reflect the full nature of its remit.

Under section 40I the Health Act 2004 the Audit and Risk Committee shall advise the Board and the CEO on financial matters relating to their respective functions including advising on the following matters:

- (a) The proper implementation by the HSE of Government guidelines on financial issues
- (b) Compliance by the HSE with specific statutory obligations namely the provisions contained in section 33 of the Health Act 2004 (management of services as per approved service plan so net non-capital expenditure limits are not breached) and section 33B of the Health Act 2004 (submission of an annual capital plan) and any other obligations imposed by law relating to financial issues
- (c) Compliance by the CEO to ensure the HSE’s net non-capital and capital expenditures do not exceed the amount allocated by the Government for a financial year or part thereof.

- (d) The appropriateness, effectiveness and efficiency of the HSE's procedures relating to
- (i) Public procurement
 - (ii) Seeking sanction for expenditure and complying with that sanction
 - (iii) The acquisition, holding and disposal of assets
 - (iv) Risk Management
 - (v) Financial Reporting and
 - (vi) Internal Audits (Internal Audit Function).

The Audit and Risk Committee is also required under the Health Act 2004 to report in writing at least once in every year to the Board and CEO on financial matters relating to the functions of the Board and the CEO in the previous year and to provide a copy of the report to the Minister.

As stipulated above the Audit and Risk Committee is required under the Health Act 2004 to advise on the appropriateness, efficiency and effectiveness of the HSE's Internal Audit function. In this regard it has a responsibility to:

- Oversee and advise on matters relating to the operation and development of the HSE's Internal Audit function, including healthcare audit;
- Review and recommend for approval the Annual Internal Audit Plan having given guidance regarding risks and problem areas that the audit plan should address and ensuring that Internal Audit has due regard for value for money principles in its audits;
- Review and monitor the adequacy of the annual Internal Audit programme and ensure that the Internal Audit function is adequately resourced and has appropriate standing within the HSE to allow it to highlight and to audit significant risk areas within the HSE;
- Monitor implementation of the Internal Audit Plan throughout the year and to receive a report on the results of the National Director of Internal Audit's work on a periodic basis;
- Make recommendations to the Board for the appointment or termination of the National Director of Internal Audit;
- Review the significant findings and recommendations of Internal Audit/Healthcare Audit and monitor actions taken by management to resolve any issues identified;
- Request special reports from Internal Audit/Healthcare Audit as the Committee considers appropriate or as requested by the Committee Chair, the Chair of the Board or the CEO;
- Ensure that the National Director of Internal Audit has direct access to the Chair of the Audit & Risk Committee, the Board Chairperson and the Audit & Risk Committee and is accountable to the Audit & Risk Committee;
- Monitor and assess the role and effectiveness of the Internal Audit function and activities, and to consider internal audit's independence, expertise, experience and adherence to professional standards and make any recommendations pertaining to the Internal Audit function that the Committee considers necessary or appropriate, including as regards organisation, resources, training, use of technology.

Chapter 7:

Accountability, Planning and Reporting Requirements

7.1 Accountability of Minister for Health

7.1.1 The Minister for Health leads the Department of Health in serving the country, its people and the Government. As a member of Government, the Minister is accountable to the Oireachtas.

7.1.2 The mission of the Minister's Department is to improve the health and wellbeing of people in Ireland by:

- supporting people to lead healthy and independent lives;
- ensuring the delivery of high quality safe health and social care;
- creating a more responsive, integrated and people-centred health and social care service; and
- promoting effective and efficient management of the health and social care service and ensuring best value from health system resources.

7.1.3 Accountability of the Minister in relation to the HSE

The Minister is required to ensure that every regulation and every order made by him/her under the Health Act 2004 is laid before each House of the Oireachtas as soon as practicable after it is made.

The Minister, following the issue of a direction to the HSE under Section 10 must ensure that a copy of the direction is laid before both houses of the Oireachtas within a period of 21 days.

The Minister is required to ensure that a copy of the approved corporate plan is laid before both houses of the Oireachtas within a period of 21 days of the plan being approved.

The Minister is required to ensure that a copy of the approved service plan (or any subsequent amendment of the plan) is laid before both houses of the Oireachtas within a period of 21 days of the plan being approved.

The Minister must upon receiving them, ensure that a copy of the audited annual financial statements together with the Comptroller and Auditor General's report to the Minister is laid before both Houses of the Oireachtas as soon as practicable.

The Minister must ensure that the HSE's annual report is laid before both houses of the Oireachtas within 21 days of receiving the report.

The Minister must ensure that any superannuation scheme approved under the Health Act 2004 is laid before both houses of the Oireachtas as soon as practicable after the scheme is approved.

The Minister may issue general written directions to the HSE and the HSE is obliged to comply with the Minister's directions.

The Minister may set priorities for the HSE and must consult with the HSE before specifying priorities. The HSE is obliged to have regard to those priorities in preparing or amending its Service Plan.

7.1.4 HSE Board's Accountability to the Minister

The Minister appoints the HSE's Board and its members are accountable to the him or her for the performance of their functions. In accordance with the Health Act 2004 the Board's functions are as follows:

- (a) It is required to satisfy itself that appropriate systems, procedures and practices are in place
 - (i) to achieve the HSE's objectives;
 - (ii) for the internal performance and accountability in respect of the HSE's: -
 - (A) performance of its functions,
 - (B) achieving its objectives in accordance with the corporate plan,
 - (C) delivery of health services in accordance with the Health Act;
 - and
 - (iii) in order to enable compliance with the policies (whether set out in codes, guidelines, or other documents, or any combination thereof) of the Government or a Minister of the Government to the extent that those policies may affect or relate to the functions of the HSE
- and
- (b) establish and implement arrangements for the management of the performance of the Chief Executive Officer.

The HSE and its Board are responsible to the Minister in the following ways:

- (a) The Minister may issue directions to the HSE and it is obliged to comply with the Minister's directions.
- (b) The Minister may set priorities for the HSE and it is obliged to have regard to those priorities in preparing or amending its Service Plan.

7.1.5 **CEO's Accountability to the Minister**

Under section 34A of the Health Act the CEO shall take steps to ensure that the HSE's net non-capital expenditure and capital expenditure for a financial year or part of a financial year does not exceed the amounts specified by the Minister. In the event the CEO forms the opinion that an action taken by the HSE will, or would result, in the specified net non-capital expenditure for a financial year or part thereof or the specified capital expenditure for a financial year or part thereof he/she will, as soon as is practicable, take steps to notify the Minister of such opinion/s.

