



Bill Digest

Health Service Executive (Governance) Bill 2018

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Abstract

The aim of the *Health Service Executive (Governance) Bill 2018* is to re-establish independent Board oversight of the Health Service Executive (HSE). It meets a key recommendation of the Oireachtas Committee on the Future of Healthcare (Sláintecare Report). The *Health Act 2004* provided for the establishment of a board of management but this governance structure was abolished by the *HSE (Governance) Act 2013* and replaced by a temporary Directorate. This Digest will examine the current structure, while outlining the leadership and governance reform provisions of the *Sláintecare report (2017)*. The international literature on the principles of health systems governance will be reviewed and the provisions of the Bill assessed in the context of the *Code of Practice for the Governance of State Bodies (2016)*.

Tuesday,
07 August 2018



Contents

Summary	3
Table of Provisions	5
Introduction	9
Policy Context	11
Health Service Executive (Governance) Act 2013	12
Current Structure of the Health Service Executive	14
New Governance Recommendations: The Sláintercare Report	16
A Scoping of the Evidence base for Health Systems Governance	19
The attributes of good governance	19
The TAPIC Framework	20
Finding the right mix of attributes	21
The role of politicians in health systems governance	21
Factors that contribute to effectiveness and quality of care	22
One approach: the NHS England Board	24
A summary of the evidence for health systems governance	25
Principal Provisions of the Bill	26
Conclusion	38

Bill published: 19th July 2018. Second stage debate not yet scheduled at time of publication. This Bill Digest may be cited as: Oireachtas Library & Research Service, 2018. Bill Digest – Health Service Executive (Governance) Bill 2018

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Summary

The Current Governance Structure of the Health Service Executive

The Health Service Executive (HSE) was established on 1st January 2005 by the [Health Act 2004](#) as a new State agency, incorporating the then Health Boards and the Eastern Regional Health Authority. The Health Act 2004 also provided for the establishment of a board of management consisting of 11 members including a Chairperson appointed by the Minister. The [Health Service Executive \(Governance\) Act 2013](#) formally abolished the Board of the HSE and provided for the establishment of a Directorate. This was comprised of a Director General and six new Directorates that were aligned to specific areas of service such as primary care, mental health, and hospitals. It replaced the chief executive function with a Director General who was both a member and Chairperson of the Directorate. The Directorate, as a collective, is the governing body of the HSE with authority to perform the operational functions of the HSE and is accountable to the Minister for performance. The Director General as Chairperson is accountable to the Minister and is responsible for managing the HSE, while the Leadership Team and their supporting structures implement operational targets. It was intended that this restructuring would facilitate the reorganisation of services to prepare the way for the 'money follows the patient principle' and the introduction of Universal Health Insurance. It was to be a temporary measure to continue only until the HSE functions moved elsewhere under the health reform programme in the Programme for Government 2011 - 2016.

The Proposed New Governance Structure of the Health Service Executive

The aim of the [Health Service Executive \(Governance\) Bill 2018](#) is to bring independent board oversight of the HSE. It meets a key recommendation of the [Oireachtas Committee on the Future of Healthcare \(Sláintecare Report\)](#), which had concluded that the current Directorate governance structure is not fit for purpose. The re-establishment of a HSE Board is one part of a broader package of recommendations in the Sláintecare Report intended to improve governance, leadership and accountability within the HSE. The Bill provides for a 9 person non-executive board including a Chairperson and deputy Chairperson. The HSE will be led by a Chief Executive Officer (CEO) who will be responsible to the Board for the performance of his/her functions. The first CEO will be the person holding the post of Director General immediately before the Board is established but this appointment will be a matter for the Board thereafter. The Board will be the governing body for the HSE and will be accountable to the Minister for Health for the performance of its functions.

Good Practice for Health Systems Governance

A scoping of the evidence base for health systems governance, with a particular focus on governing boards of health, points to the following guidance:

*Systematic reviews of health system governance report that **transparency, accountability, participation, integrity** and **policy capacity** are the defining attributes of good governance but systems supporting these frequently interfere with other desirable goals including speed, efficiency, effectiveness, flexibility, creativity, empowerment, and innovation;*

*Successful health systems are those that have right amount of **transparency, accountability, participation, integrity** and **policy capacity** so as to be embedded in the operating environment but still autonomous enough to take action in an efficient way;*

The process of patient/citizen participation in health system governance requires careful consideration due to the risk of high costs, potential to impose gridlock, bias and polarisation, but also the benefits of greater legitimacy and effectiveness of health policies;

Studies in the US and the UK have linked the composition and governance of state boards to patient safety outcomes, with higher performing boards clearly linked to better patient outcomes;

Boards that prioritise patient safety are boards that tend to set strategic goals for quality improvement and demand reports on the progress of remedies in the wake of adverse events;

Clear rules that guide the conduct of board members with procedures that clearly and transparently govern board proceedings are critical to the maintenance of public confidence and the integrity of the organisation;

The ability of a board to make key decisions is determined by the quality of the data provided but also by members' capacity to process and interpret information. The board must have access to strong research and analytical capacity;

Boards with a separate patient safety and quality of care committee are more likely to perform well in this regard.

Table of Provisions

The table below summarises all of the provisions of the *Health Service Executive (Governance) Bill 2018*. Further explanation of key specified provisions is provided in the Principal Provisions section of this Digest.

Table 1: Summary of the provisions of the *Health Service Executive (Governance) Bill 2018*

Section	Title	Description
Part 1 Preliminary and General		
1	Short title, commencement, collective citation and construction	A standard provision setting out the short title and commencement provisions of the Bill. Section 1 specifically excludes Part 3 (Miscellaneous provisions) of the proposed Act from the collective citation provisions.
2	Definition	Section 2 defines the Principal Act as the Health Act 2004 .
3	Repeals	This section provides for the repeal of: <ul style="list-style-type: none"> • Part 3A of the 2004 Act¹; and • Section 22 of the Health Service Executive (Governance) Act 2013 which contain provisions on the current Directorate and Director General of the HSE;
Part 2 Amendment of Principal Act		
4	Amendment of section 2 of Principal Act	This section provides for the amendment of the interpretation provisions in section 2 of the 2004 Act to reflect the new governance structure proposed in the Bill.
5	Amendment of section 10 of Principal Act	This section provides for the amendment of the provision governing the issuing of Ministerial directions in the 2004 Act to reflect the new governance structure proposed in the Bill.
6	Amendment of section 10B of Principal Act	This section provides for the amendment of the provision in the 2004 Act (as inserted by the 2013 Act) governing the setting of priorities by the Minister. In particular it provides for the substitution of Chief Executive Officer for Director General.
7	Board of Executive	This section proposes inserting a new Part 3B titled Board of Executive into the 2004 Act. Part 3B consists of 8 new sections, sections 16N to 16U , which govern among other things the role of the new HSE Board.
8	Chief Executive Officer	This section proposes inserting a new Part 4A, titled Chief Executive Officer into the 2004 Act. Part 4A consists of 7 new sections, sections 21A to 21G which

¹ Inserted by section 7 of the *Health Service Executive (Governance) Act 2013*
<http://www.irishstatutebook.ie/eli/2013/act/23/section/7/enacted/en/html>

Section	Title	Description
		govern among other things the appointment and functions of the CEO. It should be noted that the Bill provides for the current or acting Director General to be deemed the first CEO of the HSE.
9	Amendment of section 22 of Principal Act	This section proposes amending section 22 of the 2004 Act so as to exclude those provisions (which include the determination of the terms and conditions of employees of the HSE) from applying to the appointment of a CEO under the proposed Act.
10	Amendment of section 23 of Principal Act	This section proposes amending the pension provisions in the 2004 Act by replacing references to the Director General with references to the CEO.
11	Amendment of section 25 of Principal Act	This section proposes amending the provisions in the 2004 Act (as inserted by the 2013 Act) governing standards of integrity, conduct and concern for public interest to reflect the new governance structure proposed in the Bill.
12	Prohibition on unauthorised disclosure of confidential information	This section proposes a restatement/clarification of the provisions on the unauthorised disclosure of confidential information to reflect the new governance structure proposed in the Bill.
13	Amendment of section 27 of Principal Act	This section proposes amending the provisions in the 2004 Act governing disqualification from office resulting from membership of either House of the Oireachtas, the European Parliament or a local authority to reflect the new governance structure proposed in the Bill.
14	Amendment of section 28 of Principal Act	This section proposes removing from the interpretation provisions in section 28 of the 2004 Act the definition of Committee of Public Accounts.
15	Amendment of section 31 of Principal Act	This section proposes inserting a number of new provisions into section 31 of the 2004 Act which relate to the statutory obligation of the HSE to prepare and submit a service plan to the Minister for approval. These provisions reflect the new governance structure proposed in the Bill and mirror those that applied prior to the establishment of the current Directorate.
16	Amendment of section 34A of Principal Act	This section proposes amending the provisions in section 34A of the 2004 Act (as inserted by the 2013 Act) Act to which govern the functions of the Director General by replacing references to the Director General with references to the CEO.
17	Amendment of section 34B of Principal Act	This section proposes the same amendment as that in section 16 in respect of the provisions governing the appearance of the Director General before the Committee of Public Accounts.
18	Amendment of section 35 of Principal Act	This section proposes amendments to the provisions in the 2004 Act governing the HSE Code of Governance to reflect the changes proposed in the Bill. In particular

