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Audit of Structures and Functions in the Health System

Appendices

2003

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Audit of Structures and Functions in the Health System

Appendices

2003

DEPARTMENT
OF HEALTH AND
CHILDREN
AN ROINN
SLÁINTE
AGUS LEANAÍ

Quality and Fairness
A Health System for You
Action 114

BAILE ÁTHA CLIATH
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Table of contents

Appendix 1

Specification of requirements for the Audit of Structures and Functions in the Health System

Appendix 1

Specification of requirements for the Audit of Structures and Functions in the Health System

Specification of Requirements as set out by the Department of Health and Children

Background

The Health Strategy 2001 identifies overall national goals to guide activity and planning in the health system for the next 7-10 years. This consultancy is being commissioned to support the implementation of the Government's Health Strategy. The overall aim of the Health Strategy is to guide the health system to manage for key results while:

- working with everyone in the health system who has a role to play in improving health
- engaging with the wider community to improve health
- evaluating services so that resources are used to best effect
- reforming the way we plan and deliver services within the system
- modernising and expanding health and personal social services through focused investment
- supporting the development and contribution of people who work in the health system

The present structures in the health system evolved from a model developed over thirty years ago. During that time, the size, range of functions and complexity of managing the system have all grown dramatically. There have been significant enhancements to the original health board model, through the Health Acts 1996 and 1999, as well as considerable changes to the internal structures of the Department of Health and Children and the health boards. A number of new advisory and executive bodies have also been established in recent years. The structure of the system is set out in broad outline in Chapter 3 of the Health Strategy document. The strengths and weaknesses of the present system are also discussed in this chapter. The main conclusion is that while the system has served well in many respects, some significant concerns remain. These include the need for stronger coordination and integration of functions and services; greater consistency in access to services and delivery of services throughout the country; and greater clarity around levels of decision-making in the full range of organisations (particularly, vis-à-vis the role of the Department) and the requirement for 'whole-system' effectiveness.

The Strategy has identified an independent audit of organisational structures and functions in the health system as one of a number of actions aimed at achieving the required improved coordination, integration and consistency of service delivery.

Objectives

The purpose of the consultancy project is to determine whether the structures in the health system:

- are the most appropriate and responsive to meet current and future service needs;
- constitute an adequate framework for overall governance of the health system;
- achieve an effective integration of services across all parts of the system;
- adequately represent the views of consumers in the planning and delivery of services;
- focus sufficiently upon the principles of equity, accountability, quality and people-centeredness and the national goals of the Health Strategy;
- and to recommend any changes believed to be necessary as a result of the analysis, including an implementation strategy for any changes proposed.

Scope of the Project

The audit should critically examine:

- the number and configuration of existing health organisations (as outlined in appendix 1);
- their interaction with one another and with the Department of Health and Children
- the adequacy of governance arrangements; and
- the scope for rationalisation

The analysis and proposed changes should be guided by the need to ensure

(i) clear lines of accountability and communication between each part of the system;

(ii) no overlap or duplication between organisations; and

(iii) a proper alignment of the structure as a whole to the vision and objectives outlined in the Health Strategy.

The project will be advanced in two distinct but related phases as outlined below.

Phase 1

- Critical overview of the existing health system 'organisational map', highlighting potential overlaps or gaps in functions having regard to the wide and highly specialised range of needs embraced by the Irish health system and best organisational practice in public management internationally.
- Critical overview of arrangements for governance in the health system, based on formal statements of functions, responsibilities and accountability frameworks, as set down in the relevant legislation, establishment orders and other formal instruments e.g. service agreements.
- The critique should have regard to modern standards of corporate governance and the specific requirements of health systems based on best international practice.

The analysis from Phase 1 should identify the main areas requiring improvement, make specific recommendations for change and identify the areas and organisations requiring more detailed analysis and consultation in Phase 2. It is intended that Phase 1 will be carried out largely using literature review methodology with access by the successful

tenderer to a key link person in the Department of Health and Children for consultation as required. Validation of the analysis may entail consultation with key people in some of the agencies. The successful tenderer will be supplied with background information relating to the statutory basis of organisations encompassed by the audit and a guide to structures and functions set out in legislation or otherwise.

The analysis should take account of the organisational reforms outlined in the Health Strategy and the outcome of recent studies (e.g. Value for Money Audit of the Irish Health System, 2001). It will proceed in parallel with an exercise on restructuring the Department of Health and Children with close liaison required between both projects.

Phase 2

Following completion of Phase 1 and in consultation with the stakeholders

- Examine proposed changes in structures and functions in the Irish context in greater depth;
- Test proposals against organisational practices and day-to-day functioning;
- Make recommendations for change, including transfer of functions or possible amalgamation of agencies;
- Make recommendations to improve corporate governance arrangements in the health system; and
- Signal the potential financial implications associated with changes proposed.

Following Phase 1 it is anticipated that a smaller number of agencies or areas for consideration will have been identified for further exploration. Phase 2 is likely to require more in depth consultation and interaction with the key stakeholders regarding any proposed changes to organisation functions, structures or governance arrangements before recommendations are finalised. For example, it will have considered comments on organisational structure made during the Health Strategy consultation process; it may include additional consultation on the efficacy of current structures/organisations with non-government organisations that have direct contact with the health service bodies and it will provide an opportunity for affected organisations to make submissions in relation to their functions and governance arrangements.

Outputs required

A detailed report covering all of the areas outlined will be required at the completion of Phase 1 of the project. This will include an analysis of all agencies on the basis of the following questions:

1. Do the functions for each organisation, as formally set down, remain relevant, particularly in the new context of *Quality and Fairness: A Health System for You?*
2. Do these functions overlap with or have an impact on the functions of any organisation(s) in the health system and, if so, what is the optimal solution in terms of distribution of functions and inter-relationships to yield maximum performance in the system overall?
3. Are governance arrangements in each organisation consistent with the most recent standards of corporate governance both in regard to internal structures and systems and external reporting relationships?
4. Are there any additional measures that may be required to ensure more appropriate and responsive structures in the health system? If so they should be identified clearly.

The report will identify potential areas for change on both an individual organisation and system-wide basis. Of these, the report will also identify what further development work will be required in Phase 2 of the project to determine the feasibility and appropriateness of proposed changes to the current structures and accountability framework.

A detailed report on Phase 2 of the project will be submitted to the Department of Health and Children. It will include an analysis of all of the issues raised in the paragraph above.

It will include recommendations for change, options to meet any restructuring needs and an implementation strategy for the changes proposed.

Skills and Capacity Required

The successful tenderer will have:

- an established track record in large-scale projects involving organisational structure and management, business process re-engineering and change management;
- the capacity to deliver on a project of this scale and nature within the planned time-frame of six months from the signing of the contract
- a detailed knowledge of modern public management requirements with particular regard to the specific needs of the health sector;

Reporting Relationships

An Assistant Secretary in the Department will be designated as liaison officer with the successful tenderer and will provide or otherwise arrange for clarification on any issues within the Department's remit as necessary. The successful tenderer will have an on-going reporting relationship to the liaison officer concerning progress on the consultancy as per arrangements to be agreed with the successful tenderer following the awarding of the contract.

A Steering Group will be established to provide guidance and feedback to the successful tenderer. The terms of reference of the Steering Group will be to:

- advise the Department on choice of tenderer;
- provide overall direction to the consultancy as it develops;
- approve payment of invoices based on progress reports from the successful tenderer; and
- sign-off on the reports from Phase 1 and Phase 2.

Appendix

Health agencies

Statutory bodies and non-statutory organisations

Body	Function
An Bord Altranais (Nursing Board)	The regulatory body for the nursing profession. Its main functions are to maintain a register of nurses and to provide for the education and training of nurses and student nurses
An Bord Uchtála (Adoption Board)	Makes Adoption Orders and registers voluntary adoption societies
Board for the Employment of the Blind	Provides employment for a number of blind and visually impaired people
Bord na Radharcmhastóirí (Opticians Board)	The regulatory body for opticians. The board's main functions include the training and registration of ophthalmic and dispensing opticians and regulating the practice of optics
Breastcheck	Responsible for the National Breast Screening Programme that aims to reduce breast cancer related deaths in women
Comhairle na Nimheanna (Poisons Council)	Advises the Minister for Health and Children on the control of poisons
Comhairle na nOspidéal	The statutory body responsible for regulating the number and type of consultant and senior registrar appointments and for specifying the necessary qualifications for these posts
Dental Council	The regulatory body for the dental profession. Its functions include maintaining a register of dentists and dental specialists, ensuring that the standards of dental training are maintained and inquiring into the fitness of a dentist to practice on specific grounds
Drug Treatment Centre Board	Provides a range of programmes for the treatment of drug addiction
Food Safety Authority of Ireland	Provides advice on issues relating to safety, nutrition, food law and other matters regarding the processing and sale of food
Food Safety Promotion Board	A North/South institution which promotes food safety awareness. It also supports north/south scientific co-operation, promotes links between institutions working in the field of food safety and promotes specialised laboratory services
General Medical Services (Payments) Board	Administers payments to doctors and pharmacists under the GMS scheme
Health Research Board	Provides advice on health research and related matters
Health Services Employers Agency (HSEA)	A statutory agency representing health service employers. Its functions include the promotion and support of value for money, efficiency and effectiveness in employment practice and the negotiation of industrial relations issues with health unions
Hospitals Trust Board	Administers the Hospitals Trust Fund
Institute of Public Health (IPH)	A cross-border body established by the Department of Health and Children and the Department of Health, Social Services and Public Safety (NI). The IPH is concerned with tackling health inequalities, strengthening partnerships and networking nationally and internationally, contributing to public health information and surveillance and strengthening public health capacity
Interim Special Residential Services Board	Advises the Ministers for Health and Children and Education and Science on matters relating to children in respect of whom child detention or special care orders have been made by the courts
Irish Blood Transfusion Service	Organises and administers the national blood transfusion service including the processing and supply of blood and blood products to Irish Hospitals. It also operates the National Haemovigilance Office, the Irish Unrelated Bone Marrow Registry and the National Tissue Bank