7.2 **HSE accountability to the Oireachtas**

7.2.1 The HSE is required to conduct its dealings with members of either House of the Oireachtas in accordance with regulations which may be made by the Minister under Section 79 of the Health Act 2004) relating to:

- (a) the supply by the HSE of specified documents or specified information to members of either House;
- (b) correspondence by the HSE with those members; and
- (c) such other matters as the Minister may consider appropriate.

To date, the Minister has not made regulations under the relevant provisions of the Health Act 2004).

- 7.2.2 The Chief Executive Officer is obliged, whenever required in writing to do so to give evidence to the Oireachtas Committee on Public Accounts concerning:
- (a) The regularity and propriety of the transactions recorded, or required to be recorded, in any book or other record of account subject to audit by the Comptroller and Auditor General that the HSE is required under the Health Act 2004 to prepare;
 - (b) The economy and efficiency of the HSE in using its resources;
 - (c) The systems, procedures and practices employed by the HSE for evaluating the effectiveness of its operations; and
 - (d) Any matter affecting the HSE referred to in:
 - (i) A special report of the Comptroller and Auditor General, or
 - (ii) Any other report of the Comptroller and Auditor General that is laid before Dáil Éireann to the extent that the report relates to the matters referred to at (a) to (c) above.
- 7.2.3 When appearing before the Committee on Public Accounts, the Chief Executive Officer may not question or express an opinion on the merits of any policy of the Government or a Minister of the Government, or on the merits of the objectives of such a policy.
- 7.2.4 The Chief Executive Officer must, at the request in writing of a Committee of the Houses of the Oireachtas⁸, attend before that Committee to give an account of the general administration of the HSE.
- 7.2.5 The Chief Executive Officer is not obliged to give an account before a Committee of the Houses of the Oireachtas of any matter relating to the general administration of the HSE which is, has been, or may at a future time be, the subject of proceedings before a court or tribunal in the State.
- 7.2.6 With the permission of the Chairperson of a Committee, either
- (a) The chairperson of the Board, or
 - (b) An employee of the HSE nominated by the Chief Executive Officer
- may attend before the Committee in place of the Chief Executive Officer to give an account of the general administration of the HSE.

7.3 Corporate planning processes

- 7.3.1 Organisational and performance is measured against expected performance set out in the HSE's strategies, plans, etc. HSE Senior management are also held to account by reference to their performance against these plans. In addition to internal accountability arrangements, and accountability to the Minister, the HSE may be held accountable by its broader stakeholders, for example:
- **statutory regulators**, e.g. HIQA, the Mental Health Commission, etc.
 - **parliamentary scrutiny**, via Oireachtas committees, etc.
 - **public opinion**, via advocacy groups, the media, individual representations, etc.

⁸ Reference to a Committee of the Houses of the Oireachtas in this section does not include the Committee of Public Accounts, the Committee on Members' Interests of Dáil Éireann, or the Committee on Members' Interests of Seanad Éireann, or any sub-committee of such Committees.

- 7.3.2 Within the Health Act 2004 there are a number of requirements on the HSE to publish plans, e.g. a Corporate Plan, a Service Plan, a Capital Plan, etc. and these are discussed below.

7.4 Process of strategic planning/corporate planning

- 7.4.1 High quality corporate planning and performance reporting are fundamental requirements of the HSE. There are both statutory planning/reporting obligations to meet the needs of external stakeholders and internal management reporting obligations which support good governance and control processes within the HSE.

7.4.2 Corporate Plan

The HSE Corporate Plan is a legal requirement under Section 29 of the Health Act 2004. The purpose of the Corporate Plan is to provide strategic direction for the organisation.

- 7.4.3 The adoption of the HSE's Corporate Plan and its National Service Plan for the Minister's approval is a reserved function of the HSE's Board.

7.5 Process of annual service planning

- 7.5.1 The annual National Service Plan is framed within the context of the Corporate Plan and also is a legal requirement under Section 31 of the Health Act 2004. The approval of the HSE's Corporate Plan for submission to the Minister is a reserved function of the Board.

- 7.5.2 The primary purpose of the National Service Plan is to set out how the Vote (budget) allocated to the HSE will be spent in the given year on the type and volume of health and personal social services delivered to the people of Ireland, within the approved employment levels set out by the Minister, with the approval of the Minister for Public Expenditure and Reform. It is implemented at all levels within the organisation.

- 7.5.3 Each manager must be familiar with the annual National Service Plan and the specific operational plans for their area. They must also take responsibility for developing and implementing that plan.

7.6 Process of annual and multi-annual capital planning

7.6.1 Annual capital planning

The Minister, with the consent of the Minister for Public Expenditure and Reform determines, in each financial year, notifies the HSE of the maximum amount of funding to be made available for capital expenditure. Once the HSE is notified by the Minister it must submit for his or her approval an annual capital plan -

- (a) prepared in such form and containing such information as may be specified by the Minister,
- (b) relating to the financial year to which that notification relates.

The expectation is that the annual capital plan will be submitted at the same time as the annual service plan is submitted, i.e. within 21 days of the HSE being notified of its annual capital funding allocation. However, this does not always occur because the Minister may notify the HSE of the funding to be made available for capital expenditure on a different date than the HSE is notified of the funding to be made available for non-capital expenditure. The annual capital plan may be submitted within such longer period (not exceeding 42 days after the receipt of that notification) as the Minister may allow.

The HSE must, in its annual report include a report in the implementation of the capital plans in the financial year to which the annual report relates.

The Capital Plan may be amended on foot of a direction received by the Minister to amend an existing capital plan, or alternatively, the HSE may with the prior approval of the Minister amend an existing capital plan. The approval or the amendment of the Capital Plan for submission to the Minister for Health is a reserved function of the Board.

7.6.2 Multi-annual capital planning

7.6.3 Although the Health Act 2004 (requires the HSE to submit a capital plan annually, in practice HSE prepares a multi-annual Capital Plan, submitted to the Minister on a yearly basis, which constitutes a rolling five-year programme for the delivery of the HSE's capital programme.

7.6.4 The HSE complies with EU directives and ensures that all individual projects in the Capital Programme are assessed and managed in accordance with the DPER's Public Spending Code.

7.6.5 The HSE has published a Capital Projects Manual & Approval Protocol which outlines the specific actions necessary to give effect to the established approvals protocol for the appraisal, initiation, management and administration of all capital projects.

7.6.6 The HSE has also established a National Capital and Property Steering Committee whose role is as follows:

- apprise capital project submissions;
- recommend projects for inclusion in the multi-annual capital plan;
- recommend project initiation/allocation of funding;
- advise on the formation of the capital plan;
- ensure alignment between the National Service Plan and the Capital Plan;
- review property transactions.

7.6.7 The Capital Projects Manual & Approval Protocol complies with the principles of the Public Spending Code and is routinely reviewed and revised to ensure compliance. All projects are appraised and managed in accordance with the HSE's Protocol, its National Financial Regulations, the Department of Public Expenditure and Reform's Capital Works Management Framework and the Public Spending Code <http://publicspendingcode.per.gov.ie/>.