Section	Title	Description
		it will impose an obligation on the HSE to revise the Code as soon as practicable after the commencement of this section to reflect the roles and responsibilities of the Board and the CEO.
19	Amendment of section 40G of Principal Act	This section proposes amending the provision in the 2004 Act (as amended by the 2013 Act) so that the CEO will be the accounting officer of the HSE for the purposes of the Comptroller and Auditor General Acts.
20	Audit committee	This section proposes substituting section 40H of the Act of 2004 which provides for the establishment of an Audit Committee to reflect the changes proposed in the Bill. It provides in particular that the HSE must establish an audit committee as soon as practicable after the commencement of this section.
21	Provisions supplementary to section 40H	This section proposes a new section 40HA which provides for the dissolution of the current audit committee on a day to be appointed by the Minister. It also provides for the completion of acts commenced, and the transfer of documents and records to the new audit committee.
22	Functions of audit committee	This section proposes substituting new provisions which govern the functions of the audit committee to reflect the new governance structure proposed in the Bill.
23	Amendment of section 51 of Principal Act	This section proposes amending section 51 of the 2004 Act (part of a series of provisions which govern the complaints process) to replace a reference to the Director General with the CEO.
24	Amendment of section 55S of Principal Act	This section proposes deleting a number of provisions in the 2004 Act which relate to the penalties applicable to, and the prosecution for an offence of making a false protected disclosure. The penalties proposed in section 28 of the Bill will now apply in such cases.
25	Effect of delegation and sub-delegation of functions	This section proposes substituting a new section for section 76 of the 2004 Act which governs the delegation and sub-delegation of the functions of the HSE. The new provision will reflect the new governance structure proposed in the Bill.
26	Amendment of section 77 of Principal Act	This section proposes amending section 77 of the 2004 Act which provides that in any legal proceedings a signed certificate will be proof in and of itself of the delegation of a HSE function (subject to evidence to the contrary). The amendments reflect the new governance structure proposed in the Bill.
27	Amendment of section 79 of Principal Act	This section proposes amending a reference relating to the definition of confidential information in section 79 of the 2004 Act to take account of the new section 26 as proposed in section 12 of the Bill.
28	Amendment of Principal Act	This section proposes inserting a number of transitional

Section	Title	Description
	- insertion of sections 81 to 83	<p>provisions into the 2004 Act which provide for the Board and the CEO to complete any function or act commenced but not completed by the HSE or the Director General.</p> <p>The new section 82 provides that where a person commits an offence under the proposed Act he or she will be liable:</p> <ul style="list-style-type: none"> • on summary conviction to a class A fine (i.e. up to a max. of €5,000) and/or a term of imprisonment not exceeding 6 months; • on conviction on indictment to a fine not exceeding €50,000 and/or a term of imprisonment not exceeding 3 years. <p>The new section 83 provides that any reference to the Directorate or the Director General will after the commencement of section 3 of the proposed Act be deemed to be a reference to the Board and the CEO respectively.</p>
29	Amendment of Schedule 2 to Principal Act	This section proposes amendments to Schedule 2 of the 2004 Act which governs, among other things, the authentication of the seal of the HSE, meetings and voting to reflect the new governance structure proposed in the Bill.
Part 3 Miscellaneous		
30	Amendment of Health Act 1970	This section proposes amendments to the 1970 Act necessary to reflect the new governance structure proposed in the Bill.
31	Amendment of Unfair Dismissals Act 1977	This section amends the exclusion provisions in the 1997 Act to include a reference to the CEO of the HSE. As is the position with the Director General this would mean that the provisions of the Unfair Dismissals Act would not apply to the CEO.
32	Amendment of Children First Act 2015	This section proposes amendments to the 2015 Act necessary to reflect the new governance structure proposed in the Bill.
33	Amendment of European Union (Cosmetic Products) Regulations 2013	This section proposes amendments to the 2013 Regulations necessary to reflect the new governance structure proposed in the Bill.
34	Amendment of European Union (Manufacture, Presentation and Sale of Tobacco and Related Products) Regulations 2016	This section proposes amendments to the 2016 Regulations necessary to reflect the new governance structure proposed in the Bill.

Source: Prepared by the Library & Research Service based on the *Health Service Executive (Governance) Bill 2018*

Introduction

The aim of the [Health Service Executive \(Governance\) Bill 2018](#) is to re-establish a board of governance for the Health Service Executive (HSE). The [Health Act 2004](#) provided for the an independent board of management but this governance structure was abolished by the [Health Service Executive \(Governance\) Act 2013](#) and replaced by a temporary Directorate structure. The Bill describes a 9 person non-executive board including a Chairperson and deputy Chairperson, while providing the HSE with a Chief Executive Officer (CEO) who will be responsible to the Board for the performance of his or her functions. The first CEO will be the person holding the post of Director General immediately before the Board is established but this appointment will be a matter for the Board thereafter.

The General Scheme was published on 17th May 2018 and on 19th July 2018, the Minister for Health, Simon Harris, announced the Government's approval for the publication of the *Health Service Executive (Governance) Bill 2018*. In the [Press Release](#)² announcing the publication of the Bill, Minister Harris said:

I have no doubt that a Board governance structure, with strong skills and experience will make a critical difference in building HSE oversight and performance pending its further reorganisation. The recruitment campaign to select the Chairperson of the Board is underway and he or she will play a central part in the direction, leadership and corporate and clinical governance of the HSE, during a period of complex change.

The Department of Health had requested and was granted a waiver on pre-legislative scrutiny by the Joint Committee on Health.

The Bill responds directly to a recommendation of the [Oireachtas Committee on the Future of Healthcare \(Sláintecare Report\)](#), which concluded that the current Directorate governance structure within the HSE is not fit for purpose.³ The re-establishment of independent board oversight is one part of a broader package of recommendations in the Sláintecare Report that are intended to improve governance, leadership and accountability in the health service.

² Department of Health, Minister Simon Harris announces Government approval to publish the Health Service Executive (Governance) Bill 2018, 19th July 2018 - Minister Simon Harris announces Government approval to publish the Health Service Executive (Governance) Bill 2018 [accessed 2.8.2018]

³ ³ Houses of the Oireachtas Committee on the Future of Healthcare, *Sláintecare Report*. (Dublin: May 2017) p.84

<https://webarchive.oireachtas.ie/parliament/media/committees/futureofhealthcare/oireachtas-committee-on-the-future-of-healthcare-slaintecare-report-300517.pdf>

The HSE is a large organisation of over 100,000 people and is the body with statutory responsibility for the management and delivery of health and personal social services in the Republic of Ireland. Figure 1.1 below provides a snapshot of HSE data from 2016:

Figure 1.1 – The Health Service Executive ‘at a glance’ (2016)

HSE 2016	Total
Emergency department attendances	1,296,571
In-patience & day cases	1,692,009
Out-patient attendances	3,327,526
Health service personnel employed by the HSE	107,085
Total public health expenditure (millions of €)	€15,004⁴
Total health expenditure as a % of GDP/GNI	11% (7.7% public; 3.3% private)

(Source: Department of Health, *Health in Ireland: Key Trends*, 2017)

This Digest will examine the current governance structure of the HSE, while outlining the leadership and reform provisions of the Sláintecare report (2017). A scoping of the international literature on the principles of health systems governance – with a particular focus on boards of governance for health – will guide consideration of good practice, and [The Code of Practice for the Governance of State Bodies \(2016\)](#) provides the benchmark against which provisions of the Bill are analysed.

⁴ Total public health expenditure increased by 3% between 2016 and 2017 from €15,004 (millions of €) to €15,463 (millions of €). Data in all other categories is from 2016.

Policy Context

The HSE was established under the *Health Act 2004* as the body with statutory responsibility for the management and delivery of health and social services in the Republic of Ireland. The programme of reform undertaken in 2005 replaced 11 Health Boards with one single governing authority responsible for the administration, management and execution of health policy, while the Department of Health remained responsible for the development of health policy. As outlined in the *Health Act 2004* the objective of the HSE⁵ is 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.

The *Health Act 2004* also provided for the establishment of a board of management consisting of 11 members including a Chairperson to be appointed by the Minister. The person holding the position of chief executive is automatically appointed to the Board by virtue of his or her position. Under section 12 of the Principal Act, the Board was the HSE's governing body, delegating to the chief executive, while informing the Minister of matters it considered may require the Minister's attention.

As part of a broader process of health reform, the Programme for Government in 2011 committed to a single tier health service based on universal health insurance. It was envisaged that the HSE would cease to exist over time with its functions returning to the Minister for Health. The rationale underpinning calls for health service reform were rooted in sustained criticism of the HSE. Almost since its inception, the HSE has been subject to "high levels of controversy and criticism, whether justified or not"⁶: failures of management, oversight and governance have been particularly emphasised.⁷ The 2008 review of the Irish public service by the Organisation for Economic

⁵ Irish Statute Book, Health Act 2004 <http://www.irishstatutebook.ie/eli/2004/act/42/section/7/enacted/en/html#sec7>

⁶ M MacCarthaigh, P. and Turpin, *When, why and how to set up a state agency: the case of the Road Safety Authority*, Irish Journal of Public Policy Volume 3 (2) (2011), available at: <http://publish.ucc.ie/ijpp/2011/02>

⁷ Health Information and Quality Authority, Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise, (May 2015) http://vhllms-a01/AWData/Library2/PortlaoiseHospitalHIQAInvestigationSummary_165751.pdf; T. Christensen, States Under Pressure: Institutional Adaptation to New Policy Challenges Presentation to the ECPR Regulatory Governance Standing Group Biennial Conference 17-19 June 2010. http://regulation.upf.edu/index.php?id=dublin_2010-papers; T. McNamara, "Review of Developments, Structure and Management in the Public Sector 2011." Administration, (2012) Volume 59, No.4 2012, pp. 42-45 (section on „The HSE and its future“); Health Service Executive, External Independent Clinical Review of the Maternity Services at Portlaoise Hospital, Ballinasloe (PUH) and of 18 perinatal events which occurred between March 2008 and November 2014. Published April 2018, <http://www.saolta.ie/sites/default/files/publications/Clinical%20Review%20of%20Portlaoise%20Maternity%20services%202018.pdf>

Cooperation and Development (OECD) recommended (in the context of governance generally) that⁸

... greater clarity needs to be provided about the implementation role and responsibility of the HSE, which needs to be in line with the policy direction set by government and the Minister for Health and Children.

In a subsequent review of regulatory practices, the OECD⁹ urged Ireland to undertake,

...a broader review of government agencies, focusing not so much on savings but aiming to strengthen their governance framework to maximise efficiency and effectiveness, as well as to clarify the functions which are most appropriately delegated, would be a helpful further step.