Body	Function
Irish Medicines Board	The authority responsible for the licensing of human and veterinary medicines and the approval of clinical trials. It also acts as an advisory body to the Minister in relation to safety, control and regulation of medicines generally
Medical Council	The statutory body for the medical profession. Its functions include administering the General Register of Medical Practitioners, ensuring that the standards of medical training are maintained and inquiring into the fitness of a doctor to practise on specific grounds
National Cancer Registry Board	A statutory body established to collect and analyse data and to report on cancer incidence and mortality in Ireland
National Children's Advisory Council	Advises the Minister for Health and Children on all aspects of children's lives, on better delivery and coordination of services to children, contributes to monitoring and evaluation of implementation of the National Children's Strategy, undertakes and advises on research and advises on the development of mechanisms to consult with children
National Children's Office	Responsible for the implementation of the National Children's Strategy. It provides advice to the Minister for Health and Children, develops measures to further the goals of the strategy and is responsible for fulfilling Ireland's commitments under the United Nations Convention on the Rights of the Child
National Council for the Professional Development of Nursing and Midwifery	The body responsible for the continuing education and professional development of nurses and midwives
National Council on Ageing and Older People	Advises the Minister for Health and Children on all aspects of ageing and older people
National Disease Surveillance Centre (NDSC)	Ireland's specialist centre for surveillance of communicable diseases. The aim of NDSC is to improve the health of the Irish population by the collation, interpretation and provision of the best possible information on infectious diseases. This is achieved through surveillance and independent advice, epidemiological investigation, research and training
National Social Work Qualifications Board	A statutory body which assesses the suitability of social work education and training and advises the Minister for Health and Children on standards which should apply
Office for Health Gain (OHG)	A body established by health board chief executive officers to facilitate health boards and others working to achieve health gain in response to the 1994 health strategy
Office for Health Management (OHM)	A body established to implement the national strategy for management development for the health and personal and social services in Ireland. Its main function is to facilitate management development for the health services by acting as a central resource and commissioning body
Office of Tobacco Control/Tobacco Control Agency (proposed)	Established on an administrative basis pending legislation. The Public Health (Tobacco) Bill provides for the establishment of a Tobacco Control Agency to advise the Minister on tobacco control measures, to monitor and co-ordinate the implementation of such measures and to advise the Minister on the control and regulation of the manufacture, sale, marketing and smoking of tobacco products
Pharmaceutical Society of Ireland	The professional body for the pharmaceutical profession. Its chief functions relate to the education, examination and registration of pharmaceutical chemists
Postgraduate Medical and Dental Board	Promotes and coordinates postgraduate medical and dental education and advises the Minister for Health and Children on all matters relating to such education
Pre-hospital Emergency Care Council	Responsible for the recognition of institutions for the education and training of emergency medical technicians
Social Services Inspectorate (SSI)	Established in 1999 by the Department of Health and Children as an independent body to inspect social services provided by health boards. To date the SSI has focused on child care services
Women's Health Council	Advises the Minister for Health and Children on all aspects of women's health

Health boards

Health boards were established under the Health Act, 1970 for the administration of the health services in the State. Health boards replaced local authorities in fulfilling this role. There are currently ten health boards established: three area health boards located in the eastern region under the aegis of the ERHA and seven regional health boards covering the rest of the country.

Eastern Regional Health Authority (ERHA)

The ERHA plans, commissions, monitors and evaluates health and personal social services in the eastern region, covering counties Dublin, Wicklow and Kildare, from the three area health boards and other providers located in the region. The three area health boards in the region are responsible for the provision of health and personal social services in their area:

East Coast Area Health Board	South-eastern Dublin and the eastern portion of Wicklow
Northern Area Health Board	Dublin city and county north of the River Liffey
South Western Area Health Board	Dublin inner city area south of the River Liffey, South Dublin, Kildare and the Baltinglass area of Wicklow

Health boards

The seven regional health boards are responsible for providing or arranging the provision of health and personal social services in the following counties:

Midland Health Board	Laois, Offaly, Longford and Westmeath
Mid-Western Health Board	Clare, Limerick and Tipperary North Riding
North Eastern Health Board	Cavan, Monaghan, Meath and Louth
North Western Health Board	Donegal, Sligo and Leitrim
South Eastern Health Board	Wexford, Carlow, Kilkenny, Waterford and Tipperary South Riding
Southern Health Board	Cork and Kerry
Western Health Board	Galway, Mayo and Roscommon

The Health Boards Executive (HeBE) will also be included. The Executive was established by order in February 2002 to provide to further improve the efficiency and effectiveness of health and personal social services. Its role is to enable the health boards and the ERHA to work jointly on a national development agenda that will support the modernising of health services and to undertake other executive functions including operational functions to be devolved from the Department of Health and Children.

Hospital Boards

There are six hospitals in the health system established or currently governed under the Health (Corporate Bodies) Act. These include:

- Beaumont Hospital Board
- Dublin Dental Hospital Board
- Leopardstown Park Hospital Board
- St. James' Hospital Board
- St. Luke's and St. Anne's Hospital Board and
- Board of the Adelaide and Meath Hospitals, Dublin, incorporating the National Children's Hospital.

Appendix 2

List of agencies audited

Appendix 2

List of agencies audited

Below is the final list of agencies agreed with the Department of Health and Children. This list includes a number of agencies additional to those referred to in the terms of reference set out above. The additional agencies were considered by the Department as meriting inclusion in the Audit.

1. An Bord Altranais (Nursing Board)
2. An Bord Uchtála (Adoption Board)
3. Board for the Employment of Blind
4. Bord na Radharcmhastóirí (Opticians Board)
5. An Bord Cioch Scrudaithe Naisiunta (National Breast Screening Board)
6. Comhairle na Nimheanna (Poisons Council)
7. Comhairle na nOspidéal
8. An Comhairle Fiacloireachta (Dental Council)
9. Crisis Pregnancy Agency
10. Drug Treatment Centre Board
11. Food Safety Authority of Ireland
12. Food Safety Promotion Board
13. General Medical Services (Payments) Board
14. Health Boards Executive (HeBE)
15. Health Information and Quality Authority
16. Health Research Board
17. Health Service Employers Agency (HSEA)
18. Hospital Bodies Administrative Bureau
19. Hospitals Trust Board
20. The Institute of Public Health
21. Irish Health Services Accreditation Board
22. Irish Blood Transfusion Service
23. Irish Medicines Board
24. Medical Council
25. Mental Health Commission
26. National Cancer Registry Board
27. National Children's Advisory Council
28. National Children's Office
29. The National Council for the Professional Development of Nursing and Midwifery
30. National Council on Ageing and Older People

31. The National Disease Surveillance Centre
32. The National Hospitals Agency
33. National Social Work Qualifications Board
34. Office for Health Management
35. Office of Tobacco Control
36. The Pharmaceutical Society of Ireland
37. Postgraduate Medical and Dental Board
38. Pre-hospital Emergency Care Council
39. Social Services Inspectorate
40. Special Residential Services Board
41. Women's Health Council

Regional Health Boards

42. Midlands Health Board
43. Mid-Western Health Board
44. North Eastern Health Board
45. North Western Health Board
46. South Eastern Health Board
47. Southern Health Board
48. Western Health Board

ERHA and Area Health Boards

49. ERHA
50. East Coast Area Health Board
51. Northern Area Health Board
52. South Western Area Health Board

Statute-based hospitals

53. Beaumont Hospital Board
54. Board of the Adelaide and Meath Hospitals, Dublin, incorporating the National Children's Hospital Board
55. Dublin Dental Hospital Board
56. Leopardstown Park Hospital Board
57. St. James's Hospital Board
58. St Luke's and St Ann's Hospital Board

Appendix 3

Description of major functional groupings

Appendix 3

Description of major functional groupings

In considering the 58 individual agencies reviewed as part of the Audit, it was clear that the health system carries out a significant range of critical functions. Agencies were classified under each function on the basis of information supplied by them or set out in their terms of establishment. In certain cases, it was unclear whether or not an agency had a primary function. To avoid arbitrary or misleading assignment of primary functions, some agencies appear in more than one functional area. A detailed analysis of agency functions, including overlaps, interdependencies and inter-relationships was carried out. The results of this analysis are set out in Appendix 6 following. The agencies were classified as follows:

Development and implementation of national strategies and policies

These agencies have largely been established to strengthen system support for the particular policy areas concerned. Such agencies are typically involved in:

- Contributing to, or developing, national strategies for their particular area of interest/expertise
- Driving and coordinating the implementation of a national strategy
- Advising the Minister/Department of Health and Children in relation to a particular area of interest
- Liaison with international and inter-sectoral bodies

Relevant agencies:
Crisis Pregnancy Agency, National Children's Advisory Council, National Council on Ageing and Older Persons, Office of Tobacco Control, Women's Health Council

National advisory and coordinating functions

In addition to the agencies established to support particular national strategies or policies as described above, there are a number of discrete agencies that have been established to provide specialist input at a national level in the following areas:

- Advice to the Minister/Department of Health and Children in relation to a specialist area of interest
- Interdepartmental or international specialist coordinating agencies e.g. having a liaison role with international and inter-sectoral bodies in relation to specialist areas. Unlike the agencies established to support particular national strategies or policies, these agencies are usually involved in other functions as well as their coordinating role

Relevant agencies:
Advisory
Comhairle na nOspidéal, National Hospitals Agency (in development), Poisons Council

Coordinating — interdepartmental
Food Safety Authority of Ireland, National Children's Office, Special Residential Services Board

Coordinating — international
Food Safety Promotion Board, Health Research Board, Institute of Public Health

Service planning and delivery (including finance)

Service planning and commissioning, service delivery and service monitoring and evaluation are carried out across a wide range of health and social services provided by several agencies. These services can be categorised as follows:

- National/centralised services (e.g. blood transfusion services)
- Regional services (e.g. health and social services provided by, or through, each of the health boards)
- Stand-alone services

Relevant agencies:
National
Adoption Board, Irish Blood Transfusion Services Board, Irish Medicines Board, Special Services Residential Board

Regional
Eastern Regional Health Authority, Area Health Boards (3), Regional Health Boards (7)

Other
Board for the Employment of the Blind, Drug Treatment Centre Board, Hospital Bodies Administrative Bureau, Hospitals Trust Board, Statute-based Hospitals (6)

Shared/joint services

A limited number of services are currently delivered on a shared or joint basis in the Irish health care system. These include:

- Traditional shared services including back-office processes such as payroll
- Delivery of front-line services on a joint basis, e.g. breast screening

Relevant agencies:
Traditional shared services
GMS Payments Board, EHSS

Joint service delivery
HeBE, National Breast Screening Board

System-wide HR

The following functions are carried out by a number of agencies on a system-wide basis:

- National negotiations on pay and employment conditions
- Industrial relations
- Recruitment and retention

- Organisational and personal development
- Manpower planning

Relevant agencies:
Health Services Employer's Agency, Office for Health Management

Professional registration, regulation and development

The registration, regulation and development of professional groupings is a function which contributes to both quality of care and the protection of the patient/client, in addition to supporting the professions involved. Agencies in this area deal with matters which include:

- Maintenance of registers of practicing professionals
- Setting of professional guidelines and standards for conduct
- Conducting fitness to practice inquiries
- Setting of professional qualifications
- Accreditation of courses and training bodies
- Regulation of number and type of posts

Relevant agencies:
Comhairle na nOspidéal, Dental Council, Medical Council, National Council for the Professional Development of Nursing and Midwifery, National Social Work Qualifications Board, Nursing Board, Opticians Board, Pharmaceutical Society of Ireland, Post-graduate Medical and Dental Board, Pre-hospital Emergency Care Council

Monitoring and inspection (including quality assurance)

Agencies involved carry out functions under two broad categories:

Inspection/quality control

- Inspection of premises
- Setting of guidelines and standards for practice
- Monitoring of particular organisations and management of a particular service
- Evaluating the quality and responsiveness of services
- Monitoring of standards set

Quality assurance/service evaluation

- Setting of quality and accreditation standards
- Operation of accreditation and other quality programmes
- Accreditation of organisations
- Service evaluation and review

Relevant agencies:

Inspection/quality control

Food Safety Authority of Ireland, Irish Medicines Board, Office of Tobacco Control, Pharmaceutical Society of Ireland, Social Services Inspectorate, Mental Health Commission

Quality assurance/monitoring and evaluation

HIQA (in development), Irish Health Services Accreditation Body

Monitoring and evaluation

Area Health Boards, ERHA, Regional Health Boards

Research and development

Agencies involved in research and development in the health service typically:

- Commission specialist research
- Carry out research
- Disseminate research findings

Relevant agencies:

Food Safety Authority of Ireland, Food Safety Promotion Board, Health Research Board, Irish Blood Transfusion Service Board, Office of Tobacco Control, Statute-based hospitals (6), Health Services Employers Agency, Institute of Public Health

Health information

Agencies involved in health information typically:

- Compile relevant statistics
- Identify, collect, classify, record and store information
- Promote and facilitate the use of stored data
- Provide information to the media or public

Relevant agencies:

GMS Payments Board, National Cancer Registry, National Disease Surveillance Centre, HIQA (in development)

Appendix 4

Documentation received from the agencies audited

Appendix 4

Documentation received from the agencies audited

Set out below is the legislation and other documentation relating to the functions and governance arrangements of the health agencies audited, including a list of annual reports and other documents received from the agencies in response to a request for material from the Department of Health and Children.

Note: The Health Information and Quality Authority and the National Hospitals Agency have not yet been established

Legislation and referral sources with overall application

Health (Corporate Bodies) Act, 1961;

Health Act, 1970;

Public Service Management Act, 1997

Quality and Fairness

Primary Care — A New Direction,

Your Views About Health

Value for Money Audit of the Irish Health System

Name of Agency	Legislation and other relevant sources	Documents Received
An Bord Altranais (Nursing Board)	NURSES ACT, 1985	1. Annual Report 2000 2. Strategic Plan 2000 – 2003
An Bord Uchtála (Adoption Board)	The main legislation in this area: ADOPTION ACT, 1952 (Principal Act) ADOPTION ACT, 1988 (Adoption of children whose parents have failed in their duty to them, powers given to the board) ADOPTION ACT, 1991 (Register of Foreign Adoptions)	1. Report of the adoption board 2000 2. Information booklet on intercountry adoption 3. Understanding the assessment process 4. After the Declaration 5. An outline of Adoption law and procedure 6. Adoption Board information leaflet on Step-parent adoption
Board for the Employment of Blind	Established by constitution in 1957. Chairman and seven members appointed by the Minister for Health and Children on an honorary basis.	Letter outlining the historical background

Name of Agency	Legislation and other relevant sources	Documents Received
Bord na Radharcmhastóirí (Opticians Board)	OPTICIANS ACT, 1956	1. Opticians Act 1956 rules 1977 amendment rules 1993 2. Registers of ophthalmic and dispensing opticians for 1998
An Bord Cioch Scrudaithe Naisiunta (National Breast Screening Board)	NATIONAL BREAST SCREENING BOARD, (ESTABLISHMENT) ORDER, 1998 NATIONAL BREAST SCREENING BOARD (ESTABLISHMENT) ORDER, 1998 (AMENDMENT) ORDER, 1999 (Composition of the Board) NATIONAL BREAST SCREENING BOARD (ESTABLISHMENT) ORDER 1998 (AMENDMENT) (NO. 2) ORDER 2000 (Composition of the Board)	1. Service plan 2002 2. National Breast Screening Committee First report 1998
Comhairle na Nimheanna (Poisons Council)	POISONS ACT, 1961 COMHAIRLE NA NIMHEANNA ORDER, 1962 (Term of office, quorum and other matters)	No documentation available. Board has only met three times in the last ten years.
Comhairle na nOspidéal	HEALTH ACT, 1970 HEALTH (HOSPITAL BODIES) REGULATIONS, 1972 Comhairle na nOspidéal functions under Standing Orders adopted in 1985 under Rule 31 of the Second Schedule to the Health Act, 1970.	1. HEALTH ACT 1970 2. Press statement 3. 8th report Dec 1995 – 2000 4. Minutes of meeting between Comhairle and the Department 5. Consultant appointment procedures 6. Comhairle Committees
An Comhairle Fiacloireachta (Dental Council)	DENTISTS ACT, 1985 THE DENTAL COUNCIL (ELECTION OF MEMBERS) REGULATIONS, 1985	1. Annual Report 1999 2. Annual Report 2000
Crisis Pregnancy Agency	CRISIS PREGNANCY AGENCY (ESTABLISHMENT) ORDER, 2001	1. Business Plan 2002
Drug Treatment Centre Board	THE DRUG TREATMENT CENTRE BOARD (ESTABLISHMENT) ORDER, 1988 THE DRUG TREATMENT CENTRE BOARD (ESTABLISHMENT) ORDER 1988 (AMENDMENT) ORDER, 1992 (articles referring to functions amended)	1. Annual report 2000 2. Service level Agreement 2001 3. 5 year Strategy Plan
Food Safety Authority of Ireland	FOOD SAFETY AUTHORITY OF IRELAND ACT, 1998 BRITISH IRISH AGREEMENT ACT, 1999 (amends above act in relation to functions) HEALTH AND CHILDREN (DELGATION OF MINISTERIAL FUNCTIONS) ORDER, 2000 (delegates the powers under Section 20 of the principal act [conferral of additional functions on the Authority])	1. Annual report 2000 2. Corporate Plan 2002 3. FOOD SAFETY AUTHORITY OF IRELAND ACT 1998 4. Quality Management System 5. 3 × European Commission Health and Consumer Protection Reports