7.6.8 The HSE may also engage in public private partnership (PPP) projects and therefore, in addition to adhering to the Public Spending Codes, the governance and approval processes also complies with the Public Private Partnership Guidelines (2006).

7.7 Accountability of “Section 38” and “Section 39” service providers

- 7.7.1 The HSE framework for the Governance of non-statutory service providers includes a set of standard documents to be used to formalise service arrangements with non-statutory service providers, providing personal health and social services. All service providers in receipt of annual funding in excess of €250,000 from HSE are required to sign a Service Arrangement.
- 7.7.2 There are three versions of the Service Arrangement document for use in the following circumstances:
- **Section 38 Service Arrangement Document** – The HSE currently has a Section 38 agreement with 16 acute “voluntary” hospitals and 23 non-acute voluntary bodies. These bodies are encompassed by the HSE Employment Control Framework.
 - **Section 39 Service Arrangement Document** – This document is used in respect of all other non-statutory voluntary and community (“not-for-profit”) bodies providing personal health and social services that receive funding over €250,000 per annum from the HSE.
 - **For Profit Service Arrangements** are commercial contracts, which cover all agencies in the commercial for-profit sector, regardless of funding level.
- 7.7.3 The Service Arrangement consists of two parts:
- (a) **Part 1 Arrangement** – This consists of a number of standard form contracts which are common to all Service Arrangements. They form the main body of the Arrangement and set out the legal framework under which both parties agree to work. The HSE does not permit this part of the Arrangement to be altered for individual bodies.
 - (b) **Part 2 Schedules** – This consists of a set of Schedules to the Arrangement. These Schedules specify detailed information on services delivered locally under each Care Group with a particular organisation/service provider. The format of this part of the Arrangement cannot be altered however the specific detail that is set out in the Schedules is determined at local level between both parties. Separate sets of Schedules exist for Arrangements in relation to the provision of Acute Hospital Services and the provision of non-acute Community Care Services.
- 7.7.4 Annual Compliance Statements
- The Service Arrangement between the HSE and “Section 38” and “Section 39” Providers sets out in advance each year the nature of the relationship between both organisations. The submission of an Annual Compliance Statement is an additional requirement to the Service Arrangement process in respect of not for profit organisations.
- Each such Provider is required to furnish the HSE with an Annual Compliance Statement.
 - The Compliance Statement must be completed by the Board of Directors/Governing Body of such Provider, having reviewed the compliance of their organisation over the course of the previous year with specific requirements set out in the Service Arrangement.
 - The Statement needs to be approved by the Board of Directors/Governing Body of such Providers, signed by the Chairperson and one other Member/Director on behalf of the Board of Directors/Governing Body, and be submitted to the HSE before the end of May each year.
 - If, during the course of a year, any significant instance of non-compliance is identified, this should be immediately notified to the HSE by the Chairperson of the Board of Directors/Governing Body of such Providers.

It is recognised, however, that some organisations may not be fully compliant with all of the core governance standards required of Providers in the annual compliance statement. In these circumstances, the HSE adopts the 'comply or explain' approach. Where Providers are not in full compliance, they will be asked to explain why this is the case and to indicate the details of the changes they propose to make.

7.8 Scheme of reporting requirements

7.8.1 The HSE engages with the Department of Health on a scheduled basis as follows:

- (a) **Governance, performance, policy and reform review.** The purpose of this engagement is to review and discuss governance, performance, strategic issues and the implementation of policies and reforms. The meeting is held once a year and is attended by the Minister and the Board of the HSE.
- (b) **Review of governance, reform and performance against National Service Plan.** The purpose of this meeting is to review governance issues and significant performance issues, to agree any additional actions required, and to review progress against the NSP including reform. This meeting is held quarterly and is attended by the Minister, the Secretary General of the Department of Health, the Chair of the HSE Board, and the CEO and others as required.
- (c) **Monthly Support Meetings (Executive Engagement) (1 of 2).** The purpose of this meeting is to review escalated service issue and risk, and to agree (where appropriate) additional actions required to address escalated service issues and risks. The meeting is held monthly and is attended by the Secretary General, the Chief Executive Officer and other senior staff as appropriate.
- (d) **Monthly Executive Engagement (2 of 2).** The purpose of this meeting is to review key service issues and risks, and to agree (where appropriate) actions required to address service issues and risks identified. The meeting is held monthly and is attended by the Deputy Secretary General (Governance and Performance) and the Chief Operating Officer and others as required.

Chapter 8:

Performance Reporting and Performance Accountability Framework (PAF)

8.1 Introduction

8.1.1 The HSE seeks to provide the highest quality services to those who need them. Operational oversight of the performance of HSE services (and HSE-funded services). Performance oversight is a function delegated by the CEO to the Chief Operations Officer, who chairs a National Performance Oversight Group for that purpose.

8.2 Service level reporting

8.2.1 High quality corporate planning and performance reporting are fundamental requirements of the HSE. There are both statutory planning and reporting obligations to meet the needs of external stakeholders, and internal obligations which support good governance and control processes within the HSE.

8.2.2 The HSE prepares a monthly Performance Profile which monitors progress against the HSE's objectives and targets as set out in the National Service Plan. The Performance Report provides an overall corporate analysis of key performance information from finance, human resources, acute and primary & community services.

8.2.3 Monthly engagements take place between the Department of Health and the HSE to monitor progress against the annual Service Plan

8.3 National Performance Oversight Group

8.3.1 The National Performance Oversight Group (NPOG) serves as a key performance and accountability oversight and scrutiny process for the health service and to support the Chief Executive Officer and the Board in fulfilling their accountability responsibilities.

8.3.2 It is the responsibility of the National Performance Oversight Group as a part of the overall accountability process, to scrutinise the performance of the health service provider organisations, in particular Hospital Groups, CHOs, NAS, PCRS and other national services, to assess performance against the National Service Plan. The NPOG meets on a monthly basis to review performance across the health service, and its current membership is:

- Chief Operations Officer (Chair);
- Chief Strategy Officer;
- Chief Clinical Officer;
- Chief Financial Officer;
- National Director of Human Resources;
- National Director of Acute Operations;
- National Director Community Operations;
- National Director, National Services.