The Health Service Executive (Governance) Act, 2013

At a meeting of the Board of the HSE in 2012, then Minister for Health, James Reilly TD, requested the resignation of Board members, while subsequently establishing an interim governance structure made up of senior officials from the Department and the HSE. The *Health Service Executive (Governance) Act 2013* formally abolished the Board of the HSE and provided for a Directorate to be the new governing body. The rationale underpinning this restructuring was that it would allow for the reorganisation of services to prepare the way for a ‘money follows the patient principle’ and the introduction of Universal Health Insurance.¹⁰ The abolition of the HSE Board constituted a first step towards a “process of dismantling the HSE, evolving it into a Health Commission” as outlined by The Programme for Partnership Government in 2016.¹¹ The 2013 Act provided for a Director General and six new Directorates that were aligned to specific areas of service provision such as primary care, mental health, and hospitals. It replaced the chief

⁸ Ireland: Towards an Integrated Public Service OECD Public Management Reviews OECD 2008, pp. 268, available at: <http://www.oecd.org/ireland/oecdpublicmanagementreviews-irelandtowardsanintegratedpublicservice.htm#3>

⁹ OECD (2010), *Better Regulation in Europe: Ireland 2010*, Better Regulation in Europe, OECD Publishing, Paris, <https://doi.org/10.1787/9789264095090-en>.

¹⁰ Health Service Executive Media Centre, *Statement on Health Service Executive (Governance) Bill 2012* (Wednesday 18th July 2012) -

<https://www.hse.ie/eng/services/news/media/pressrel/newsarchive/2012archive/july2012/goverancebill.html> [accessed 14th May 2018]

¹¹ The Programme for Partnership Government, May 2016: 60

executive function with a Director General who was both a member and Chairperson of the Directorate. As Chairperson, the Director General was accountable to the Minister on behalf of the Directorate with communication facilitated through the Secretary General of the Department of Health.

The *Health Service Executive (Governance) Act 2013* aimed to put in place a more direct line of accountability between the HSE and the Minister. During the Second Stage Dáil debate on the *Health Service Executive (Governance) Bill* in January 2013, former Minister of State at the Department of Health, Roisín Shortall TD, described the HSE as an “*amorphous body with no clear lines of responsibility, no clear demarcation between service areas and a lack of transparency in its functions*”¹² She went on to outline concerns about the proposed Directorate structure in which the Director General would report to his or her own management team in the boardroom, who in turn reported to the Director General outside the boardroom:¹³

With a normal governance structure, the management team reports to the CEO and the CEO reports to the board. In the very unusual arrangement regarding the governance of the HSE, the Director General is answerable to the directors in the boardroom of the HSE but when they go outside the boardroom, the accountability is reversed because the appointed directors are part of the management team and are answerable to the director general. It is absolutely unworkable because it is one way inside the boardroom and the reverse outside it. It is not only unworkable but unacceptable and highly unorthodox.

In the same debate, some deputies welcomed the Bill particularly the new structure, which some suggested would bring operational decisions closer to the point of service delivery¹⁴ but others were deeply critical of the Bill, arguing that it would not remedy the problems in the HSE.

Notwithstanding a mixed reception to the *Health Service Executive (Governance) Bill 2013*, it was passed into law on 3rd July 2013.

¹² Dáil Debates, Thursday 31st January 2013, Health Service Executive (Governance) Bill 2012: Second Reading

<http://debatesarchive.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2013013000028?opendocument>

¹³ Ibid.

¹⁴ Ibid

The Current Structure

The broad structure of accountability provided by the *Health Service Executive (Governance) Act 2013* extended the Minister's powers to direct policy and established additional accountability mechanisms:

- The Director General is currently required to inform the Minister of measures taken by the HSE through the Secretary General of the Department of Health;
- The Minister may set performance targets and issue directions to the HSE with regard to policy objectives but he/she may not issue specific instructions in relation to individual service users;
- The Director General is required to inform the Minister of measures taken to comply with Ministerial directions for health policy implementation;
- The Act provides for the establishment of an audit committee which must advise the Director General on financial matters, and report at least annually to the Director General. This Report must be provided to the Directorate and the Minister.

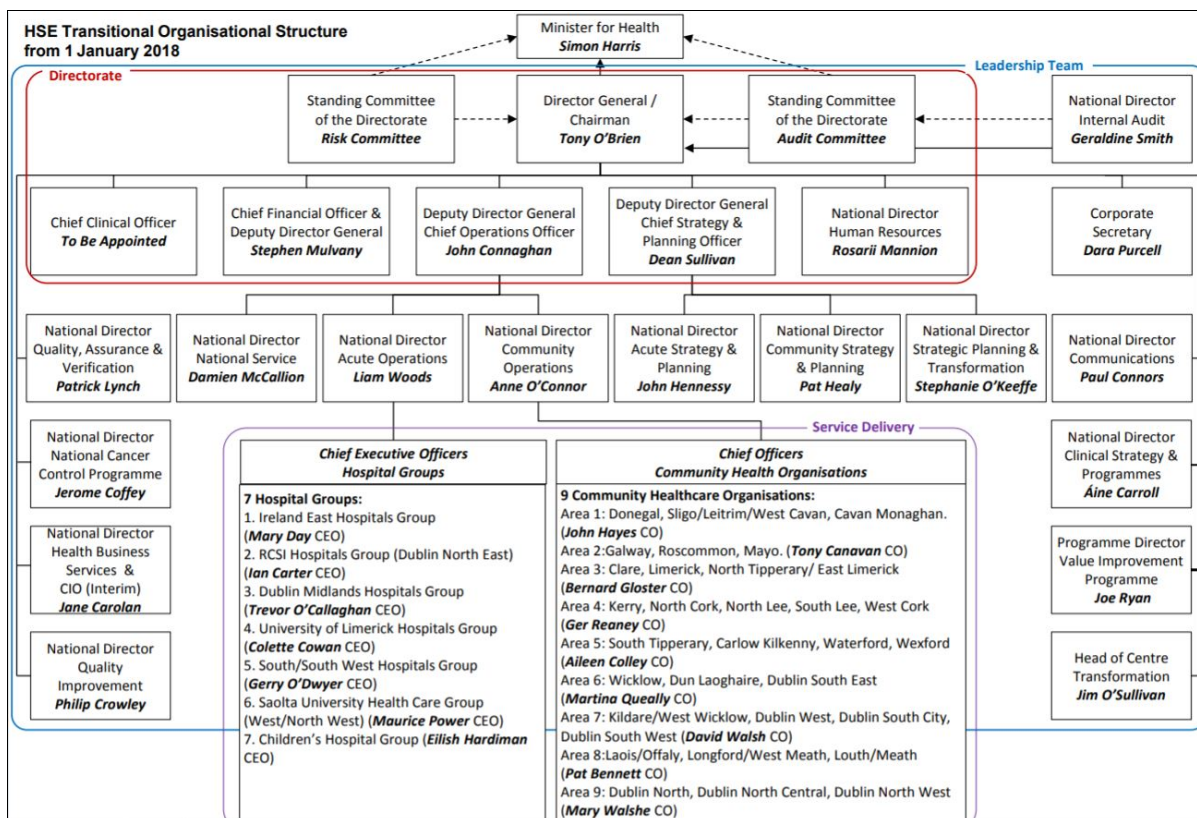
The 2013 Act further stipulated that the number of persons appointed to the Directorate at any time must be no fewer than two or greater than eight, while the Director General is also the Chairperson of the Directorate. Other members of the Directorate may be appointed by the Minister from persons employed as HSE National Directors. The Directorate as a collective is the governing body of the HSE with authority to perform the operational functions of the HSE and is accountable to the Minister for performance. The Director General as Chairperson reports to the Minister and is responsible for managing the HSE, while the Leadership Team and their supporting structures implement operational targets. A number of Committees have been established to support the work of the Directorate including an Audit Committee and a Risk Committee, each of which comprises one appointed National Director and external nominees. These Directorate Committees act in an advisory capacity and have no executive function.¹⁵ The current Directorate structure of the HSE as described herein is illustrated by *Figure 1.2 Health Service Executive Transitional Organisational Structure, 2018*.

The *Health Service Executive (Governance) Act 2013* recognised that neither the Directorate nor the Director General could exercise all of these functions personally and provides for a formal system of delegations under Sections 16C and 16H. As such, a *Delegations Policy Framework* sets out the policy architecture that underpins good governance throughout the HSE. The objective

¹⁵ Health Service Executive, *Building a Better Health Service Annual Report and Financial Statements* (Dublin: 2016) p.10-11 <https://www.hse.ie/eng/services/publications/corporate/annual-report-and-annual-financial-statements-2016.pdf> [accessed 14th May 2018]

of such a system of delegation is to ensure that relevant managers and HSE personnel are delegated/sub-delegated appropriate legal authority to carry out statutory functions.¹⁶

Figure 1.2 Health Service Executive Transitional Organisational Structure, 2018¹⁷



Any delegated function that is carried out by an employee of the HSE “has the same force and effect as if it was carried out by the Director General.”¹⁸

Under the *Health Act 2004*, the HSE is required to have a [Code of Governance](#) in place. The principles and practices associated with good governance were updated in 2015 and are compliant with the requirements of the [Code of Practice for the Governance of State Bodies \(2016\)](#)¹⁹. The HSE Code describes the governance, structures and organisational processes together with the policies, procedures, protocols and guidelines that are in place to ensure good governance throughout the organisation. The Chairman of the Directorate confirms when submitting the annual report to the Minister that the HSE has complied with the key reporting requirements in the *Code of Governance for State Bodies*.²⁰

¹⁶ Health Service Executive, *Delegation Policy Framework and Governance Arrangements* (National Delegations Office, Limerick: 2015) p.3-4 <https://www.hse.ie/eng/about/who/delegations-office/delegation-framework-and-government-arrangements.pdf>

¹⁷ Health Service Executive, *Organisational Structure, 2018* - <https://www.hse.ie/eng/about/who/hse-organisational-structure.jpg> [accessed 14th May 2018]

¹⁸ HSE, *Delegation Policy Framework*, 2015: 4

¹⁹ HSE, *Code of Governance* (2015)

<https://www.hse.ie/eng/about/who/directoratemembers/codeofgovernance/hsecodeofgovernance2015.pdf> [accessed 14th May 2015]

²⁰ HSE, *Code of Governance* (2015), p. 4

New Governance Recommendations: Sláintecare Report

In June 2016, the [Oireachtas Committee on the Future of Healthcare](#) was established to develop political consensus on a long-term policy direction for Ireland's healthcare system. The Committee considered how best to ensure that everyone has access to an affordable, universal, single-tier healthcare system, in which patients are treated promptly on the basis of need, rather than ability to pay.²¹ The [Sláintecare Report](#) envisages the establishment of a universal single tier health service where patients experience equitable access, while re-orientating the model of care towards primary and community care.