Name of Agency	Legislation and other relevant sources	Documents Received
Food Safety Consultative Council	As above	N/A
Scientific Committee of the Food Safety Authority of Ireland	As above	N/A
Food Safety Promotion Board	BRITISH IRISH AGREEMENT ACT, 1999	1. Safe food for everyday people, in everyday situations 2. Corporate Strategy and interim plan 2001
General Medical Services (Payments) Board	GENERAL MEDICAL SERVICES (PAYMENTS) BOARD (ESTABLISHMENT) ORDER, 1972 GENERAL MEDICAL SERVICES (PAYMENTS) BOARD (ESTABLISHMENT) ORDER, 1972, (AMENDMENT) ORDER, 1990 (extends the area of responsibility) GENERAL MEDICAL SERVICES (PAYMENTS) BOARD (ESTABLISHMENT) ORDER, 1972 (AMENDMENT) ORDER, 1994 (extends the functions)	1. Report for year ended 31st December 2000 2. Report 2001 3. Financial and Statistical Analysis of Claims and Payments 2001 4. Business Statement and Information Systems Strategy 5. GMS (Payments Board) — Clinical Messages Scheme, Scoping Paper 6. GMS (Payments Board) — Implementation of Unique Patient Identifier — Scoping Study 7. GMS (Payments Board) — Business Statement and Information Systems Strategy 8. National Review of Immunisation/Vaccination Programmes
Health Boards Executive (HeBE)	THE HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT, 1999 (HEALTH BOARDS EXECUTIVE) (ESTABLISHMENT) ORDER, 2002 (ESTABLISHMENT DAY)	1. Position document 2. FAQ sheet 3. Presentation 4. List of current projects
Health Information and Quality Authority	To be established on a statutory basis. See Action 111 of Quality and Fairness pp127-129	N/A
Health Research Board	THE HEALTH RESEARCH BOARD (ESTABLISHMENT) ORDER, 1986. THE HEALTH RESEARCH BOARD (ESTABLISHMENT) (AMENDMENT) (NO.1) ORDER, 2002 (Extends the term of office)	1. Consolidated order 2002 2. Corporate Strategy 2002 – 2006 3. Business plan 2002 4. A strategy for health research 5. Annual report and accounts 2000
Health Service Employers Agency (HSEA)	THE HEALTH SERVICE EMPLOYERS AGENCY (ESTABLISHMENT) ORDER, 1996.	1. Annual report 2000 2. Corporate plan 1998 – 2001
Hospital Bodies Administrative Bureau	HOSPITAL BODIES ADMINISTRATIVE BUREAU (ESTABLISHMENT) ORDER, 1973	Covered under Comhairle na nOspidéal documentation.

Name of Agency	Legislation and other relevant sources	Documents Received
Hospitals Trust Board	PUBLIC HOSPITALS ACT, 1933 (National Hospital Trustees established, functions defined) PUBLIC HOSPITALS (AMENDMENT) ACT, 1938 (Hospitals Trust Board established, transfer of functions from National Hospital Trustees to Hospitals Trust Board)	This body was set up to distribute the funds that came from the Hospital Sweeps Stakes. There are no longer any funds and the Sweep Stakes no longer operates.
The Institute of Public Health	A cross-border non-statutory body established by the Department of Health and Children and the Department of Health, Social Services and Public Safety (NI).	1. Strategic Plan 2000-2003
Irish Health Services Accreditation Board	IRISH HEALTH SERVICES ACCREDITATION BOARD (ESTABLISHMENT) ORDER, 2002	N/A
Irish Blood Transfusion Service	THE BLOOD TRANSFUSION SERVICE BOARD (ESTABLISHMENT) ORDER, 1965 THE BLOOD TRANSFUSION SERVICE BOARD (ESTABLISHMENT) (AMENDMENT) ORDER, 1988 (allows for the establishment of an eye bank to facilitate corneal transplantation) BLOOD TRANSFUSION SERVICE BOARD (ESTABLISHMENT) ORDER 1965 (AMENDMENT) ORDER, 1994 (provides for the remuneration of the chairperson)	1. Re-organisation plan May 1996 2. Implementation of reorganisation plan 3. Fact Finding and analysis Recommendations May 1995 4. Report of the expert group on the Blood Transfusion Service Board January 1995.
Irish Medicines Board	IRISH MEDICINES BOARD ACT, 1995	1. Annual report 2000 2. A guide to information held by the Irish Medicines Board 3. Strategic Plan 2000 -2003
Advisory Committee for Human Medicines	As above	N/A
Advisory Committee for Veterinary Medicines	As above	N/A

Name of Agency	Legislation and other relevant sources	Documents Received
Medical Council	MEDICAL PRACTITIONERS ACT, 1978 (This piece of legislation is currently under review) THE MEDICAL COUNCIL (ELECTION OF MEMBERS) REGULATIONS, 1978 (terms of office and manner of election) MEDICAL PRACTITIONERS (AMENDMENT) ACT, 1993 MEDICAL PRACTITIONERS (AMENDMENT) ACT 2000 MEDICAL PRACTITIONERS (AMENDMENT) ACT 2002	1. The list of recognised specialities 2. The list of specialist training bodies 3. MEDICAL PRACTITIONERS ACT, 1978 4. MEDICAL PRACTITIONERS (AMENDMENT) ACT, 1993 5. MEDICAL PRACTITIONERS (AMENDMENT) ACT, 2002 6. Medical Council (Election of Members) Regulations 1978 7. European Communities (Medical Ionizing Radiation) Regulations, 1988 8. A list of fee charges 9. A guide to ethical conduct and behaviour — fifth edition 1998 10. A guide to ethical conduct and behaviour, amendment no 1 to fifth edition 1998 11. The Medical Council Report and Financial Statements 1999 12. The Medical Council Report and Financial Statements 2000 13. The Medical Council Report and Financial Statements 2001 14. Term Report 1989/1994 15. Publications dealing with policies of the Council Statement of Core Policies for 2000 16. Intern Job Description and Log Book 17. Medical Council Guidelines for the Intern Year 18. Reform of the Intern Year 19. A Survey of Registered Medical Practitioners 2001 20. Review of Medical Schools in Ireland 2001 21. Competence Assurance Structures: Agenda for Implementation 22. The list of primary qualifications of Member States of the EU 23. Qualifications of certain countries which are accepted for the purposes of full registration 24. Medical Council Statement on Medical Education — 1997 25. Statistics for 2000 and 2001
Mental Health Commission	MENTAL HEALTH ACT, 2001	Material received from the Department of Health and Children 1. Press releases 2. Mental Health Act 2001
National Cancer Registry Board	THE NATIONAL CANCER REGISTRY BOARD (ESTABLISHMENT) ORDER, 1991 THE NATIONAL CANCER REGISTRY BOARD (ESTABLISHMENT) ORDER, 1991 (AMENDMENT) ORDER, 1996 (appointment of staff, remuneration)	1. An introduction 13th May 2002 2. Proposals for a national cancer surveillance plan 3. Service Plan 4. All Ireland cancer statistics 5. Cancer in Ireland 1994-1998

Name of Agency	Legislation and other relevant sources	Documents Received
National Children's Advisory Council	Non-statutory body	National Children's Strategy Press releases: Hanafin Launches National Children's Advisory Council
National Children's Office	Non-statutory body	1. Business Plan 2002 2. National Children's Strategy 3. Executive Summary of above 4. National Children's Office — Statement of Strategy 2003 – 2005 (received January 2003)
The National Council for the Professional Development of Nursing and Midwifery	THE NATIONAL COUNCIL FOR THE PROFESSIONAL DEVELOPMENT OF NURSING AND MIDWIFERY (ESTABLISHMENT) ORDER, 1999	1. Statutory Instrument 2. Report of the commission on Nursing (Chapter 6) 3. Draft Annual report 2001 4. Strategic Plan 2001-2003 5. Progress report on Operational Plan 6. Service Plan 2002 7. Progress report on service plan 8. Criteria and Processes for the allocation of additional funding for continuing education by the National Council 9. Application for funding for Continuing Education Programme 10. Clinical Nurse/Midwife Specialists intermediate pathway 11. Aid to developing job descriptions 12. CNS/CMS Intermediate pathway post and post holder information 13. Framework for the Establishment of ANP and AMP posts 14. 6 × Newsletters spring 2001 — summer 2002
National Council on Ageing and Older People	THE NATIONAL COUNCIL ON AGEING AND OLDER PEOPLE (ESTABLISHMENT) ORDER, 1997	1. Annual report 2000 2. Strategy 2000-2003 3. Operational plan 2002 4. Review of staffing requirements and other issues 5. Catalogue of Council publications
The National Disease Surveillance Centre	Non-statutory body	1. Annual report 2000 2. The purpose and functions of the NDSC 1999 3. Service plan 2002

Name of Agency	Legislation and other relevant sources	Documents Received
The National Hospitals Agency	To be established on a statutory basis. See Action 80 of *Quality and Fairness*	N/A
National Social Work Qualifications Board	THE NATIONAL SOCIAL WORK QUALIFICATIONS BOARD (ESTABLISHMENT) ORDER, 1997	1. Strategic Plan 2000 – 2003 2. Freedom of information manual 3. Annual report 2000
Office for Health Gain	Non-statutory The Office for Health Gain was founded in 1995 by the Chief Executive Officers of the eight Health Boards resulting from their consideration of how best to advance the aims and objectives of the 1994 Health Strategy, 'Shaping a Healthier Future'.	THIS BODY HAS NOW BEEN SUBSUMED INTO THE HEALTH BOARDS EXECUTIVE
Office for Health Management	Non-statutory The Office for Health Management was set up in 1997 following the publication of *The Management Development Strategy for the Health and Personal Social Services* (1996)	1. Annual Report 2001 2. Proposed Activities in 2002 3. Service Plan 2002 4. Publication List 5. Managing Talent 6. Clinicians in Management 7. *Best Practice Guidelines for Developing a Human Resources Strategy* 8. *Report on Nursing Competencies*
Office of Tobacco Control	PUBLIC HEALTH (TOBACCO) ACT 2002	1. Ireland — A Smoke Free Zone 2. PUBLIC HEALTH (TOBACCO) ACT 2002
The Pharmaceutical Society of Ireland	THE PHARMACY ACT (IRELAND), 1875 THE PHARMACY ACT (IRELAND), 1875 (AMENDMENT) ACT, 1890 PHARMACY ACT, 1951 (repeals and amends) PHARMACY ACT, 1962 (repeals and amends) MISUSE OF DRUGS ACT, 1977 (enforcement)	1. Five year plan of the Council 2001-2005 2. Blueprint for the future regulation of pharmacy in Ireland
Postgraduate Medical and Dental Board	MEDICAL PRACTITIONERS ACT, 1978 (This piece of legislation is currently under review)	1. 4th report 1996 — 2002 2. Activities related to dentistry 1996-2002 3. The postgraduate Medical and Dental Board
Pre-hospital Emergency Care Council	PRE-HOSPITAL EMERGENCY CARE COUNCIL (ESTABLISHEMENT) ORDER, 2000	1. Detailed Background information letter 2. Draft annual report 2002 3. Statutory Instrument no. 109 of 2000 4. Budget against the Service Plan 2002 5. Information sheet Oct 2001 6. Strategic review of the Ambulance service 2001 7. Draft information sheet June 2002