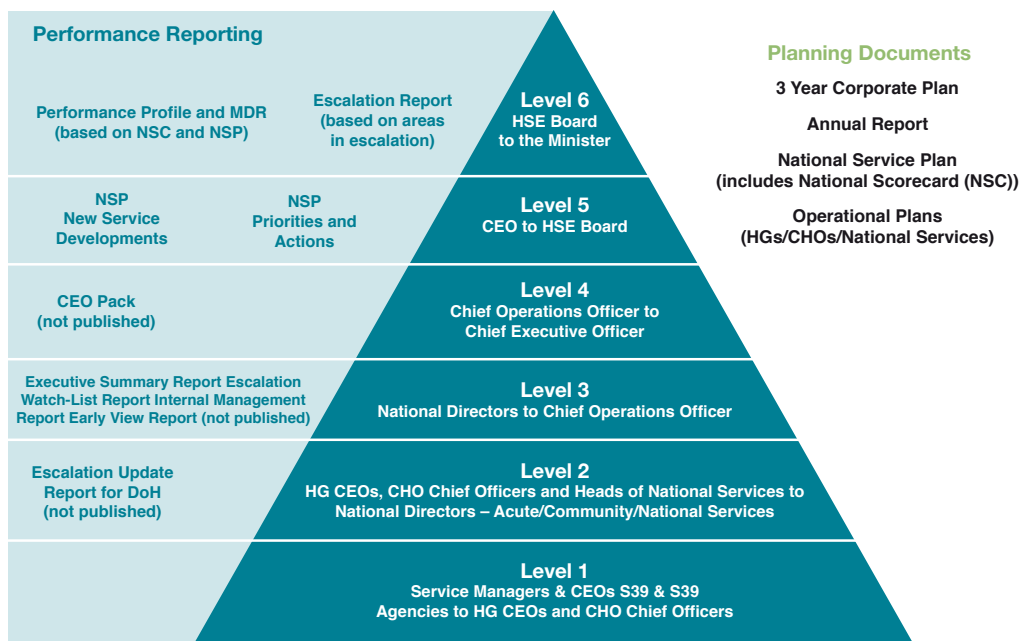
8.3.3 Operational performance is viewed through four lenses:

- (a) **Access to and Integration** of services;
- (b) The **Quality and Safety** of those services;
- (c) achieving the (a) and (b) within specific **Financial, Governance and Compliance Requirements**; and by
- (d) effectively harnessing the efforts of our **Workforce**.

8.3.4 The accountability structure for the HSE is set out in the below in tabular and diagrammatic format below:

1. Service Managers and the CEOs of Section 38 and 39 agencies are **accountable to** the Hospital Group CEOs and CHO Chief Officers.
2. Hospital Group CEOs, CHO Chief Officers, the Head of the NAS, the Head of PCRS and the Heads of other national services are **accountable to** the National Directors Acute Operations, Community Operations and National Services
3. National Directors Acute Operations, Community Operations and National Services are **accountable to** the Chief Operations Officer
4. The Chief Operations Officer is **accountable to** the Chief Executive Officer
5. The Chief Executive Officer is **accountable to** the Board
6. The Board is **accountable to** the Minister.


Figure 8: Performance and Accountability Framework



- 8.3.5 For the purpose of the HSE’s Delegation and Performance and Accountability Framework (PAF), Hospital Group CEOs, CHO Chief Officers, the Head of the NAS, the Head of PCRS and the Heads of other national services are considered the “**accountable officers**” for their areas of responsibility. They are therefore fully responsible and accountable for the services they lead and deliver. The PAF clarifies:
- the named individuals who have delegated responsibility and accountability for all aspects of service delivery across the four domains of the National Scorecard.
 - that these named individuals are accountable and responsible for managing the performance of services within their allocated budget.
 - for these named individuals, what is expected of them, what happens if targets are not achieved and the nature of the supports, interventions and sanctions that will apply if these targets are not achieved.

8.4 Accountability levels/processes

- 8.4.1 There are six main levels of accountability covered under the Accountability Framework.



Level 6 Accountability	Accountability of HSE, through the Board, to the Minister
Level 5 Accountability	CEO to the HSE Board
Level 4 Accountability	Chief Operations Officer to the CEO
Level 3 Accountability	National Directors, i.e. those who report to the Chief Operations Officer.
Level 2 Accountability	Hospital Group CEOs, CHO Chief Officers, and Heads of National Services to National Directors (Acute, Community, National Services).
Level 1 Accountability	Service Managers and the CEOs of Section 38 and Section 39 agencies to Hospital Group CEOs and CHO Chief Officers

(a) **Level 6: Accountability of HSE, through the Board, to the Minister**

An Engagement Process has been agreed, as outlined in the Oversight Agreement whereby the Minister for Health, Secretary General of the HSE, the Chair of the HSE Board and the Chief Executive Officer review process against the NSP, including significant performance issues, and agree any additional actions required.

(b) **Level 5: CEO to the HSE Board**

The CEO is accountable to the HSE Board. The Board is responsible for establishing and implementing arrangements for the management of the performance of the Chief Executive Officer. In order to enable the Board to discharge this role, the CEO ensures that the Performance and Delivery Committee is kept updated about the HSE’s performance against the NSP. The CEO provides the Board with a periodic overview of the HSE’s performance as part of the CEO Report.

(c) **Level 4: Chief Operations Officer to the CEO**

The Chief Operations Office has delegated responsibility for monitoring performance, which is achieved via the NPOG. The Chief Operations Officer submits a report to the CEO and Executive Management Team against the National Service Plan under the four headings of the Balanced Scorecard

(d) **Level 3: National Directors reporting to the Chief Operations Officer**

National Directors are accountable for the delivery of their respective components of the National Service Plan and this is reflected in the Performance Agreements. The Performance Agreement also focuses on a number of key priorities contained in the Service Plan. These priorities are captured in a Balanced Scorecard which ensures accountability for the four dimensions of Access to services, the Quality and Safety of those services, Finance and Workforce.

(e) **Level 2: Hospital Group CEOs, CHO Chief Officers, and Heads of National Services to National Directors**

The National Directors (Acute, Community, National Services) execute performance agreements with Hospital Group CEOs, Chief Officers of Community Healthcare Organisations and heads of National Services (e.g. PCRS, National Ambulance).

The National Directors formally reviews the delivery of these Performance Agreements at monthly Performance Review Meetings with each individual Hospital Group CEO, CHO Chief Officer, etc. and their senior management team. These are the principal accountability meetings at which progress against Performance Agreements and the Divisional Service Plan with each are reviewed.

(f) **Level 1: Section 38 and 39 Agencies Accountability to Hospital Group CEOs and CHO Chief Officers**

The HSE provides funding of more than €3 billion annually to the non-statutory sector to provide a range of health and personal social services. The Service Arrangement or Grant Aid Agreement is the principal accountability agreement between the Hospital Group CEOs and CHO Chief Officers and Section 38 and 39 funded Agencies. There is a named manager responsible for managing the contractual relationship for overseeing the negotiation of the Service Arrangements or Grant Aid Agreements including specific service specification, financial and quality schedules etc. They are also responsible for monitoring the performance and financial management of the specified agreement.