The [Second Interim Report of the Committee on the Future of Healthcare](#) grouped over 150 submissions into thematic categories with governance and management issues, including clinical governance, highlighted as key issues by groups of healthcare professionals.²² Minister for Health Simon Harris, emphasised that he had informed the Sláintecare Committee, that the governance structure provided by the *Health Service Executive (Governance) Act 2013* “does not provide an adequate governance arrangement for the HSE.”²³ This view is reflected in the final report, particularly the need for improved governance and accountability to better deliver an integrated model of care, while leadership, governance and accountability are identified as “critical functions of any health system.”²⁴ The Committee's governance assessment led to the conclusion that,²⁵

...the current HSE governance structure is not fit for purpose. An independent board needs to be put in place.

The Committee consequently recommended that:

- The Minister for Health be held responsible and accountable on a legislative basis for delivery of healthcare, the health system and health reform;

²¹ Houses of the Oireachtas Committee on the Future of Healthcare, *Sláintecare Report*. (Dublin: May 2017) p.9
<https://webarchive.oireachtas.ie/parliament/media/committees/futureofhealthcare/oireachtas-committee-on-the-future-of-healthcare-slaintecare-report-300517.pdf>

²² Committee on the Future of Healthcare, *Second Interim Report of the Committee on the Future of Healthcare*, (January 2017: 8)
https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-01-20_second-interim-report-on-the-future-of-healthcare_en.pdf

²³ Department of Health, *Government to establish new independent Board for the HSE*, Press Release 15th May 2018
https://merriestreet.ie/en/News-Room/News/Government_to_establish_new_independent_Board_for_the_HSE.html

²⁴ Committee on the Future of Healthcare, *Sláintecare Report*, p.84

²⁵ Committee on the Future of Healthcare, *Sláintecare Report*, p.84

- An independent Board and Chair is appointed to the HSE at the earliest opportunity, by the Minister, following a selection process through the Public Appointments Service. Board membership should reflect the skills required to provide oversight and governance to the largest public service in the State;
- The Chair of the Health Service Board must be accountable to the Minister for Health;
- The Health Service Director General is accountable to the Board.²⁶

The re-establishment of independent board oversight is one part of a broader package of recommendations in the Sláintecare Report that are intended to improve governance, leadership and accountability within the HSE. It is envisaged that a new national structure will have overall responsibility for establishing population needs, strategic planning and operational management, while regional structures will be responsible for embedding initiatives for health system strengthening at local level:²⁷



Membership of integrated care organisations in each region will be determined by the 'Health Service National Centre', CHO Chief Officers and Hospital Group CEOs, working with a Sláinte Programme Implementation Office.²⁸ The Committee on the Future of Healthcare emphasised the need for good governance structures that are accessible with reporting structures that promote open communication, integration and adaptation to change. The Joint Committee on the Future of Healthcare envisaged that the delivery of integrated care requires both 'horizontal' co-ordination - involving professional and departmental boundaries, such as interdisciplinary team working – and 'vertical' coordination between primary, secondary and tertiary care domains²⁹.

²⁶ Committee on the Future of Healthcare, *Sláintecare Report*, p.84-85

²⁷ Committee on the Future of Healthcare, *Sláintecare Report*, p.85

²⁸ Committee on the Future of Healthcare, *Sláintecare Report*, p.86

²⁹ Committee on the Future of Healthcare, *Sláintecare Report*, p.73

The Sláintecare Report appears to be generally accepted by Government and the opposition as a blueprint for the development of healthcare over the next decade.³⁰ The Taoiseach, Leo Varadkar, has warned, however, that due to resource constraints, implementation of the Sláintecare recommendations will be slower than anticipated³¹.

Following the publication of the Sláintecare Report in May 2017, Minister of Health, Simon Harris, said:³²

While I don't for one minute believe that structural change will be the panacea for improvement in our health services, I do firmly believe that our current structure is not best serving patients, or indeed staff within our health services

The Minister has emphasised that the *Health Service Executive (Governance) Bill 2018* is brought forward as part of a comprehensive package of recommendations arising from the work of the Committee on the Future of Healthcare (Sláintecare). It is also intended to restore public confidence in the HSE in the wake of the cervical check controversy in which an audit reported that more than 200 cervical screening patients may have benefited from earlier intervention.

³⁰ Dáil Debate, Dáil Éireann debate, Thursday, 22 Jun 2017 <https://www.oireachtas.ie/en/debates/debate/dail/2017-06-22/51/>

³¹ Martin Wall, Fiach Kelly, [Sláintecare may progress at slower pace due to cost restraints](#), Irish Times 23rd July 2018

³² The Health Management Institute of Ireland, Health Manager Website, *Minister to establish HSE board*, <http://www.healthmanager.ie/2017/07/minister-to-establish-hse-board/> [accessed 19th June 2016]

A Scoping of the International Evidence for Good Governance of Health Systems

This section of the Digest will provide an overview of good practice for health systems governance as indicated by the international evidence base, with a particular focus on governing boards of health. This evidence scoping is time-bound and as such is neither comprehensive nor systematic.

The attributes of good governance for health systems

All disciplines and institutions are concerned with governance as it outlines the ways in which various actors function, operate and take decisions for action. [Health 2020](#) is the health policy framework for the World Health Organisation (WHO), European Region, which emphasises the importance of good governance for strengthening health systems and improving the health and wellbeing of citizens. While acknowledging that governance for health is challenging, *Health 2020* emphasises strategic thinking as a core objective while embedding improved leadership and participatory governance for health as a priority action for strategic development across Europe.

In light of this policy priority, the WHO/European Observatory on Health Systems and Policies³³ - an intergovernmental partnership committed to the development of evidence-based health policy - has conducted a comprehensive review of academic and practitioner literature focused on strengthening health system governance throughout Europe. This review has uncovered five attributes - **transparency, accountability, participation, integrity and policy capacity** - as the building blocks of good governance for health systems.³⁴ The **TAPIC** framework is rooted in a whole-of-government approach and has been rigorously tested in a range of European countries. The attributes of good governance are mutually reinforcing and when balanced with other desirable goals, such as effectiveness and efficiency, can realise important gains for health system performance.

Figure 1.3 illustrates the attributes of good governance for health systems, the interventions required to achieve them and the conditions that maximise outcomes for effective health service delivery:

³³ One of the co-authors, Dr. Josep Figueras, is Director of the European Observatory on Health Systems and Policies and provided the Oireachtas Committee on the Future of Healthcare with an international perspective on health systems and universal health throughout the development of the Sláintecare Report (May 2017).

³⁴ Scot L. Greer, Matthias Wismar, Josep Figueras (Eds), *Strengthening Health System Governance: Better policies, stronger performance* (WHO/European Observatory on Health Systems and Policies, 2016) p.xi

Figure 1.3 The TAPIC Framework of Attributes of Good Governance for Health Systems

Attributes of Good Governance	Definition/ What does it mean for health systems?	Delivery Mechanisms	Works best when there is...
Transparency	Health institutions inform the public and other actors about upcoming decisions & the grounds upon which decisions are made.	Watchdog committees; inspectorates; performance management, & clear & useful public information. Specific employees must be charged with responsibility for reviewing and sharing information with relevant bodies. ³⁵ Transparency arrangements should be subject to performance-based measurement using logic models or similar tools.	<ul style="list-style-type: none"> ...support from the highest echelons of government; Independence to investigate any official; Authority to access relevant materials and witnesses; A reputation of having leaders with integrity; Approval from societal members who have the power to undermine efforts; Necessary resources to carry out investigations.³⁶
Accountability	Describes the process of informing & explaining or giving an account of one's actions. Accountability suggests that there should be consequences if actions and explanations are inadequate, particularly if there is a mandate that has been violated.	Financial mechanisms, such as pay for performance; organisational separation & conflict of interest policies; standards & codes of conduct. Ensuring accountability also means creating separate agencies with specific responsibilities to enable greater flexibility & less political oversight, ³⁷ but there is no guarantee that these will be more effective ³⁸	<ul style="list-style-type: none"> ...awareness that too many layers of accountability can interfere with efficiency; A reduction in the number of accountability relationships can make an organisation more effective.
Participation	Stakeholders have access to decision-making so that they acquire a meaningful stake in the work of the institution. Participation offsets the problems that can arise when affected populations have no access to decision making.	Stakeholder forums; consultations; appointed representatives to boards, or the establishment of advisory committees.	<ul style="list-style-type: none"> ... careful consideration around the process of patient or citizen participation due to the risk of high costs; Participation can impose gridlock, bias & polarisation, but also the benefits of greater legitimacy & effectiveness of health policies. An adequate budget must be assigned to ensure they are done well.³⁹
Integrity	Good health system management but it is also synonymous with predictability, anti-corruption, ethics, the rule of law, and clearly defined roles & responsibilities.	Solid & rewarded internal career trajectories; personnel policies, budgets & procedures. Internal & financial audits, procedures, & clear organisational roles & purposes can lessen confusion & make it easier for citizens to accept the legitimacy of the organisation ⁴⁰ .	<ul style="list-style-type: none"> ...a match between integrity in the form of day-to-day controls with effective accountability, so that there is a balance with the need for people to do their jobs. Clear rules that guide the conduct of the board with procedures that clearly and transparently govern board proceedings are critical to the maintenance of public confidence.
Policy capacity	The ability to develop policy that is aligned with resources in pursuit of goals, while turning a political idea into a well thought-out proposal.	Specific technical resources at the disposal of a senior policy-maker: that is a small number of highly skilled people who develop regulatory frameworks to produce the best possible outcomes. ⁴¹	<ul style="list-style-type: none"> ...strong research and analytical capacity among suitably experienced staff who are affiliated with a broader research community. Performance information is central to strong policy leadership as it enables policy makers to identify problems in good time.