Name of Agency	Legislation and other relevant sources	Documents Received
Social Services Inspectorate	CHILD CARE ACT, 1991 CHILDREN ACT, 2001	1. Annual report 2001 2. Business Plan 2002
Special Residential Services Board	CHILDREN ACT, 2001	1. Some press material
Women's Health Council	THE WOMEN'S HEALTH COUNCIL (ESTABLISHMENT) ORDER, 1997	1. S.I NO 278 OF 1997 2. S.I NO 92 OF 2001 3. Annual report Oct 1999 4. Strategic Plan 2002 5. WHC explanatory leaflet
Health Boards	HEALTH ACT, 1970 HEALTH (AMENDMENT) ACT, 1996 HEALTH (AMENDMENT) (NO. 2) ACT, 1996 HEALTH (AMENDMENT) (NO. 3) ACT, 1996	**MID-WESTERN HEALTH BOARD** 1. Strategy Statement on intellectual disability 2. Annual Report 2001 3. Annual Financial Statement 2001 4. Strategy for acute hospital services 5. Report of the Director of Public Health 2001 6. Strategy for Elderly Care 7. Mental Health Strategy 8. Strategy Statement on Physical and Sensory Disability **SOUTHERN HEALTH BOARD** 1. Annual report 2001 2. Service plan 2002 3. Report of the Director of Public Health April 2002 4. Interim Management Structure and Arrangements 5. Good practice Guide to Strategy Development 6. Corporate Development Plan — 2000-2003 (supplied by DoHC 26/07/02) **NORTH EASTERN HEALTH BOARD** 1. 2002 Service Plan 2. Summaries of Key Strategies 3. Draft Annual Report 2001 **NORTH WESTERN HEALTH BOARD** 1. Financial Statement and Service Plan for 2002 2. Annual report 2000 **SOUTH EASTERN HEALTH BOARD** 1. Annual report 2000 2. Service plan 2002 3. Strategy Statement 4. Documentation in relation to the board's recent organisational change initiative 5. Briefing note for external consultants regarding evaluation of the Optical Model for purchasing, storing and supply 6. Review of the organisation of community care 7. Review of regional adoption services

Name of Agency	Legislation and other relevant sources	Documents Received
		MIDLAND HEALTH BOARD 1. Service Plan 2002 2. Annual report 2001 3. Statistical Addendum to above 4. Childcare Strategy 2002-2004 5. Human Resources Strategy 2001-2010 6. Quality Strategy May 2001 **WESTERN HEALTH BOARD** 1. Service Plan 2002 2. Annual Report 2001 3. Primary Care Strategy 2000-2005 4. Acute Hospital Strategy 2001-2006 5. Men's Health Strategy March 2000 6. Health Promotion Strategy 2000-2003 7. Suicide Prevention — September 2001 8. Older People Health Strategy 2001-2006 9. Child and Family Care Strategy 2001-2005 10. Suicide Prevention — Annual Report 2000 11. *PARTNERSHIP DOCUMENTS: Galway City Development Board — Strategy for Economic, Social, and Cultural Development 2002-2012* 12. *Roscommon County Development Board — Ten Year Strategy* 13. *Roscommon County Development Board — Audit of Service Provision 2001* 14. *Galway County Development Board — Strategy 2002-2012* 15. Update of Partnership Committee Local Projects 16. Property Sub-committee — Terms of Reference 17. Terms of Reference of the Internal Audit Committee
Eastern Regional Health Authority	HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT, 1999	1. Directory of Health Services Personnel in Eastern Region 2. Public Health in the Eastern Region November 2001 3. Protocols for Hospitals Re: post mortem queries from families 2001 4. Review of services for people with Autism 5. Review of the implementation of the Ten Year Action Plan for Older People 1999-2008, October 2001 6. A Human Resource Strategy for the Eastern Region 7. Annual Report 2001 8. Evaluation of the Irish Wheelchair Association's Personal Assistance Service Draft Report, July 2002 9. Draft Standards of Care for Residential Services for Older People

Name of Agency	Legislation and other relevant sources	Documents Received
		EAST COAST AREA HEALTH BOARD 1. Annual report 2000 2. Keep the change! — Transformational change management programme **NORTHERN AREA HEALTH BOARD** 1. Annual report 2000 2. Provider plan 2001 **SOUTH WESTERN AREA HEALTH BOARD** 1. Annual report 2000 2. Provider Plan 2001
Beaumont Hospital Board	BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1977 BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER 1977, (AMENDMENT) ORDER 1988 (Functions) BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER 1977, (AMENDMENT)(NO.2) ORDER, 1988 (Number of board members 12-15)	1. Annual Report 2000 2. Provider Plan 2001 3. Strategic plan 1999 – 2004 4. Partnership Annual report 5. Establishment order 1977
Board of the Adelaide and Meath Hospitals, Dublin, incorporating the National Children's Hospital	THE HEALTH ACT, 1970 (SECTION 76) (ADELAIDE AND MEATH HOSPITAL, DUBLIN, INCORPORATING THE NATIONAL CHILDREN'S HOSPITAL) ORDER, 1996 The Hospital is established under a Charter, agreed by Dáil Éireann on 1st August 1996. It is a public voluntary teaching Hospital.	1. Provider Plan 2001 2. Bi-Annual Report 1999 & 2000
Dublin Dental Hospital Board	DUBLIN DENTAL HOSPITAL (ESTABLISHMENT) ORDER, 1963 DUBLIN DENTAL HOSPITAL (ESTABLISHMENT) ORDER, 1963 (AMENDMENT) ORDER, 1985 (Additions to the selection board)	1. Section 15 (FOI Act) Manual October 2001 2. Section 16 (FOI Act) Manual October 2001
Leopardstown Park Hospital Board	LEOPARDSTOWN PARK HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1979	1. Provider plan agreement 2001 2. Annual report 1998 -2000
St. James's Hospital Board	ST JAMES'S HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1971 ST JAMES'S HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1971, (AMENDMENT) ORDER, 1998 (to reduce membership of the board from 18-15)	1. Annual Report 2000 2. Corporate Strategy 3. Provider Plan 2001
St Luke's and St Ann's Hospital Board	SAINT LUKE'S AND SAINT ANNE'S HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1988.	1. Provider Plan 2001

Appendix 5

List of reference material for the main report

Appendix 5

List of reference material for the main report

Brian Nolan & Miriam M. Wiley (2000) *Private Practice in Irish Public Hospitals* — ESRI

Butler Michelle (2000) *Performance Measurement in the Health Sector* — CPMR Discussion Paper 14

Central Statistics Office (2002) *Census 2002 Preliminary Report*

Deloitte & Touche (2001) *Value for Money Audit of the Irish Health Service*

Department of Finance (2001) *Standards in Public Office Bill*

Department of Finance (2002) *Report of the Working Group on the Accountability of Secretaries General and Accounting Officers*

Department of Health (2002) *The NHS Plan*

Department of Health and Children (2001) *Your Views about Health — Report on Consultation*

Department of Health and Children (2001) *Acute Hospital Bed Capacity — A National Review*

Department of Health and Children (2001) *Action Plan for People Management in the Health Service*

Department of Health and Children (2001) *Primary Care — A New Direction*

Department of Health and Children (2001) *Quality and Fairness — A Health System for You*

Department of Health and Children (1999) *Building Healthier Hearts — National Cardiovascular Health Strategy*

Department of Health and Children (1999) Annual Report of the Chief Medical Officer

Department of Health and Children (1996) *Cancer Services in Ireland A National Strategy*

Department of Health, Social Services and Public Safety (2002) *Independent review of the current provision of acute hospital services*

Department of the Taoiseach (2002) *An Agreed Programme for Government between Fianna Fáil and the Progressive Democrats*

Derek Wanless (2002) *Securing our Future Health: Taking a Long-Term View* — Health Trends Review, HM Treasury

Harry P.A. van de Water & Loes M. van Herten (1998) *Health Policies on Target*

Health Trends Review, HM Treasury (2002) *Health care systems in eight countries: trends and challenges*

Huw Talfryn Oakley Davies & Russell Mannion (1999) Discussion paper 165 — *Clinical Governance: Striking a Balance Between Checking and Trusting* — The University of York

Karen Bloor & Alan Maynard (1998) *Clinical Governance: Clinician, heal thyself?* — The Institute of Health Services Management — IHSM Policy document

Mc Kinsey & Company, Inc. (1970-71) *Towards Better Health Care*

Office for Health Management (2002) *Public and Patient Participation in Healthcare — A discussion document for the Irish health services*