8.5 Performance agreements

- 8.5.1 It is the responsibility of managers to proactively identify issues of underperformance and to act upon them promptly and to the greatest extent possible to avoid the necessity for escalation within the organisation. The PAF acknowledges that in a minority of cases, achieving performance against plan may not be fully within the control of the accountable individual. Where this is the case, the individual is required to clearly identify and quantify these issues and share accountability for both the remedial plans and actions required to address these challenges. These shared accountabilities will be the exception rather than the rule and will not dilute the accountability of accountable officers for delivering on their overall budget and plan.
- 8.5.2 Once these issues have been identified and quantified, they will be specifically reflected within the relevant **Performance Agreements**. A Performance Agreement sets out the scope of what an accountable officer is responsible for and against which they will be held to account, including the specific budget and staffing levels to achieve the deliverables agreed. It constitutes written confirmation that accountable officers:
- (a) accept responsibility and accountability for producing and delivering their operational and financial plans; and
 - (b) accept the regime of supports, interventions and sanctions set out under the PAF;

If an accountable officer fails to deliver performance, there is an escalation process in place, described in subsequent paragraphs. A graduated approach is in place to deal with underperformance, involving:

- (i) **Supports**;
- (ii) **Interventions**, where supports have not remedied the performance issue; and
- (iii) **Sanctions**, at both organisational and individual accountable officer level, where supports and interventions have not worked, and such is considered warranted.

Individual managers, including Hospital Group CEOs and CHO Chief Officers may be required to attend before the NPOG where specific performance issues or escalation warrant explanation and/or improvement.

Monthly performance information is provided to accountable officers and the NPOG for oversight of performance and use in internal performance meetings. IN addition, a monthly performance profile is produced setting out monthly performance against the Balanced Scorecard, and this profile is the basis of the NPOG performance oversight process. Monthly performance data, the performance profile and an overview of areas in escalation and actions planned are provided to the Minister/the Department of Health on a monthly basis. A quarterly performance report is also compiled and published on the HSE's website and on the Government's open data website.

8.6 Process of performance escalation

The PAF makes provision for the formal escalation of individual Hospital Groups, CHOs, or other services that are not achieving national performance expectations set out in the National Service Plan and Balanced Scorecard. Escalation reflects an increased level of concern in relation to performance which requires more intense focus, action and scrutiny in order to bring about improvement. In the context of the Escalation and Intervention Framework, underperformance also includes performance that:

- places patients or service users at risk;
- fails to meet the required standards for that service;
- departs from what is considered acceptable practice.

There are four degrees of escalation, as outlined below:

<p>Level 0 <i>[Accountable Officer]</i></p>	<p>Steady state Performance is being achieved against plan.</p>	<p>Performance subject to routine performance monitoring by the relevant accountable officer.</p>
<p>Level 1 <i>[Accountable Officer]</i></p>	<p>A variance emerges. A variance from plan is identified and intervention and support in response to early signs of difficulty is managed at a provider level</p>	<p>A decision to escalate an area of underperformance in individual services under their remit is made by CHO Chief Officers, Hospital Group CEOs, the Head of the NAS, the Head of PCRS and the Heads of other national services.</p>
<p>Level 2 <i>[NDs Acute Operations and Community Operations and National Services]</i></p>	<p>The problem persists. It becomes harder to fix and potentially spreads to other organisations. Intervention and support are required.</p>	<p>A decision to escalate an area of underperformance in individual Hospital Groups, CHOs, NAS, PCRS or other national services is made by the relevant National Director for Acute Operations, Community Operations or National Services. Support from PMIU will typically be deployed at the discretion of the National Director.</p>

Level 3

[Chief Operations Officer]

The problem becomes critical or where prolonged underperformance puts quality, safety and financial sustainability at risk.

The performance issue persists and the organisation has failed to reverse underperformance. Significant intervention is required.

A decision to escalate an area of underperformance **is made by** the Chief Operations Officer. External supports, interventions or sanctions may be required.

The PMIU may be commissioned to lead on specific improvement initiatives.

Level 4

[Chief Executive Officer]

Significant governance or organisational risks are identified that affect the functioning or reputation of the health service

The actions determined by NPOG do not achieve the necessary impact and action is required by the Chief Executive Officer.

A decision to escalate the **significant governance or organisational risks is made by** the Chief Operations Officer or the CEO

The level of escalation does not necessarily indicate the seriousness of a particular issue but rather the need for the organisational response to be led at a more senior level.

Every month the NPOG produces an Escalation Report for the Chief Executive Officer. The Report contains the areas of performance that are the subject of a Level 3 or Level 4 Escalation. It records actions agreed in response to the area of escalation and whether these actions have been delivered or not. The Report also identifies those individual services which are the subject of escalation, together with the name of the accountable officer. This report is published quarterly.

8.7 Recovery and improvement

Where significant and sustained underperformance has been identified and where support or remedial actions have not been successful, the NPOG may request the development of a Recovery or Improvement Plan. The Plan will be required at a minimum to contain the following elements.

- A full analysis and diagnostic identifying the reasons for poor performance;
- Detailed actions for improving performance. These actions should be specific and measurable;
- The planned improvement trajectory, with targets set out by quarter and showing how long it will take to achieve the national target or the desired level of improvement as determined by NPOG/the Chief Operations Officer. This information together with the agreed improvement actions will be used to assess the success of the Plan;
- The plan may also describe how the HSE's Performance and Accountability Framework will be invoked where actions are not delivered, and performance does not improve in line with the Plan.

Actions must have clear, named owners who will be accountable for delivering on the actions. If there is a return to the required performance level, or if NPOG is satisfied that there is a credible improvement plan in place the issue may be deescalated.

8.7.1 Where remedial actions do not work

Where remedial action is not possible or is not achieving the required correction, it must be discussed with the next level of management for the purpose of further advice, support or intervention as necessary. It is always expected that managers will in the first instance be responsible for initiating corrective actions. The Performance and Accountability Framework envisages that performance issues may be escalated by a more senior level of management where;

- There are concerns that the appropriate level of management are not taking the appropriate actions to address underperformance;
- There is a lack of engagement by managers with a formal performance improvement process;
- The actions required to address underperformance lie outside of the control of accountable officers;
- When an area of performance has been escalated, primary responsibility for managing performance remains with relevant accountable officer unless this authority has been removed.

8.8 Performance Management Improvement Unit (PMIU)

8.8.1 The PMIU was established by the HSE to support improvement activities across the health service, and its support can be commissioned in three ways:

- (a) following a request by a specific provider organisation seeking support for a specific performance improvement initiative; or
- (b) by the National Directors for Acute Operations, Community Operations and National Services in response to a **LEVEL 2** escalation under the Performance and Accountability Framework; or
- (c) by the NPOG where it determines significant improvement is required for systemic performance issues or within specific provider organisations.