³⁵ Lillvis et al, *Strategies for policy success*, 2016: 58

³⁶ Lillvis et al, *Strategies for policy success*, 2016: 58

³⁷ Christopher Pollitt, *New Labour's re-organization: hyper-modernism and the costs of reform – a cautionary tale*, Public Management Review, (2004) 9: 529–43.

³⁸ Amanda Jane Smullen. *Translating Agency Reform: Rhetoric and Culture in Comparative Perspective*. (Basingstoke: Palgrave Macmillan, 2010) p.3

³⁹ Greer et al, *Strengthening Health System Governance* (2016: 37);

⁴⁰ Lillvis et al, *Strategies for policy success*, 2016: 78

⁴¹ Scott L. Greer, Matthias Wismar, Josep Figueras and Charlotte McKee, *Governance: A Framework*, in Scot L. Greer, Matthias Wismar, Josep Figueras (Eds), *Strengthening Health System Governance: Better policies, stronger performance* (WHO/European Observatory on Health Systems and Policies, 2016) p 31-40

Getting the right mix of attributes for good governance

While the above described attributes of accountability, transparency, participation, integrity and policy capacity are associated with positive outcomes, their implementation may interfere with other desirable goals including speed, efficiency, effectiveness, flexibility, creativity, empowerment, and innovation. Some authors warn that the strict application of governance frameworks can undermine their usefulness - resulting in systems that are too rigid to respond to the demands of effectiveness and efficiency. Top-down policies can compromise legitimacy of service provision but the process of enabling participation is very often costly and time consuming. Accountability can also result in costs if there are too many accountability mechanisms built into the system – for example, too many inspectorates visiting a hospital may inhibit staff capacity to fulfil their primary health care function. Transparency can also become problematic if it is taken to mean more than clarifying decisions and the basis of those decisions. Extensive transparency about the decision-making process facilitates well-resourced interests to intervene to a damaging extent and this is particularly a problem when there is an imbalance of both resources and access between interest groups. The European Observatory concludes that it may be best to avoid health policies that demand unrealistically effective governance arrangements. It is also best to remedy governance deficiencies before implementing policies that make significant demands on governance structures. Greer *et al*⁴² conclude that,

Successful innovation and bureaucratic effectiveness come from having the right amount [of good governance procedures], so that an organization is embedded in its environment but still autonomous enough to take action.

The role of politicians in achieving good governance for health systems

A number of studies emphasise health governance relationships that are responsive to patient needs, preferences and demands.⁴³ This relationship between patients and health care providers is operationalised through citizen mechanisms that hold public officials to account such as

⁴² Greer *et al*, Governance: A Framework, 2016: 41

⁴³ Researchers at the Liverpool School of Tropical Medicine conducted a systematic review of the literature in 2016 to describe the concept of governance as it is applied to health systems. They identified 16 frameworks that had been developed to assess governance in the health system. The focused on frameworks originating from political science and public administration that are interested in the way that collective decisions are made and accounted for. Thidar Pyone, Helen Smith and Nynke van den Broek, *Frameworks to assess health systems governance: a systematic review*, Health Policy and Planning, 32, 2017, 710–722 doi: 10.1093/heapol/czx007 Advance Access Publication Date: 3 March 2017; Brinkerhoff *et al*, Health governance, 2013: 687

community initiatives that lobby local representatives, health-focused civil society organisations with expertise in budget monitoring and service delivery report cards, or ‘cyberactivism’ that taps collective national and international patient experiences.⁴⁴ Health care is an issue that is often of interest to politicians, as it touches the lives of almost all constituents. In this regard, policy makers act as important actors in good governance for health in specifying objectives and standards, while agreeing resources and support. Policy makers are primary actors in terms of setting the parameters of accountability and may influence incentives for compliance; pay for performance is a tool that a number of countries are experimenting with as a means of improving health system governance.⁴⁵

Factors that contribute to effective boards and quality of care

In 2017, the HSE developed [A Board’s Role in Improving Quality and Safety Guidance and Resources](#), which provides practical guidance for boards of management to help them discharge their responsibilities for quality and safety in healthcare. It aims to assist new and existing boards in using practices which support “positive decision-making, governance and accountability; where service users’ needs come first in driving safety, quality and cultures of person centeredness.”⁴⁶ The guidance draws on the international evidence base to better align governance structures with improved patient safety and quality of care goals. It is based on studies conducted in the United States (US) and the United Kingdom (UK) that have linked the composition and governance of state boards to patient safety outcomes.⁴⁷ Oversight of patient safety at board level coupled with strong leadership from the CEO (Director General) is associated quality improvement and patient safety.⁴⁸ Boards that prioritise patient safety are those that tend to set strategic goals for quality

⁴⁴ Brinkerhoff et al, *Health governance*, 2013: 687

⁴⁵ C. Eldridge, N. Palmer, *Performance-based payment: some reflections on the discourse, evidence and unanswered questions*. Health Policy and Planning (2009) 24: 160–6. R. Eichler, P. Auxila, U. Antoine, B. Desmangles. *Performance-based Incentives for Health: Six Years of Results from Supply-side Programs in Haiti*. Working Paper No. 121. (Washington, DC: Center for Global Development, 2007)

⁴⁶ Health Service Executive, Quality Improvement Division, *A Board’s Role in Improving Quality and Safety Guidance and Resources* (September 2017: 3) <https://www.hse.ie/eng/about/who/qid/governancequality/board-role-improving-quality-and-safety/a-board-s-role-in-improving-quality-and-safety-guide-final.pdf>

⁴⁷ Millar Ross, Russell Mannion, Tim Freeman, and Huw Davies, *Hospital Board Oversight of Quality and Patient Safety: A Narrative Review and Synthesis of Recent Empirical Research*. The Milbank Quarterly (2013) no. 4: 738. JSTOR Journals, EBSCOhost (accessed May 17, 2018); Jha, A.K., and A.M. Epstein. *Hospital Governance and the Quality of Care*. Health Affairs (2010) 29(1):182–87; Jha, A.K., and A.M. Epstein. *Governance around Quality of Care at Hospitals That Disproportionately Care for Black Patients*. Journal of General Internal Medicine (2012) 27(3):297–303; Joshi, M.S., and S. Hines. *Getting the Board on Board: Engaging Hospital Boards in Quality and Patient Safety*. Joint Commission Journal on Quality and Patient Safety (2006) 32(4):179–87; Kroch, E., T. Vaughn, M. Koepke, et al. *Hospital Boards and Quality Dashboards*. Journal of Patient Safety (2006) 2(1):10–19.

⁴⁸ Conway, J. *Getting Boards on Board: Engaging Governing Boards in Quality and Safety*. Joint Commission Journal on Quality and Patient Safety (2008) 34(4):214–20; Gautam, K.S. *A Call for Board Leadership on Quality in Hospitals*. Quality Management in Health Care (2005) 14(1):18–30; Healthcare Commission. *Safely Does It: Implementing Safer Care for Patients*. London (2009); Sandrick, K. *One Giant Leap for Quality. When Boards Get behind Quality Initiatives, Patient Care Benefits*. Trustee (2005) 58(3): 22–24. Schyve, P.M. *What You Can Do: The Trustee, Patient Safety, and JCAHO*. Trustee (2003) 56(2):19–21.

improvement and demand reports on the progress of remedies in the wake of adverse events⁴⁹. A national survey of 722 Chairpersons of hospital boards in the US found that respondents from low-performing hospitals were less likely than those from high performing hospitals to publicly disseminate goals or to perceive themselves as having an important impact on the organisation.⁵⁰ This study also found that most boards were largely focused on financial issues, while assuming that the quality of care was adequate.

Policy capacity, as outlined above, proved to be central to good governance and decision making in these studies: The ability of a board to make key decisions is determined by the quality of the data provided but also by members' capacity to process and interpret information. Clear data and expert advice assists board-level decision making for quality and patient safety⁵¹. Evidence from U.S. hospital surveys indicates that boards that regularly review and track their organisation's performance are more likely to have better patient outcomes.⁵² It is important to note that board chairs in both US and UK studies have tended to hold exaggerated views about the performance of health institutes for which they have oversight responsibilities compared to the findings of reviews conducted by external agencies. Hence, it is important to ensure that there are mechanisms in place that operate internal board oversight including monitoring and evaluation mechanisms.

The literature is increasingly interested in board oversight of patient safety, with findings from US hospitals pointing to the need to have quality of care and patient safety as a standing item on a board's agenda.⁵³ Boards that spent 20 percent or more of meeting time on quality tended to report better process-of-care rates⁵⁴ than hospitals whose boards spent less time on quality.⁵⁵ This finding corresponds with the Healthcare Commission report in the UK that found that patient safety and clinical quality of care rarely featured on board agendas, while a later study found that these issues were considered less important than financial and organisational matters or the need to

⁴⁹ Jiang, H.J., C. Lockee, K. Bass, and I. Fraser. Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders. *Journal of Healthcare Management* (2008) 53(2):121–34

⁵⁰ Jha and Epstein, *Hospital Governance and the Quality of Care* (2010)

⁵¹ Bader, B.S. Best Practices for Board Quality Committees. *Great Boards*. (2006) Available at http://www.greatboards.org/newsletter/reprints/Board_quality_committees_best_practices.pdf

⁵² Jiang, H.J., C. Lockee, K. Bass, and I. Fraser. Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders. *Journal of Healthcare Management* (2008) 53(2):121–34; Jiang, H.J., C. Lockee, K. Bass, and I. Fraser. Board Oversight of Quality: Any Differences in Process of Care and Mortality? *Journal of Healthcare Management* (2009) 54(1):15–30.