PA Consulting Group (March 2002) *Evaluation of the Strategic Management Initiative*

The Hampel Report on Corporate Governance (1998) Hampel Committee

The National Economic and Social Forum (Forum Report no. 25) *Equity of Access to Hospital Care*

The Romanow Commission (2002) *Building on values: The future of Health Care in Canada*

Report of the Commission on Health Funding (1989)

Richard Boyle and Síle Fleming (2000) *The role of Strategic Statements* — CPMR research Report 2

Síle Fleming (2000) *From Personnel Management to HRM* — Institute of Public Administration

Study on Organisational costs in the HPSS in Northern Ireland (May 2002) — The Northern Ireland Confederation for Health and Social Services (NICON)

Tim O Sullivan & Michelle Butler (2002) *Current issues in Irish Health Management* — Institute of Public Administration

The Health Boards Executive (2002) *Community Participation Guidelines*

WHO Regional Publications, European Series, No. 72 (1997) *European Health Care Reform*

Yukata Imai, Stephane Jacobone & Patrick Lenain (2000) *The Changing Health System in France* — OECD Paris

Legislation

HEALTH ACT, 1970

HEALTH (CORPORATE BODIES) ACT, 1961

HEALTH (AMENDMENT (No. 2) (No. 3)) ACT, 1996

HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT, 1999

PUBLIC SERVICE MANAGEMENT Act, 1997

(Note: material cited in Appendices 4/6/7 on individual agencies is fully referenced at that point)

Appendix 6

Relevance, overlaps and interdependencies: Analysis of the individual agencies reviewed

Appendix 6

Relevance, overlaps and interdependencies: Analysis of the individual agencies reviewed

Structure of Individual Tables

The following tables provide a summary of the analysis conducted of the relevance, overlaps and interdependencies of individual agencies audited

The findings from this analysis are considered in Chapter 3 and Chapter 10 when making recommendations on:

- The optimal number and configuration of agencies in the current health system model
- The redistribution of functions where appropriate
- Other comments in relation to gaps, interfaces etc

Presentation of findings

The tables for each agency are organised as follows:

1. Evidence provided in relation to the following categories:

- Rationale for the establishment of the agency
- Stated functions of the agency
  - Statutory functions refer to those functions outlined in the legislative base of the agency, where present
  - Other stated functions refer to additional functions outlined in other corporate documentation
- Responsibility assigned in *Quality and Fairness*:
  - Assigned responsibility refers to specific actions for which responsibility has been assigned directly/'by name' to the agency in question, either solely or jointly with other agencies
  - Indirect responsibility/impact refers to specific actions which will require action by a group of agencies (e.g. training bodies, service providers), or will have a particular impact on the structure or function of the agency in question

2. Commentary on findings based on available evidence as submitted by agencies themselves

This section provides a summary of conclusions drawn from available evidence under the following headings:

- Relevance and distribution of function(s)
- Overlap with/impact on functions of other agencies audited
- Role identified in *Quality and Fairness*

References:

Material provided by individual agencies for the purpose of the audit, including:

- Statutory Instruments/legislative bases
- Relevant corporate documentation — e.g. annual reports, corporate strategies, service plans etc

An Bord Altranais (Nursing Board)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
NURSING ACT, 1985: To regulate the nursing profession, to ensure high standards of practice in the delivery of health care by nurses and midwives Also a vehicle through which nurses and midwives can influence healthcare policy through its advice to the Minister	**Statutory Functions (Nurses Act, 1985) — overview** To promote high standards of professional education and training and professional conduct among nurses *Registration* • To maintain a register of nurses in accordance with Rules made by the Board *Education/Training (entry level)* • To provide for courses of training and examination for candidates for registration • To set standards for nurse training and examinations • To approve hospitals and institutions for training of nurses or candidates for registration and inspect this training • To set minimum standards for entry to nurse training • To ensure that standards set are compliant with EU directives *Fitness to practice* • To provide for an inquiry into the fitness to practice of a nurse • To impose appropriate sanctions on a nurse found guilty of professional misconduct or unfit to practice *Advisory functions* • To advise the Minister on matters related to the functions of the Board • To give guidance to the nursing profession on matters to do with ethical conduct and behaviour • To advise the public on matters of general interest regarding the functions of the Board **Other stated functions (Strategic Plan 2000-2003, Annual Report 2000)** The National Council for the Professional Development of Nursing and Midwifery is now charged with responsibility for post-registration continuing education of nurses and midwives. Both bodies work together on aspects of standards for professional practice	**Assigned responsibility** • P. 80 — 81 — Action 50 & 51 • P. 119 — Action 104 **Indirect responsibility/impact** • P. 119 — Action 105 • Actions relevant to training bodies • Actions relevant to professional bodies

Commentary on findings based on available evidence

- The following functions are solely carried out by an Bord Altranais (however, similar functions in respect of different professions are carried out by other agencies)
  - Maintenance of a register of nurses
  - Fitness to practice inquiries and sanctions
  - Advice to nursing profession on matters of professional conduct
  - Promotion and setting of educational and training standards for nurses (at entry level only)

Overlap with/impact on functions of other agencies audited

- The agency's responsibility for the promotion and setting of educational and training standards for nurses at entry level impacts on the responsibility of the National Council for the Professional Development of Nursing and Midwifery in relation to post-registration education and training
  - It is noted that both agencies are working together on aspects of standards for professional practice

Role identified in *Quality and Fairness*

- While there are no specific actions assigned directly to an Bord Altranais, a number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104) collectively
- Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions

An Bord Uchtála (Adoption Board)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Established under the ADOPTION ACT, 1952 (Principal Act) Statutory functions further established under: • ADOPTION ACT, 1988 (Adoption of children whose parents have failed in their duty to them, powers given to the board) • ADOPTION ACT, 1991 (Foreign adoption) The primary function of the Board is to grant or refuse applications for adoption orders in relation to Irish adoptions; to register and supervise the Registered Adoption Societies; to grant or refuse to grant declarations of eligibility and suitability in relation to Intercountry Adoption and to maintain the Register of Foreign Adoptions	**Statutory functions (*Adoption Acts*) — overview** The Board, with the consent of the Minister, may make rules for the regulation of its procedure or for any matter referred to in this Act as prescribed. The legislation refers to rules around: • Who may apply for an adoption order • Religion • Suitability of adopters • Consents to adoption/validity of consent *Specified functions* • Power to make adoption orders (singly by an individual or jointly in the case of a married couple) • Hearing of applications • Making interim orders • Re-adoption/existing adoption • Correction of adoption order • Maintenance of Adopted Children's register • Restriction on making arrangements for adoption • Registration of adoption societies • Furnishing of information and inspection of books • Restriction on sending children abroad. *Source Adoption Act 1952* *Foreign Adoption* • Register of Foreign Adoptions • Assessments by health and registered adoption societies • Eligibility to be granted on an adoption order. *Source: Adoption Act 1991*	**Assigned responsibility** • N/A **Indirect responsibility/impact** • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)
- The following functions are solely carried out by the Adoption Board:
  - Granting or refusal of Irish adoption orders
  - Registration and supervision of Registered Adoption Societies
  - Granting of, or refusal to grant, declarations of eligibility and suitability in relation to Intercountry Adoption
  - Maintain registers of national and foreign adoptions
- It is noted that following Government acceptance, a project team has been established to implement the recommendations of a recent report — Organisation and Management Review, 2000 — in relation to matters such as the management, functions, organisation and structures of the agency

Overlap with/impact on functions of other agencies audited
- The Adoption Board has close working relationships with the Health Boards and registered adoption agencies which carry out the assessments on behalf of the Adoption Board

Role identified in *Quality and Fairness*
- There are no specific actions assigned directly to the Adoption Board
- However, as a service provider, a number of actions are likely to both impact upon, and require a response from, the agency (e.g. Action 49 — introduction of best practice models of customer care including a statutory system of complaint handling)

Board for the Employment of the Blind

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
An industrial workshop for the blind has existed in Dublin for over 150 years. The first two workshops, St. Joseph's in Drumcondra and Richmond Institute fell into serious financial difficulties, the Minister for Social Welfare agreed to establish a Board for the Employment of the Blind In 1972, responsibility for the Board's operations were transferred to the Department of Health The agency is funded from sales of products and services, capitation grants from individual health boards and direct deficit funding from the Department of Health and Children	**Stated functions (letter to Department 4/7/02)** Service organisation, central activity is the manufacturer of high quality divan beds and mattress for sale to the retail trade, in addition the traditional craft of basket making and french cane work are continued by craftspeople, manufacture of hair care products for the hotel hospitality market	**Assigned responsibility** • N/A **Indirect responsibility/impact** • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- It is noted that in December 1999 the Board made recommendations to the Minister for Health and Children regarding the future of the organisation. Having looked at various options in detail, the Board unanimously recommended that the operation be closed through a process that would be sensitive to the needs of the workforce. Following consultation the Minister decided against closure of Blindcraft. No new appointment of Chairman or Board members has taken place due to uncertainties regarding the legal status of the organisation
- It is also noted that no other providers of this type of service appear to be under the direct responsibility of the Department of Health and Children

Role identified in *Quality and Fairness*

- There are no specific actions assigned to the Board for the Employment of the Blind