8.8.2 Supports

A number of supports are available, including:

- Assistance with the improvement plan, including diagnosis, actions, milestones and timelines;
- Specialist resources to work with the accountable officer and his or her senior staff;
- Putting a dedicated improvement team in place led by the Performance Management Improvement Unit (see below).

8.8.3 Interventions

If performance does not improve, despite on-going monitoring and support, or where plans that have been committed to are not being delivered upon, specific interventions may be put in place by the relevant accountable officer, National Director, the Chief Operations Officer or the Chief Executive Officer. These interventions may include;

- (a) enhanced monitoring through formal review meetings with the relevant line manager.
- (b) additional controls being put in place.
- (c) setting out, in writing, the explicit performance requirements, arrangements for monitoring and consequences where performance does not improve.
- (d) commissioning of an external Improvement initiative through the Performance Management Improvement Unit, performance or governance diagnostic review.
- (e) performance meetings with the National Director and the Chief Operations Officer culminating in a set of performance expectations and requirements, which may include additional improvement actions and expectations, supports, and interventions.

8.9 Sanctions

8.9.1 Organisational Sanctions

While the focus of the Escalation process will be on supporting managers to improve operational performance in a particular area, in the case of continued underperformance despite remedial plans, supports and interventions being in place, the PAF also provides for sanctions to be applied. Sanctions may be applied at organisational level and/or at the individual level, depending on the circumstances.

Section 38 and Section 39 organisations, who are also subject to the PAF, are subject to the sanctions contained within their contracts (i.e. the Service Arrangement between the HSE and the relevant Organisation), which provides for the issuing of contractual Performance Notices, and allow the HSE to take specified courses of action, including:

- withholding of a percentage of funding;
- precluding any requests for funding of additional services or for capital funding until such time as any performance issues are addressed;

In respect of HSE Services, a formal **First Performance Notice** will be issued to the appropriate accountable officer, which specifies the reason for the notice, the performance improvement expectation, timeframe, accountability arrangements and consequences where there is insufficient improvement. An organisational Performance Improvement Plan will be required on foot of receipt of a Performance Notice. Where improvement is not seen within the timeframe of the First Performance Notice, or where actions agreed have not been implemented a **Second Performance Notice** will be issued. The decision to issue a Performance Notice must be notified to NPOG.

8.9.2 Individual (Accountable Officer) Sanctions

The performance of an individual “accountable officer” may need to be addressed in the following circumstances:

- (a) where, following Escalation and agreed intervention(s), the performance issue persists and there is no apparent underlying reason for the continued underperformance; and/or
- (b) where it is apparent that interventions agreed in Escalation may not have been actioned; or
- (c) where the “accountable officer” may have otherwise failed to take appropriate action(s) in relation to a performance issue.

8.9.3 Where the formal Performance Achievement Process is invoked;

- the “accountable officer” will be advised formally in writing that there is an issue with their performance. This notification will detail the specific area/s of underperformance.
- he or she will be required to attend one or more individual performance meetings with the National Director or other Line Manager.
- he or she will, following these meeting(s) be required to produce and agree an individual **Performance Improvement Plan** (PIP) with their National Director or other Line Manager.

- 8.9.4 The Performance Improvement Plan will set out performance improvement expectations and the nature of any support arrangements which may be put in place. These support arrangements may include the appointment of mentoring, advisory or specialist support or formal partnering arrangements with a high performing manager from another area of the HSE and/or another organisation.
- 8.9.5 The Performance Improvement Plan will also outline specific actions, deliverables, timeframes as well as the monitoring and accountability arrangements to be put in place and the consequences where performance does not improve in accordance with the Performance Improvement Plan.
- 8.9.6 Removal from post
Where there continues to be underperformance following the initiation of the Performance Achievement process, i.e. where the expectations set under the PIP are not achieved, the process may ultimately culminate in disciplinary action, which may include (for example), removal of the named manager from post and/or reassignment to other duties.

8.10 Board Strategic Scorecard

8.10.1 Overview of Strategic Scorecard

The Board Strategic Scorecard provides the HSE Board with a monthly report on progress against key identified programmes/priorities identified for a given financial year. In doing so the Board Strategic Scorecard aims to:

- track progress of key programmes/priorities at a high level;
- highlight issues relating to progress in a timely manner;
- support Board discussions;
- minimise multiple requests and duplication of effort in collating reports for Board and the Department of Health.

The Scorecard is structured as follows:

- A one-page summary position across all the programmes/priorities including KPI/Data visualisation of Performance Rating (1-5) for each programme/priority;
- A detailed one-page across each programme/priority to include: overview and highlights; quantitative KPIs; outcome/output/progress updates (qualitative report); and key issues arising.

8.10.2 Rating System

The Strategic Scorecard includes a rating system (in the range of 1 to 5), where a rating of 1 reflects 'not on track' and 5 reflects 'on track' against the year-end targets /outputs/deliverables (see table below).

Zone	Rating	Criteria
Green	5	<ul style="list-style-type: none"> Strong assurance that the 2021 Ambition Statement will be fully achieved All KPIs and Outputs/Deliverables are progressing according to annual trajectory There are no issues or dependencies that are expected to impede delivery of year-end targets
	4	<ul style="list-style-type: none"> Strong assurance that the 2021 Ambition Statement will be substantially achieved All or most KPIs and Outputs/Deliverables are progressing according to annual trajectory There are particular issues or dependencies that may impact on the delivery of year-end targets
Amber	3	<ul style="list-style-type: none"> Reasonable assurance that the 2021 Ambition Statement will be substantially achieved Most KPIs and Outputs/Deliverables are progressing according to annual trajectory There are particular issues or dependencies that may impact on the delivery of year-end targets
	2	<ul style="list-style-type: none"> Concerns that the 2021 Ambition Statement will not be substantially achieved A number of KPIs and Outputs/Deliverables are not progressing according to annual trajectory There are issues or dependencies that will impact on the delivery of year-end targets
Red	1	<ul style="list-style-type: none"> Significant concerns that the 2021 Ambition Statement will not be substantially achieved A number of KPIs and Outputs/Deliverables are not progressing according to annual trajectory There are issues or dependencies that will impact materially on the delivery of year-end targets

The rating is based broadly upon the following:

- assurance in achieving the Ambition Statement
- progress against KPI targets
- progress updates on each of the Outputs/Deliverables
- key issues and dependencies for the Programme/Priority
- input from the Executive Management Team

8.10.3 Improvement Plan

An Improvement Plan is appended to the Scorecard for those Programmes/Priorities which were assigned a 1 or 2 rating in the previous month.