⁵³ Jha and Epstein, *Hospital Governance and the Quality of Care* (2010)

⁵⁴ "Process of care denotes what is actually done in giving and receiving care, i.e. the practitioner's activities in making a diagnosis, recommending or implementing treatment, or other interaction with the patient." Source: Jan Mainz; Defining and classifying clinical indicators for quality improvement, *International Journal for Quality in Health Care*, Volume 15, Issue 6, 1 December 2003, Pages 523–530, <https://doi.org/10.1093/intqhc/mzg081>

⁵⁵ Jiang *et al*, *Board Oversight of Quality*, 2009.

meet government targets.⁵⁶ Board members also report a low level of understanding of information covering quality of clinical care with some studies pointing to a need for board members to be initiated and trained in these areas to ensure that there is appropriate oversight of quality of care issues.⁵⁷ The formal structure of boards is also important for oversight of patient safety with studies in the US indicating that boards with a separate quality committee are more likely to perform well in this regard.⁵⁸ Patient safety and quality of care is optimised when systemic and organisational factors are aligned with clinical efforts.⁵⁹

An approach to good governance for health: the NHS Board

The NHS England Board consists of a Chair and eight non-executive directors and four voting executive directors. The executive directors who are also members of the Board hold the following posts: the National Director of Transformation and Corporate Operations; the National Director of Strategy and Innovation; the National Director of Operations and Information; the National Medical Director, the Chief Nursing Officer and the Chief Financial Officer. While time is put aside for a private 'closed' meeting of Board members, the meetings of the NHS England Board are live streamed although members of the public do not take part. In the interests of openness and transparency, the NHS Board conducts as much of its business as possible in such a way that members of the public are welcome to attend. The Board is responsible for financial stewardship, strategic planning and holds the Executive to account. The chairperson acts as the NHS Accounting Officer and is accountable to Parliament for annual health service funding.

The [Healthy NHS Board: principles for good governance](#) was developed by the National Leadership Council (NLC) to bring the latest research, evidence and thinking together to encourage boards across the system to make use of the guide as they work to address the challenges of improving quality for patients. It is broadly comparable with the HSE's [A Board's Role in Improving Quality and Safety Guidance and Resources](#). The role of the NHS board is threefold: 1. to develop strategy; 2. to ensure accountability, and 3. to shape culture.⁶⁰

⁵⁶ Machell, S., P. Gough, D. Naylor, V. Nath, and K. Steward, *Putting Quality First in the Boardroom: Improving the Business of Caring*. (London: King's Fund, 2010)

⁵⁷ Joshi *et al*, *Getting the Board on Board*, 2006.

⁵⁸ Bader, B.S. *Best Practices for Board Quality Committees*. *Great Boards* (2006) Available at http://www.greatboards.org/newsletter/reprints/Board_quality_committees_best_practices.pdf (

⁵⁹ Health Service Executive, Quality Improvement Division, *A Board's Role in Improving Quality and Safety Guidance and Resources* (September 2017: 9-10) <https://www.hse.ie/eng/about/who/qid/governancequality/board-role-improving-quality-and-safety/a-board-s-role-in-improving-quality-and-safety-guide-final.pdf>; Vincent, C. *Patient Safety*. (London: BMJI Books, 2011); Ross *et al*, *Hospital Board Oversight of Quality and Patient Safety*, 2013, p. 760;

⁶⁰ NLC, *Healthy NHS Board*, p.9

Figure 1.4 - A summary of the evidence-base for health systems governance

- Systematic reviews of health system governance find that **transparency, accountability, participation, integrity and policy capacity** are the defining attributes of good governance but they frequently interfere with other desirable goals including **speed, efficiency, effectiveness, flexibility, creativity, empowerment, and innovation**;
- Strict application of governance frameworks can undermine their usefulness resulting in systems that are too rigid to respond to the demands of effectiveness and efficiency. Successful health systems are those that have right amount of core attributes to be embedded in the operating environment but still autonomous enough to take action in an efficient way;
- The process of patient/citizen participation in health system governance should be carefully considered due to the risk of high costs, potential to impose gridlock, bias and polarisation, but also the benefits of greater legitimacy and effectiveness of health policies;
- Studies in the US and the UK have linked the composition and governance of boards to outcomes in terms of patient safety, with higher performing boards clearly linked to better patient outcomes;
- Oversight of patient safety at board level coupled with strong leadership from the CEO is associated quality improvement and patient safety;
- Boards that prioritise patient safety are boards that tend to set strategic goals for quality improvement and demand reports on the progress of remedies in the wake of adverse events;
- Clear rules that guide the conduct of board members with procedures that clearly and transparently govern board proceedings are critical to the maintenance of public;
- The ability of a board to make key decisions is determined by the quality of the data provided but also by members' capacity to process and interpret information;
- Ensuring an organisation has strong research & analytical capacity among experienced staff who are affiliated with a broader research community, helps to offset potential problems;
- Policymakers are primary actors in terms of setting the parameters of accountability and may provide incentives for compliance;
- Mechanisms must be in place to ensure internal board oversight;
- Patient safety and clinical quality of care rarely feature on board agendas and studies have found that these issues were considered less important than financial and organisational matters or the need to meet government targets;
- Boards with a separate quality committee are more likely to perform well in this regard;
- Patient safety and quality of care is optimised when systemic and organisational factors are aligned with clinical efforts.

Principal Provisions of the Bill

This section of the Bill Digest examines selected key provisions of the Bill. It assesses these provisions in the context of the evidence base as presented in the previous chapter, where possible, and the [Code of Practice for the Governance of State Bodies \(2016\)](#) – hereafter called the *Code of Practice*.

Part 1 of the Bill contains a number of standard provisions including the short title and collective citation of the Bill. It also provides for the repeal of Part 3A of the [Health Act, 2004](#) which governed the original HSE Board before the [Health Service Executive \(Governance\) Act 2013](#) instituted the Directorate governance structure.

Changes to terminology

A number of sections in the Bill (including sections 4, 5, 6, 16, 17 and 23) seek to amend, insert or delete definitions in the *Health Act 2004* to reflect the structural changes proposed in the Bill, for example the substitution of “the Chief Executive Officer” for “the Director General” and the deletion of the definition of Committee of Public Accounts in section 28 of the Principal Act.

The HSE Board

Section 7 of the Bill proposes to insert a new Part 3B, **sections 16N to 16U**, into the 2004 Act which contains provisions in relation to the membership and role of the new HSE Board.

Membership of the Board

Section 16N(1) provides for a board of management for the HSE composed of a chairperson, a deputy chairperson and seven ordinary members, all of whom will be appointed by the Minister. The appointment of members by the Minister will be made in accordance with the Minister’s opinion as to the requisite level of experience and expertise. The Bill also proposes that the Minister, in so far as practicable, endeavours to ensure that there is an equitable balance between men and women on the Board. A person is not eligible for membership of the HSE Board, or a Committee of the Board, if he/she is a member of either Houses of the Oireachtas or the European Parliament, or elected to the European Parliament to fill a vacancy. A person is also ineligible for Board membership if he/she is a member of a local authority.

It is proposed that the chairperson, deputy chairperson and ordinary members will hold office for no more than 5 years from the date of appointment. Four of the ordinary members will hold office for a period of three years from the date of appointment, while three ordinary members will hold office for a period of five years. Those who hold office for three years must be selected by unanimous agreement of the ordinary members. In the event that agreement cannot be reached for whatever reason, it is proposed that ordinary members may draw lots to select members who will hold office for three years. The Bill also provides that a member of the Board whose term of office expires may be eligible for reappointment but such a person may not serve more than two consecutive terms or more than ten years. Members may resign from the Board by means of a letter sent to the Minister.

The Bill provides for the removal of Board members by the insertion of a new **Section 16R** into the 2004 Act. This section specifies conditions which may prompt the removal of a member of the Board from office or the automatic cessation of membership of the HSE Board. The removal of a member from the Board must be undertaken by the Minister and may occur if, in the Minister's opinion, a member is incapable of performing his or her duties due to:

- ill health;
- misbehaviour; or
- unethical conduct including under **Section 25 (1) of the 2004 Act (to be amended by section 11 of the Bill)** which stipulates that "a person shall maintain proper standards of integrity, conduct and concern for the public interest."⁶¹

A member may automatically cease to hold office in the event that he or she is bankrupt, makes an arrangement with creditors, is convicted of a serious offence or an offence involving fraud or dishonesty. Membership of the HSE Board will also cease if a member, for whatever reason, is sentenced to:

- a term of imprisonment;
- is the subject of a disqualification order under Section 160 of the Companies Act 1990 or Part 14 of the Companies Act 2014;
- or has been removed from a professional register by a competent authority⁶².

A member will also cease to be a member where he or she has failed to attend Board meetings for a consecutive period of 6 months.

⁶¹ Section 25 (1), Health (Amendment) (HSE Board) General Scheme 2018

⁶² Except for non-payment of a fee.

Alignment of Board membership provisions with the evidence base and the Code of Practice

The *Code of Practice* stipulates that Board appointments must be made in compliance with the Public Appointments Service process set down in the [Guidelines on Appointments to State Boards \(2014\)](#) published by the Department of Public Expenditure and Reform, except “where the manner of such appointment is otherwise prescribed in the specific statutory provisions relating to the State body.”⁶³ The appointment of members to the HSE Board will be governed by the *Guidelines on Appointments to State Boards*, which provides that the appointment of candidates is a matter for the Minister, while appointees should not serve on more than two state boards or serve more than two full terms. Furthermore, at the time of the appointment of new members of state boards, it is required that information will be published by, in this case, the Department of Health.⁶⁴

The *Code of Practice* provides that a chairperson is responsible for leadership of a board and ensuring its effective performance, management and oversight. The chairperson must also set standards in terms of culture, values, and behaviours throughout the organisation and should inform the Minister of Health in the event that particular skills are missing from the Board. It is also the responsibility of the chairperson to provide the Minister with a comprehensive report on the performance of the Executive at least annually. Provisions governing the removal of Board members are also broadly consistent with ethical standards as outlined in the *Code of Practice*, although these standards are not explicit.

These provisions are also consistent with the international evidence which suggests that reasons for membership termination must be clear to boards of governance for health. Performance-based measurement is an assessment of programme results and efficiency and could also be used to assess whether or not the HSE Board is keeping its promises to the public.