Bord na Radharcmhastóirí (Opticians Board)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Established under the OPTICIANS ACT, 1956 to maintain the Register of Ophthalmic Opticians/Dispensing Opticians, issue certificates to registered members, regulate the prescribing, dispensing of prescriptions or sales of spectacles, approve particular courses/examinations for registration	**Statutory Functions (*Source Opticians Act, 1956*) — overview** Set up, maintain and publish the Register of Ophthalmic/Dispensing Opticians • The Board will register a person who applies to be registered, who has undergone training and passed examinations (Training and examinations under part V of the Act) (issue a certificate of registration) • The Board will register a person who has trained outside the state • The Board will register a person who satisfied the conditions prior to the establishment day • Refusal of registration • Removal of names from the register • Appeal of removal • Restoration of names • Register of Dispensing Opticians (registration, outside the state, removal, refusal, appeal and restoration). The Board may, in accordance with rules, provide or make provision for the courses of training and examinations to be taken by candidates for registration in the Register of Ophthalmic Opticians and candidates for registration in the Register of Dispensing Opticians and such rules may specify the manner in which and the conditions under which training shall be provided and may, in particular, provide— • For the approval by the Board for the purposes of such rules of lecturers and teachers • For the conditions of admission to the examinations • For the granting of certificates to persons taking the courses and passing the examinations • Approval of the Board of institutions suitable for training • Develop rules for regulation and control of prescribing, dispensing of prescriptions or sales • Scholarships • Annual fees for any registrations, restoration to a register, certificates, courses or examinations which are awarded under this Act.	**Assigned responsibility** • N/A **Indirect responsibility/impact** • P. 119 — Action 105 • Actions relevant to training bodies • Actions relevant to professional bodies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The following functions are solely carried out by the Opticians Board (however, similar functions in respect of different professions are carried out by other agencies)
  - Maintenance of a register of opticians
  - Rules for regulation and control of prescribing, dispensing of prescriptions or sales
  - Provide or make provision for the courses of training and examinations to be taken by candidates for registration
  - Approval of training institutions

Role identified in *Quality and Fairness*

- While there are no specific actions assigned directly to the Opticians Board, a number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104) collectively
- Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions

An Bord Cíoch Scrudaithe Naisiunta (National Breast Screening Board — Breastcheck)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Board was established under the NATIONAL BREAST SCREENING BOARD, (ESTABLISHMENT) ORDER, 1998 A pilot programme was established in 1989 by the Mater Foundation. It was one of six pilot programmes, was part of an EU initiative and received support from 'Europe against cancer'. Following an independent evaluation of the epidemiological aspects of the pilot programme, in 1995, the Minister announced his decision to introduce a phased breast screening programme. Therefore Breastcheck was introduced on a phased basis to reduce the incidence of breast cancer mortality in the 50-64 age group Phase 1 is providing screening in the ERHA, Midland Health Board and North Eastern Health Board catchment areas	**Statutory functions (Section 5; Establishment Order, 1998)** 1. The Board shall, in accordance with the directions of the health boards, prepare, institute and carry out the Programme 2. The Board shall carry out the Programme in stages beginning with Phase I and shall commence to carry out Phase I as soon as may be 3. The Board shall commence to carry out the subsequent phases of the Programme at such times as the Minister may determine and specify to the Board 4. (a) In the performance of its functions, the Board shall have regard to the policies and objectives of the Minister in relation to the early diagnosis and primary treatment of breast cancer in women (b) The Board shall have all such powers as are necessary or expedient for the performance of its functions and, in particular but without prejudice to the generality of the foregoing, shall establish appropriate systems for the planning, administration and carrying out of Phase I and for obtaining such information as it may require in relation to the management and administration of the Board (including its financial arrangements) (c) (i) The Board shall prepare and submit each year to the Minister a plan for the implementation of Phase I of the Programme. Such plans should include an estimate of expenditure proposed to be incurred by the Board (ii) The Board shall keep under review the Programme and its effectiveness and the plans aforesaid and the finances of the Board and may, if it considers it appropriate to do so, amend, with the consent of the Minister, the Programme and the annual plan (d) The Board shall, at such times as the Minister considers appropriate and specifies to the Board, prepare and submit to the Minister plans for the carrying out of the subsequent phases of the Programme (e) The Board shall carry out a plan, or a plan as amended under paragraph I of this Article, in accordance with its terms	**Assigned responsibility** • P. 163 — Action 11 **Indirect responsibility/impact** • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- Health boards, GPs and hospitals can organise for breast screening to take place but this is a targeted programme aimed at prevention, creating awareness and reducing breast cancer for women in the target group
- As the breast screening programme is likely to evolve from a pilot programme as it is extended on a national basis, there is the potential to mainstream the functions of the agency

Overlap with/impact on functions of other agencies audited

- The Breast Screening Board has close working relationships with the pilot Health Boards, and is in consultation with other Health Boards concerning the provision of additional centres and mobile units to extend the screening programme nationwide
- The Breast Screening Board also has interdependencies with information and research agencies such as the National Cancer Registry Board and the Women's Health Council
- Responsibility for the monitoring and evaluation of the programme currently appears to rest with the Board itself. It is likely that HIQA might play a key role in future monitoring and evaluation of such services

Role identified in *Quality and Fairness*

- Action 11 — the extension of the programmes of screening for breast and cervical cancer have been assigned directly to the Health Boards in conjunction with Breastcheck
- In addition, as a service provider, a number of actions are likely to both impact upon, and require a response from, the agency (e.g. Action 49 — introduction of best practice models of customer care including a statutory system of complaint handling)

Comhairle na Nimheanna (Poisons Council)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The council was established under the POISONS ACT, 1961 and the COMHAIRLE NA NIMHEANNA ORDER, 1962 (detailing the Council's term of office, quorum, etc) to advise on poisons	**Statutory functions (*Poisons Act, 1961*)** 1. The Council shall advise the Minister in relation to any regulations under section 14 (regulations in relation to poisons generally) of this Act and the Minister for Agriculture in relation to any regulations under section 15 (regulations in relation to use of poisons for agricultural and veterinary purposes) of this Act 2. The Council shall advise the Minister or the Minister for Agriculture on such other matters in relation to poisons, their manufacture, storage, transport, distribution, sale and use and the regulation, limitation, control and supervision of such manufacture, storage, transport, distribution, sale and use as the Minister or the Minister for Agriculture, as the case may be, shall refer to it 3. The Council shall advise the Minister in relation to any regulations made or proposed to be made after the commencement of this section under section 65 of the Health Act, 1947, which he refers to it	**Assigned responsibility** • N/A **Indirect responsibility/impact** • N/A

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- While the Poisons Council has been established to advise both the Minister for Health and Children as well as the Minister for Agriculture, it is noted that the Council has only met 3 times in the past 10 years

Overlap with/impact on functions of other agencies audited

- Under Section 14, the Minister for Health may make regulations on foot of advice/consultation with the Council which can provide for the following:
  - Licensing or registering by health authorities of persons (other than registered medical practitioners, pharmaceutical chemists, dispensing chemists and druggists and registered druggists) engaged in selling or offering or keeping for sale poisons and of premises in which poisons are sold or offered or kept for sale (otherwise than by registered medical practitioners pharmaceutical chemists, dispensing chemists and druggists or registered druggists) and for the description of premises so licensed or registered
  - The charging of fees by health authorities for such licensing or registering
  - The cancellation, suspension or restoration by health authorities of licences or registrations issued or made by them under the regulations
  - The enforcement and execution of the provisions of the regulations, by officers of the Minister, with the consent of the Minister for Agriculture, by officers of that Minister, by the Pharmaceutical Society of Ireland and its officers, and by health authorities and their officers
  - The prosecution of offences under section 17 of this Act in relation to the regulations by the Minister, the Pharmaceutical Society of Ireland or health authorities
- Under Section 15, the Minister for Agriculture may make regulations on foot of advice/consultation with the Council which can provide for the following:
  - The enforcement and execution of the provisions of the regulations by officers of the Minister for Agriculture
- The functions of the Council as outlined above would appear to have an impact on the following:
  - The Irish Medicines Board is currently responsible for the safety of medicinal products for human and veterinary use