Following consideration by the Board, the Scorecard will be submitted to the Department of Health on a monthly basis, as part of the reporting arrangements in the DOH-Executive Performance Engagement Model and Oversight Agreement.

Development of the Scorecard is an important step in the HSE's ambition to become a high-performing organisation with more rigorous reporting arrangements. However, there are several key considerations in relation to the purpose of the Scorecard, which are described below.

- The approach is not intended to be punitive
Risk flags and concerns identified in the Scorecard are not intended to be punitive or to highlight failings. They are intended to raise issues for discussion, and to guide and support the strengthening and/or improvement of Programme/Priority achievement.
- The approach is intended to support performance conversations
The approach provides the basis for a collaborative conversation on achievement and should not be viewed as a means to an end. Rather, it should capture the current position of the Programme/Priority and provide a realistic forecast each month so as to adopt a 'no surprise' approach to year-end evaluation.
- The approach is intended to support and strengthen the Department of Health / HSE working relationship
This reporting approach provides the opportunity to identify dependencies which include the important role that the Department of Health plays in improving health and social care services in Ireland. The Scorecard also acts as a helpful tool in supporting conversations between the HSE and the Department.

APPENDICES

APPENDIX 1 – Glossary

Some of the terminology used throughout the Code may not be familiar to every stakeholder or reader, and for that reason we have provided an explanation of what is meant by the following words, abbreviations, and terms:

Definition	Interpretation
Accounting Officer	<p>the Officer referred to in Section 22 of the Exchequer and Audit Departments Act, 1866 to whom the duty of preparing the Appropriation Accounts of a Department is assigned. In the case of the HSE, the Accounting Officer is the Secretary General of the Department of Health, save as below:</p> <ul style="list-style-type: none"> the CEO of the HSE shall be the Accounting Officer in relation to the appropriation accounts of the HSE for the financial year ending on 31 December 2014 and for each of the previous financial years back to and including the financial year ending on 31 December 2005.
Accountable Officer	<p>for the purposes of the HSE's Delegation and Performance and Accountability Framework, refers to employees holding senior positions who are deemed fully responsible for the services that they lead and deliver. Currently the Accountable Officers group comprise Chief Executive Officers of Hospital Groups, Chief Officers of Community Healthcare Organisations, the Head of the National Ambulance Services, the Head of the Primary Care Reimbursement Services, and Heads of other National Services. Accountable Officers have formal performance management arrangements in place concerning the individual services that they are responsible for, to ensure delivery against performance expectations and targets.</p>
Accountable Person	<p>a term referred to in the DPER Code, (but not defined in the Health Act 2004) referring to the person within the State Body who is accountable to the Oireachtas. The CEO of the HSE is the Accountable Person by reason of his functions and responsibilities under Section 34A and 34B of the Health Act 2004.</p>
Annual Compliance Statement	<p>a statement which confirms an individual's compliance with a particular requirement set out in legislation, or in policies, procedures, or guidelines which are applicable to the HSE.</p>
Appropriation Account	<p>a set of accounts which provides details of the outturn for the financial year against the amount provided to the HSE by the Department of Health, based on the cash amounts of payments and receipts.</p>
Assurance	<p>an assurance engagement in which a practitioner expresses a conclusion designed to enhance the degree of confidence of the intended users, other than the responsible party, on the outcome of the evaluation or measurement of a subject matter against criteria.</p>
Authorised Person	<p>in the context of a protected disclosure, refers to the person to whom an act or acts of wrongdoing in the workplace (protected disclosures) are disclosed to.</p>

Definition	Interpretation
“Balanced Scorecard”	The Balanced Scorecard (BSC) is a tool developed originally by Kaplan and Norton to articulate, execute and monitor corporate strategy using a mix of financial and non-financial measures. The BSC is an integral part of the HSE’s Performance and Accountability Framework, and is designed to translate the HSE’s vision and its strategy into objectives and measures across four balanced perspectives, namely: (i) Access to and Integration of services, (ii) the Quality and Safety of those services, (iii) achieving Financial, Governance and Compliance Requirements , and (iv) effectively harnessing the efforts of our Workforce .
C&AG	the Comptroller and Auditor General
Capital Plan	a capital plan approved by the Minister for Health in accordance with Section 31 of the Health Act 2004 (as amended).
Carltona Principle	the legal principle that each minister must both bear political responsibility to the Dáil, and legal responsibility in the courts, for actions taken by his or her own Department. In law, ministers are regarded as being one and the same as the government departments of which they are the political heads. Conversely, departmental officials act in the name of the minister. In making administrative decisions, therefore, discretion is conferred on a Minister, not simply as an individual, but rather as the person who holds office as head of a government department, which collectively holds a high degree of collective corporate knowledge and experience, all of which is imputed to the political head of the Department.
CCO	the Chief Clinical Officer
CFO	the Chief Finance Officer
CHOs	Community Healthcare Organisations
CIO	the Chief Information Officer
Code of Conduct	principles, values, standards, or rules of behaviour that guide the decisions, procedures, and systems of the HSE in a way that contributes to the welfare of its key stakeholders and respects the rights of all individuals affected by its operations.
COI	a conflict of interest
Community Healthcare Networks	a network of health professionals in a given geographical area, working in the community, usually comprising between 4-6 primary care centres, which deliver services to a population of approximately 50,000.
COO	the Chief Operations Officer

Definition	Interpretation
Confidential Recipient	the person appointed by the Chief Executive Officer to whom concern(s) about a vulnerable adult or person with a disability, in the care of the HSE, or of a service funded by the HSE, can be made.
Corporate Plan	the plan approved by the Minister under Section 29 of the Health Act 2004 and specifies: (a) the key objectives of the HSE for the three year period concerned and the strategies for achieving those objectives (b) the manner in which the HSE proposes to measure its achievement of those objectives; and (c) the uses for which the HSE proposes to apply its resources.
Corporate Procurement Plan	the plan published periodically by the HSE, to provide continuity of supply of quality goods and services in addition to achieving value for money.
CSO	the Chief Strategy Officer
Delegation Order	A document which records the delegation (or sub-delegation) of a one or more of the HSE's functions, or those of the CEO to a named employee, and the extent of that employee's authority to exercise that function or functions, or to sub-delegate that function or functions in whole or in part to another employee.
Designated Directorships	a person who holds, or in the preceding year, held a position in a public body, and who in accordance with regulations made by the Minister for Public Expenditure and Reform, is required to furnish an annual statement of interests, disclosing any interest held by that person and of any interests held, to the person's actual knowledge, by his or her spouse or civil partner, a child of the person, or a child of a spouse, which could materially influence the person in or in relation to the performance of his or her official functions.
DPER Code	the (revised) Code of Practice for the Governance of State Bodies published by the Department of Public Expenditure and Reform on 17 August 2016. The DPER Code provides a framework for best practice and is based on the underlying principles of good governance: accountability, transparency, probity, and a focus on the sustainable success of the organisation over the longer term.
Engagement Model	the process agreed between the HSE and the Department of Health, outlining how the HSE will account to the Department for its performance in the delivery of health and personal social services.
EMT	the Executive Management Team
Estimates Process	the Estimates of expenditures and receipts prepared by the Government and presented to Dáil Éireann accordance with the provisions of Article 28 of the Constitution.