⁶³ Department of Public Expenditure and Reform, Code of Practice for the Governance of State Bodies, (August 2016) p.24
<https://www.per.gov.ie/en/revised-code-of-practice-for-the-governance-of-state-bodies/>

⁶⁴ Department of Public Expenditure and Reform, Guidelines on Appointments to State Boards, (2014) p.8
https://www.publicjobs.ie/restapi/documents/2014_1125_Guidelines_Appointments_to_State_Boards.pdf

The provisions of the proposed new **section 16N(1)** are consistent with international good practice, which points to the importance of clear processes and procedures governing the appointment of board members. Procedures which outline the optimal number of board members, eligibility criteria, processes of appointment, disclosure of confidential information and procedures that take cognisance of gender equity, contribute to **integrity**, one of the five core attributes of good governance for health systems. However, the Bill has made no provision for the inclusion of a patient representative on the HSE Board. The evidence base is not clear in this regard: on one hand **participation** is a core attribute of health system governance and has been shown to offset problems that can arise when affected populations have no access to the decision making process. The evidence suggests that it is notoriously difficult to identify patient representatives at the policy or governance level. Effective **participation** need not necessarily be met by patient representation at board level but could be met by stakeholder forums; consultations; appointed representatives, or advisory committees (see Figure 5.1). All of these options, when undertaken correctly, are, however, costly and time consuming. Ultimately, there is a need for careful consideration around the process of patient/citizen **participation** in health system governance due to the risks but also benefits that may result.

Policy capacity has proved to be central to good governance and decision making at both organisational and board level, hence it is particularly important that board members demonstrate the capacity to interpret and process sometimes complex information.⁶⁵ The HSE's policy guidance for the selection of Board members urges the inclusion of people with quality / safety expertise from a range of professions.⁶⁶ In selecting Board members, the NHS emphasises the need for members to have a comprehensive understanding of the operating environment with capacities in policy analysis, economics, and law with an appreciation of the institutional landscape, regulation and the wider determinants of health.

Furthermore, NHS Board members' must have the requisite capacity to engage with qualitative and quantitative data and assess information 'in the round'.⁶⁷ Drawing on a Canadian perspective, HSE guidance for quality and patient safety, emphasises selecting people with the right "stuff" (meaning the need for clarity about the skills the organisation needs) while ensuring that adequate training and support is available to grow and develop the skills of Board members.⁶⁸

⁶⁵ Bader, B.S. *Best Practices for Board Quality Committees*. Great Boards. (2006) Available at http://www.greatboards.org/newsletter/reprints/Board_quality_committees_best_practices.pdf

⁶⁶ Health Service Executive, Quality Improvement Division, *A Board's Role in Improving Quality and Safety: Guidance and Resources* (11 September 2017: 20) <https://www.hse.ie/eng/about/who/qid/governancequality/board-role-improving-quality-and-safety/a-board-s-role-in-improving-quality-and-safety-guide-final.pdf>

⁶⁷ NLC, *Healthy NHS Board*, p.9

⁶⁸ HSE, *A Board's Role in Improving Quality and Safety*, 2017: 43

The Role of the HSE Board

Section 16P (as proposed in section 7 of the Bill) outlines the role of the HSE Board which is to act as the governing authority of the HSE replacing the current Directorate structure. The Board is accountable to the Minister for performance and may delegate functions to the CEO and the Board is required to notify the Minister of functions delegated to the CEO. The Board must also inform the Minister of any matter which it considers requires the Ministers attention.

It is proposed that a quorum for a meeting of the Board may be four ordinary members of the Board, preferably the chairperson, deputy chairperson and two ordinary members of the Board. In the event that the chairperson is not present, the deputy chairperson will chair the meeting. An ordinary member of the Board may be appointed to chair the meeting in the event that neither the chairperson nor the deputy chairperson is present.

It is proposed that questions arising during the course of a meeting may be decided by majority vote and the chairperson of the meeting will have a second or casting vote.

Alignment of the role of the Board provisions with the evidence base and the Code of Practice (2016)

These procedural provisions are consistent with the requirements of the *Code of Practice*, which suggests that boards need to be clear about their mandate, while identifying the various functions, roles and responsibilities pertaining to that mandate. It is also clear that a board must be collectively responsible for holding the CEO to account for the effective performance of their responsibilities.⁶⁹

Committees of the HSE Board

The HSE Board may establish advisory committees as provided for by a new **Section 16T** (as proposed in section 7 of the Bill) and is free to determine membership.⁷⁰ Committees are intended to assist and advise the Board and the actions undertaken by a committee are subject to Board approval. The Board may remove a member from a committee at any time for stated reasons or indeed nominate a particular individual to act as chairperson. The Bill further provides that a committee may be dissolved by the Board at any time.

⁶⁹ *Code of Practice*, 2016: 13

⁷⁰ Subject to consideration of a person's knowledge and experience.

Section 20 of the Bill proposes amending **section 40H of the Act of 2004** which provides for the establishment of an audit committee: this is not a new concept as an audit committee is also provided for by the 2004 Act. The proposed audit committee will consist of one Board member and no fewer than 4 other people with relevant skills and expertise⁷¹. At least one person on the audit committee must hold a professional accountancy or auditing qualification. The Board will designate a chairperson and determine the duration of each member's service. The terms and conditions of the committee will be determined by the Board and the CEO, who will furnish the committee with necessary secretarial and other resources to enable it to perform its functions.

The proposed functions of the audit committee are:

- to advise the CEO on financial matters relating to his or her functions and the Board in relation to its functions;
- to report in writing at least once in every year to the CEO and the Board on the activities of the committee in the previous year, and
- to provide a copy of reports to the Board and the Minister.

It is proposed that the audit committee will advise on the following matters:

- the proper implementation by the Executive of Government guidelines on financial issues and compliance with all obligations imposed by law; and,
- the appropriateness, effectiveness and efficiency of the Executive's procedures relating to public procurement, assets, risk management, financial reporting and internal audits.

It is proposed that the audit committee will meet at least four times in each year and may invite any person it considers appropriate (including HSE staff members) to attend a meeting of the committee. The Bill further provides that the CEO of the HSE must ensure that the audit committee is provided with all of the HSE's audit reports, audit plans and monthly reports on expenditure, and must notify the committee of suspected misappropriation of money or other fraudulent activities.

Section 21 of the Bill proposes to insert a new **Section 40 of the Health Act 2004**, which provides that on a day appointed by the Minister the current Audit Committee will be dissolved. It further provides for a number of transitional provisions in respect of anything commenced but not completed by the current Committee and the transfer of any documents and records held by this Committee.

⁷¹ Employees of the HSE are not eligible for appointment as one of these members.

Alignment of committee provisions with the evidence base and the Code of Practice (2016)

The *Code of Practice* includes specific guidance to state boards in making appropriate arrangements for their audit and risk committees, and to assist these committees in carrying out their roles and responsibilities.⁷² The provisions of the proposed **section 40H of the Act of 2004** are consistent with audit and risk guidance as articulated by the *Code of Practice*.⁷³ The establishment of an audit committee is, however, the only committee explicitly provided for by the Bill and while a committee focused on financial matters is important in terms of good governance, the evidence points to a tendency for boards that over-emphasise financial issues to assume that quality of care is adequate.⁷⁴

The HSE's policy guidance - *A Board's Role in Improving Quality and Safety Guidance and Resources (2017)* – and the international evidence is clear with regard to the need for boards to ensure that quality of care and patient safety are standing items on a board's agenda. Boards that spend 20 percent or more of meeting time on quality of care report better outcomes.⁷⁵ The HSE's internal guidance recommends that boards spend a minimum of 25% of meeting time on quality of care and patient safety⁷⁶. Furthermore, studies in the US indicate that boards with a separate quality committee are more likely to perform well in this regard. The Bill does not provide for a committee with a focus on patient safety or quality of care.

Remuneration and expenses of members of Board and Committees

The remuneration and allowances for expenses that may be extended to members of the Board and subcommittees are provided for in the new **Section 16U** (as proposed in section 7 of the Bill) and will be determined by the Minister with the consent of the Minister for Public Expenditure and Reform. Remuneration and allowances for Board and committee members will be paid for by the HSE, while remuneration and allowances for any person appointed by the Minister to conduct an independent review will be paid for by the Minister out of monies provided by the Oireachtas.

⁷² Department of Public Expenditure and Reform, Audit and Risk Committee Guidance, (2016) [accessed <https://govacc.per.gov.ie/wp-content/uploads/Audit-and-Risk-Committee-Guidance.pdf>]

⁷³ Audit and Risk Committee Guidance, 2016: 4

⁷⁴ Jha and Epstein, Hospital Governance and the Quality of Care (2010)

⁷⁵ Jiang et al, Board Oversight of Quality, 2009; Machell, S., P. Gough, D. Naylor, V. Nath, and K. Steward, Putting Quality First in the Boardroom: Improving the Business of Caring. (London: King's Fund, 2010)

⁷⁶ Health Service Executive, Quality Improvement Division, *A Board's Role in Improving Quality and Safety: Guidance and Resources* (11 September 2017) <https://www.hse.ie/eng/about/who/qid/governancequality/board-role-improving-quality-and-safety/a-board-s-role-in-improving-quality-and-safety-guide-final.pdf>

Alignment of remuneration and expenses provisions with the evidence base and the Code of Practice (2016)

The *Code of Practice* contains a separate document guiding good practice for remuneration and superannuation to be observed by state bodies. Chairpersons and boards of all state bodies are required to implement government policy in relation to a total remuneration package which may include basic salary, allowances, and all other benefits in cash or in kind.⁷⁷ The authorised fee levels to be paid to the Chairperson or other members of a board must be laid out in the proposed legislation as is the case here. However, the 'One Person One Salary Rule' was instigated in November 2011 and as such public servants and public sector employees who sit on state boards may not be paid board fees.⁷⁸

Appointment and functions of the Chief Executive Officer (CEO)

The appointment and functions of the CEO of the HSE are covered by the insertion of a new Part 4A, **sections 21A to 21G**, into the 2004 Act (as provided for in section 8 of the Bill). It should be noted, however, that the Bill provides for the current or acting Director General to be deemed the first CEO of the HSE.

Any subsequent appointment of the CEO must be made in line with the provisions of the [Public Service Management \(Recruitment and Appointments\) Act 2004](#).⁷⁹ A person is not eligible for appointment to the role if he or she is a member of the Houses of the Oireachtas or European Parliament including having been elected to the European Parliament to fill a vacancy, and a person may not be a member of a local authority. The terms and conditions of employment including remuneration must be determined by the Board with the approval of the Minister and the Minister for Public Expenditure and Reform. The CEO will not be a member of the Board or any Committee of the Board⁸⁰ and he or she may not hold any other office or employment or carry on any business without the consent of the Board.

Good practice guidance in this regard is clearly outlined in the [Code of Practice for the Governance of State Bodies: Remuneration and Superannuation \(August 2016\)](#). The new **section**

⁷⁷ Department of Public Expenditure and Reform, Code of Practice for the Governance of State Bodies: Remuneration and Superannuation (August 2016) [accessed 25th May 2018] <https://govacc.per.gov.ie/wp-content/uploads/Remuneration-and-Superannuation.pdf>

⁷⁸ DPER, Remuneration and Superannuation, (2016:7)

⁷⁹ The proposed section 21G provides for the appointment by the Board of an acting CEO in certain circumstances, including where the CEO is suspended from office.

⁸⁰ However the CEO may, where in line with any procedures established by the Board, attend, speak and advise at Board and Committee meetings.

21A will allow for continuity between the Directorate structure provided for by the [Health Service Executive \(Governance\) Act 2013](#) and the new structure provided for by this Bill.

Section 8 of the Bill also provides for the insertion of a new **section 21B** into the 2004 Act which governs the resignation, removal or disqualification of the CEO. It provides, among other things, that the Board may remove the CEO from office in certain specified circumstances, including where in the opinion of the Board the removal is “necessary for the effective and efficient performance by the Executive of its functions.”⁸¹ The Board must provide the CEO with a statement of the reasons for his or her removal. The proposed new section also provides a number of scenarios where the CEO will cease to qualify for or hold office, similar to those applicable to Board members (for example, where he or she is sentenced to a term of imprisonment).

The new **section 21C** (as proposed in section 8 of the Bill) outlines the functions of the CEO as follows:

- to carry on, manage, and control generally, the administration and business of the Executive and perform such other statutory functions as are conferred on him or her;
- 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 Executive as the Board may require, and
- to assist and provide the accounting officer with such information (including financial information and records).

The CEO will be accountable to the Board for the “effective and efficient management of the Executive”⁸² and the performance of his or her functions.

Alignment of appointment and functions of the CEO with the evidence base and the Code of Practice (2016)

These provisions are consistent with the requirements of the *Code of Practice*, while the evidence suggests that strong leadership from the CEO is associated with quality improvement and patient safety when combined with specific oversight and management of patient safety at board level.⁸³

⁸¹ Health Service Executive (Governance) Bill 2018: 7

⁸² Ibid

⁸³ Conway, J. *Getting Boards on Board: Engaging Governing Boards in Quality and Safety*. Joint Commission Journal on Quality and Patient Safety (2008) 34(4):214–20; Gautam, K.S. *A Call for Board Leadership on Quality in Hospitals*. *Quality Management in Health Care* (2005) 14(1):18–30; Healthcare Commission. *Safely Does It: Implementing Safer Care for Patients*. London (2009); Sandrick, K. *One Giant Leap for Quality. When Boards Get behind Quality Initiatives*, *Patient Care Benefits*. *Trustee* (2005) 58(3): 22–24. Schyve, P.M. *What You Can Do: The Trustee, Patient Safety, and JCAHO*. *Trustee* (2003) 56(2):19–21.

Delegation of functions

The new **section 21D** (as proposed in section 8 of the Bill) specifies that the CEO may delegate (in writing) any of his or her functions to an employee of the HSE. All delegated or sub-delegated functions occur under the general direction and control of the CEO and do not preclude the CEO from performing the function herself/himself or indeed, revoking the delegation. However, the Board may issue directions to the CEO, with which he or she must comply in relation to the power to delegate functions.

Alignment of delegation functions with the evidence base and the Code of Practice

Boards of management generally delegate functions to CEOs, and the international literature appears to suggest that tensions can arise when the interests of a CEO are not well aligned with those of a board.⁸⁴ This highlights the need for a recruitment process that is clearly aligned with the vision, goals and objectives of the HSE. Effective delegation from the board to the CEO rests on the quality of the relationship, with some studies pointing to problems with delegation when a CEO acquires significant dominance in an organisation.⁸⁵ The international literature is not wholly reliable or clear with regard to the delegation of functions between boards and CEOs, but clear organisational guidelines supporting delegation and devolution of responsibility for decision-making are common within health systems throughout Europe.⁸⁶ While not provided for by this Bill, delegation to expert committees, groups or agencies that employ technical experts is an approach that permits governments to hold experts to account⁸⁷.

Attendance by and accountability of the CEO to Oireachtas Committees

The Governance Framework⁸⁸ outlined in the [Code of Practice](#) illustrates the relationship between the CEO of a state body, the Public Accounts Committee and other Committees of the Oireachtas. The new **section 21E** (as provided for in section 8 of the Bill) proposes that at the written request of a Committee of the Oireachtas (other than the Public Accounts Committee⁸⁹), the CEO of the HSE is required to attend before it to give account of the general administration of the Executive.

⁸⁴ Wienclaw, Ruth A. *Agency Theory and Corporate Governance*. Research Starters: Sociology (2013) (Online Edition) Research Starters, EBSCOhost (accessed May 25, 2018).

⁸⁵ Lecovich, Esther, and Hadara Bar-Mor. *Relationships Between Chairpersons and CEOs in Nonprofit Organizations*. Administration In Social Work 31, (2007) no. 4: 21-40. SocINDEX with Full Text, EBSCOhost (accessed May 25, 2018).

⁸⁶ Iestyn Williams, *The governance of coverage in health systems: England's National Institute for Health and Care Excellence (NICE) in Greet et al, Strengthening Health System Governance* (2016: 159)

⁸⁷ Scott Greer, *Intergovernmental governance for health: federalism, decentralization and communicable diseases in Greet et al, Strengthening Health System Governance* (2016: 197)

⁸⁸ DPER, Code of Governance, 2016: 10

⁸⁹ **Section 34B** (as amended by S17 of the Bill) provides for the appearance of the CEO before the Public Accounts Committee

He or she will not be required to give an account of any matter that is, has been or is likely to be the subject of court/tribunal proceedings but must set out reasons why it will not be possible to give account of a particular issue either in person or in writing. The Bill also provides for more extraordinary circumstances in which a CEO's attendance before a committee of the Oireachtas to speak on a particular matter may be determined by the High Court.

Alignment of accountability provisions with the evidence base and the Code of Practice (2016)

This provision is consistent with requirements of the *Code of Practice* and practice in other jurisdictions, notably in the UK where the CEO of NHS England is frequently required to appear before Select Committees of the House of Commons.⁹⁰

Prohibition of unauthorised disclosure of confidential information

Section 12 of the Bill proposes substituting new provisions on the unauthorised disclosure of confidential information for those contained in section 26 of the 2004 Act. Making any unauthorised disclosure will now be an offence under the 2004 Act and any person convicted of such offence will be liable:

- on summary conviction to a class A fine (i.e. up to a max. of €5,000) and/or a term of imprisonment not exceeding 6 months;
- on conviction on indictment to a fine not exceeding €50,000 and/or a term of imprisonment not exceeding 3 years.

A person must not disclose confidential information obtained in the performance of his or her functions unless required to do so by law or duly authorised by the HSE or the Minister. The meaning of confidential information in the Bill is dependant on the person concerned. In respect of a member of the Board or a Committee of the Board, the CEO, any employee of the HSE, or an adviser engaged by the HSE it means:

- information that is expressed by the HSE to be confidential either as regards particular information or as regards information of a particular class or description; and
- information relating to proposals of a commercial nature or tenders submitted to the Executive by contractors, consultants or any other person.

⁹⁰ NHS England, NHS England Board - <https://www.england.nhs.uk/about/board/roles/> [accessed 28th May 2018]

As regards a person appointed by the Minister to conduct an independent review of the Board it means:

- information that is expressed by the Minister to be confidential either as regards particular information or as regards information of a particular class or description; and
- information relating to proposals of a commercial nature or tenders submitted to the Executive by contractors, consultants or any other person.

The section further clarifies that a person will not contravene section 26 where the disclosure is a protected disclosure under Part 9A of the [Protected Disclosures Act 2014](#).

Submission of a Service Plan

Section 15 of the Bill seeks to amend Section 31 of the *Health Act 2004* which provides that the HSE must prepare a service plan and submit it to the Minister. The amendments relate to the HSE's failure to submit such a plan. The plan which should reflect requirements and targets set by the Minister must be submitted within a certain timeframe and if not received, the Bill provides that the Minister may issue a direction to the CEO.

Conclusion

The Oireachtas Committee on the Future of Healthcare concluded that the Directorate structure provided by the *Health Service Executive (Governance) Act 2013* is not fit for purpose and that an independent board needs to be put in place. As such, the *Health Service Executive (Governance) Bill 2018* meets a key recommendation of the *Sláintecare Report* and constitutes one part of a broader package of measures that are intended to strengthen and improve governance, leadership and accountability within the HSE.

The provisions of the Bill are broadly commensurate with the requirements of good governance and accountability as outlined in the *Code of Practice for the Governance of State Bodies (2016)*. However, the international evidence base and the HSE's own internal guidance points to the need for a focus on quality of care and patient safety at board level. These items rarely feature on board agendas while at the same time research evidence emphasises that patient safety and care are optimised when systemic and organisational factors are aligned with clinical efforts. Furthermore, the audit committee is the only sub-structure provided for by the Bill and evidence from the USA and the UK points to better outcomes for quality of care if a separate quality of care committee is provided.

Systematic reviews of health system governance identify transparency, accountability, participation, integrity, and policy capacity as the core attributes of good governance but warn that successful health systems are those that arrive at the right balance of these attributes.

Transparency and accountability mechanisms frequently interfere with other desirable goals including speed, efficiency, effectiveness, flexibility, creativity, empowerment, and innovation. In the same way, there are both benefits and risks associated with patient/citizen participation with the former realising greater legitimacy and effectiveness of health policies but sometimes at a high cost.

The Bill provides clear rules that govern the conduct of Board members with procedures that openly and transparently guide operations. These provisions are well aligned with evidence that points to the importance of transparent procedures in the maintenance of public confidence in the health system. Finally, the international evidence and the HSE's own policy guidance for improving quality and patient safety emphasises the importance of selecting board members with key competencies in a range of areas including research and analysis, while ensuring that the board is informed by high quality data and technical specialisation.



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