Definition	Interpretation
Fiduciary Duty	a duty which is exercised by a person or persons (e.g. a board) for the benefit of another person or persons.
Grant Aid Agreement	an agreement which sets out the the terms and conditions which apply to grant of financial assistance (subject to an upper monetary threshold) to voluntary and community agencies/organisations under Section 39 of the Health Act 2004.
Health Vote	the area of Government expenditure which is the responsibility of the Department of Health for which Department is in turn accountable to the Dáil for the expenditure shown.
Health Act	the Health Act 2004 as amended by the Health Service Executive (Governance) Act 2013 and the Health Service Executive (Governance) Act 2019 and any other amending legislation.
HIQA	Health Information and Quality Authority, a body established under the Health Act 2007, whose object is to promote safety and quality in the provision of health and personal social services for the benefit of the health and welfare of the public.
HSE Seal	an implement consisting of two opposing metal plates legibly engraved with the HSE logo and its official name. When the two metal plates are pressed together on a sheet of paper the HSE logo and its name are clearly embossed on the paper. The seal is authenticated in the manner prescribed in Schedule 2 to the Health Act 2004 (as amended).
Independent/ Independence	<p>(a) Independence of mind – the state of mind that permits the expression of a conclusion without being affected by influences that compromise professional judgment, thereby allowing an individual to act with integrity and exercise objectivity and professional scepticism.</p> <p>(b) Independence in appearance - the avoidance of facts and circumstances that are so significant that a reasonable and informed third party would be likely to conclude, weighing all the specific facts and circumstances, that an individual's, integrity, objectivity or professional scepticism has been compromised.</p>
In-patient services	services provided for a person while maintained in a hospital, convalescent home or home for persons with a physical or mental disability, or in accommodation ancillary thereto.
Long-term residential care services	a facility predominantly for the care of older people, and designated by the HSE as such, in which nursing care is provided on the basis that at no time will there be less than one registered nurse on the facility available to provide nursing care for persons maintained in the facility.

Definition	Interpretation
Mental Health Commission	an independent body, established under the Mental Health Act 2001, whose object is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in hospitals.
Minister	the Minister for Health
NCP	National Clinical Programmes
NFR	National Financial Regulations
National Healthcare Charter	a statement of commitment by the HSE describing what patients and service users can expect when availing of services from the HSE, and explaining what patients and services users can do to help the HSE to deliver more effective and safe services.
National Performance Oversight Group (NPOG)	a management group, established by the CEO of the HSE and accountable to him or her, which has responsibility to oversee performance and accountability of the HSE, and through a defined process of escalation, to take corrective action where performance is below profile in any particular area of the HSE's activities.
National Service Plan	a plan prepared in accordance with Section 31 of the Health Act 2004) for a given financial year, approved by the Minister, that sets out <i>inter alia</i> , the type and volume of health and personal social services to be provided by the HSE during the period to which the plan relates.
Out-patient services	Services other than in-patient services provided at, or by persons attached to, a hospital or home, or at a laboratory, clinic, health centre or similar premises, but not including dental, ophthalmic, or aural services.
Oversight Agreement	a written statement between the Department of Health and the HSE (a body "under its aegis"), which clearly defines the terms of the Department's relationship with the HSE.
PCR	Periodic Critical Review
PDA	Performance Delivery Agreements
PMCC	Performance Management and Control Committee
"Performance and Accountability Framework"	A system of operational performance management focused on ensuring clear lines of authority, responsibilities and accountability and then ensuring "accountable officers" are being held to account for the performance of the services and the systems for which they are responsible.

Definition	Interpretation
Performance Indicators	quantitative and qualitative measures of the nature and extent to which the HSE is using resources, providing services, and achieving its service performance objectives. The types of performance indicators used to report service performance information relate to balanced scorecard inputs, outputs, outcomes, efficiency, and effectiveness. Performance Indicators underpin all performance management processes in the HSE.
PPP	Public Private Partnership
Protected Disclosure of Information	<p>the provision of information by an employee regarding potential wrongdoing in the workplace, which is protected in the manner prescribed by law under the Health Act 2004 (as amended by Part 14 of the Health Act 2007),</p> <p>and/or (as the case may be)</p> <p>the provision of information made by a worker regarding potential wrongdoing in the workplace, which is protected under the Protected Disclosures Act 2014, as the case may be.</p>
Public Accounts Committee	the Committee on Public Accounts, a standing committee of Dáil Éireann which focuses on ensuring public services are run efficiently and achieve value for money.
Residential Support Services	accommodation provided to a person by or on behalf of the HSE.
Risk	the effect of uncertainty on objectives, which can be positive or negative.
Risk Management	Coordinated activities to direct and control the HSE with regard to risk.
“Section 38 body”	a body which the HSE has entered into an arrangement with, in accordance with Section 38 of the Health Act 2004 (as amended), to provide health services on its behalf.
“Section 39 body”	a body which provides similar services to the HSE and which the HSE has entered into an arrangement with to provide assistance to that body under Section 39 of the Health Act 2004.
“Strategic Scorecard”	A document produced on a monthly basis for the HSE Board, which tracks progress of identified key programmes/priorities at a high level, highlights emerging issues in a timely manner, and supports HSE Board role in oversight and decision-making role, and in discharging its statutory role to be accountable to the Minister.

Definition	Interpretation
Sláintecare	the report of the Committee on the Future of Healthcare published in May 2017, outlining a ten-year programme to transform Irish health and social care services, and associated implementation plans.
Stakeholder	any person, group, or entity that has an interest in the HSE's activities, resources, or output, or that is affected by that output. Stakeholders can include patients, staff, government departments, trade unions, regulators, etc.
Service Arrangement	an agreement which sets out the terms and conditions under which the HSE makes an arrangement with a person or a body for either (a) the provision of services on behalf of the HSE, or (b) the giving of assistance for the provision of a service similar or ancillary to a service that the HSE may provide in accordance with Section 38 and Section 39 of the Health Act 2004, respectively.
Standards in Public Office Commission	a body which oversees certain legislation, such as the Ethics in Public Office Acts.





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