Role identified in *Quality and Fairness*

- There are no specific actions assigned to the Poisons Council

Comhairle na nOspidéal

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Established under the HEALTH ACT 1970, the HEALTH (HOSPITAL BODIES) REGULATIONS, 1972 (S.I. NO. 164 OF 1972) and the HEALTH (HOSPITAL BODIES) REGULATIONS, 1972 (AMENDMENT) REGULATIONS 1978 (S.I. NO. 338 OF 1978)	**Statutory Functions *(Section 40b Health Act, 1970)*** • To regulate the number and type of appointments of consultant, medical staffs and such other officers or staffs as may be prescribed, in hospitals engaged in the provision of services under this Act • To specify qualifications for appointments referred to in subparagraph (i), subject to any general requirements determined by the Minister • To advise the Minister or any body established under this Act on matters relating to the organisation and operation of hospital services • To prepare and publish reports relating to hospital services • To perform any functions which may be prescribed, after consultation with the Council and with such bodies engaged in medical education as appear to the Minister to be appropriate, in relation to the selection of persons for appointments referred to in subparagraph (i) • To perform such other cognate functions in relation to hospital services as may be prescribed	**Assigned responsibility** • N/A **Indirect responsibility/impact** • P. 102 — Action 80 • P. 119 — Action 102 • P. 119 — Action 105 • Actions relevant to training bodies • Actions relevant to professional bodies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The following functions are solely carried out by Comhairle (however, similar functions in respect of different professions are carried out by other agencies)
  - Regulation of number and type of hospital consultants and other relevant staff
  - Specification of qualifications for relevant appointments
  - Provide or make provision for the courses of training and examinations to be taken by candidates for registration
  - Approval of training institutions
- At the request of the Minister for Health and Children, Comhairle has regulated consultant appointments in learning disability since 1983, and appointments of consultant medical staffs under the Irish Blood Transfusion Service since 1995
- In its submission on the development of the National Health Strategy (June 2001), Comhairle:
  - Indicated its intent to embark on a process of consultation with specialist training agencies and employing authorities on the implications for Consultant numbers and hospital medical workforce planning of the implementation of the Report on the Forum on Medical Manpower and the Hanly Report on NCHD working hours
  - Welcomed the establishment of a National Task Force on Medical Manpower to quantify the resource and other implications of the two reports, and looks forward to participating in, and contributing to, its work
- The arrangements outlined for a National Hospitals Agency (Action 80) are recognised as 'having implications for Comhairle na nOspidéal, many of whose existing functions will be carried out by the National Hospitals Agency on its establishment' (p. 103)
- In its press statement of 3rd January, 2002 Comhairle:
  - Noted that four of the six functions identified for the proposed National Hospitals Agency are currently undertaken by Comhairle as part of its statutory remit.
  - Would welcome the opportunity to take on the additional two functions (manage a new national waiting time database, and to facilitate closer linkages with the private hospital sector)
  - Advises that provision of expert objective advice on the organisation and development, location and configuration of hospital services and the designation of national specialist services is inextricably linked to the regulation of consultant posts on a national basis and the specification of qualifications for such posts in a consistent and objective manner
  - Recognises the value of streamlining the way in which consultant posts are currently funded, regulated and filled (many of the streamlining mechanisms are outlined in the Report on Consultant Appointment Procedures (June 2000) — which has yet to be implemented)
  - Suggests the value of one national agency with both advisory and regulatory functions (as distinct from advisory only)
  - Intends to engage in an examination of its own statutory functions and those for the proposed National Hospitals Agency with a view to proposing a revamping of existing structures and making the best use of the specialist knowledge and expertise (both medical and managerial) residing with members and officials

Comhairle na nOspidéal — *continued*

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*

Overlap with/impact on functions of other agencies audited

- Comhairle conducts reviews of individual specialties involved in service delivery on request of specialist and training bodies
- Notwithstanding the proposed National Hospitals Agency, the functions of Comhairle would appear to overlap with the following:
  - National Task Force on Medical Staffing which has been assigned responsibility for preparation and overseeing implementation of detailed strategies for:
    - Phased reduction of working hours of NCHDs
    - Addressing the medical staffing needs of the Irish hospital system and the associated medical training requirements
  - Other agencies carrying out reviews of hospital services, e.g. ERHA Bed Capacity report, Acute Hospital Bed Capacity — A National Review (Department of Health and Children)
- Consideration of posts arising from specific national policies (e.g. Cancer Strategy) involves Comhairle working in partnership with DoHC, National Forum on Cancer Services, Health Boards, voluntary hospitals and national Breast Screening Board

Role identified in *Quality and Fairness*

- There are no specific actions assigned directly to Comhairle na nOspidéal in the Strategy
- However, in relation to the functions carried out by the agency, the following references are made:
  - Action 80 — a National Hospitals Agency will be established, with the following primary functions:
    - To prepare a strategic plan for the expansion of capacity in the acute hospital system
    - To advise on the organisation and development of all acute hospital services
    - To advise the Minister on the designation of national specialist services and the development of designated services
    - To develop a strategic relationship with the private hospital sector
    - To manage a new national waiting time database and to co-ordinate actions to reduce waiting lists and waiting times
    - To liase with regulatory and professional bodies with decision-making roles in areas that affect acute hospital service delivery
  - Action 102 — the approach to regulating the number and type of consultant posts will be streamlined — where it is decided to establish a new hospital service or to expand an existing service (on the recommendation of the NHA), approval to the provision of any consultant post(s) involved will be dealt with through the relevant health board's service plan, taking account of the National Task Force on Medical Manpower (replacement posts will also be dealt with in the context of the service plan of the relevant health board)
  - Action 102 — the streamlining of the approach to regulating the number and type of consultant posts — assigned to the Department and Health Boards
  - Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions
  - Action 100 — integrated workforce planning will be introduced on a national basis (DoHC/Health Boards)

An Comhairle Fiacloireachta (Dental Council)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*

Established under the DENTISTS ACT, 1985 to provide for the regulation of dentists	**Statutory functions (Dentists Act, 1985)**
	• To provide for the registration and control of persons engaged in the practice of dentistry and to provide for other matters relating to the practice of dentistry
	• To promote high standards of professional education and professional conduct among dentists
	• To prepare and maintain a Register of Dentists (Section 26), and a Register of Dental Specialists (Section 28)
	• To satisfy itself from time to time:
	  • As to the suitability of the dental education and training provided by any body referred to in the Second Schedule
	  • As to the standards of theoretical and practical knowledge and clinical experience required at examinations for primary qualifications
	  • As to the adequacy and suitability of postgraduate education and training provided by bodies recognised by the Council for the purpose of dental specialist training (Section 34)
	• The Council shall ensure that the requirements relating to education and training for a qualification in dentistry shall satisfy the minimum standards specified in any EU Directive (Section 35)
	• The Council may, from time to time with the consent of the Minister, determine the specialties which it shall recognise for the purpose of specialist registration (section 37)
	• The Council or any person may apply to the Fitness to Practise Committee (established by the Council) for an inquiry into the fitness of a registered dentist . . . on the grounds of his alleged professional misconduct or his alleged unfitness to engage in such practice by reason of physical or mental disability (section 38)
		Assigned responsibility
		• P. 85 — Action 62
		
		Indirect responsibility/impact
		• P. 119 — Action 105
		• Actions relevant to training bodies
		• Actions relevant to professional bodies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The following functions are solely carried out by the Dental Council (however, similar functions in respect of different professions are carried out by other agencies)
  - Maintenance of a register of dentists
  - Fitness to Practice inquiries and sanctions
  - Promotion of high standards of professional education and professional conduct among dentists
  - Promotion and setting of educational and training standards for dentists

Overlap with/impact on functions of other agencies audited

- Postgraduate Medical and Dental Board in relation to education and training
  - Both agencies are involved in the promotion of, and setting of standards for, professional educational for dentists at postgraduate level
- Functions impact on Dublin Dental Hospital Board as provider of courses of study and training for post-graduate students of dentistry and dental surgery

Role identified in *Quality and Fairness*

- Joint responsibility is assigned to the Council (along with the Department and Health Boards) to expand specialist dental services (Action 62)
- A number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104)
- Action 105 recognises the role of statutory registration and regulation of professions by providing for the strengthening and expansion of statutory provisions

Crisis Pregnancy Agency

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*

The Agency was established under the CRISIS PREGNANCY AGENCY (ESTABLISHMENT) ORDER, 2001.
 	
In November 2000 the Oireachtas All-Party Committee on the Constitution published its fifth report, which dealt with the abortion issue. In the course of its deliberations, the Committee also discussed crisis pregnancy generally and recommended the establishment of an Agency under the sponsorship of the Department of Health and Children to focus specifically on the reduction of the number of crisis pregnancies
	Statutory functions (*Section 4; Establishment Order, 2001*)
	• In consultation with Departments of State specified in the Schedule and with such other persons as considered appropriate, to prepare a strategy to address the issue of crisis pregnancy, this strategy to provide, inter alia, for:
	  • A reduction in the number of crisis pregnancies by the provision of education, advice and contraceptive services
	  • A reduction in the number of women with crisis pregnancies who opt for abortion by offering services and supports which make other options more attractive
	  • The provision of counselling and medical services after crisis pregnancy
	• To work in partnership with the appropriate agencies to promote and co-ordinate the attainment of the objectives contained in the strategy
	• To promote the development by Departments of State and appropriate agencies of an operational plan to implement the strategy in its own sphere of responsibility
	• To monitor and review the attainment of the objectives in the operational plans
	• To produce periodic reports on progress and to propose remedial action where required
	• To take such measures and engage in such activities as it considers necessary to address the issue of crisis pregnancy
	• To draw up codes of best practice for consideration by agencies and individuals involved in providing services to women with crisis pregnancies
	• To promote and commission research into aspects of crisis pregnancy, as considered necessary
	• To furnish whenever it is so required by the Minister or on its own initiative, advice to the Minister or other Ministers of the Government on issues relating to crisis pregnancy
	• To perform any other function in relation to crisis pregnancy that the Minister may from time to time assign to it
	
	Other stated functions
	The Oireachtas Committee also recommended that the Agency would organise certain programmes itself where required and that it would be possible for such matters as ensuring that codes of practice exist for service deliverers, that service deliverers have proper training and sufficient resources and that the reach of the programmes is national
		Assigned responsibility
		• P. 71 — Action 28
		
		Indirect responsibility/impact
		• General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)
- The following functions would appear to be conducted solely by the Agency
  - Preparation of a strategy to address crisis pregnancy
  - Promote, monitor, review and report on operational plans of relevant agencies and Departments to implement the strategy
  - To draw up codes of best practice for agencies involved in providing related services
- As the Crisis Pregnancy Agency has been established to focus specifically on the reduction of the number of crisis pregnancies through the development of a supporting strategy, the potential to mainstream the functions of the agency after a particular time period has been identified

Overlap with/impact on functions of other agencies audited
- *'Health Boards already provide some services aimed at supporting woman in crisis pregnancies, teenagers who are pregnant and pregnant woman living in poverty. They will work closely with the new Agency in developing services to provide increased support at regional and local levels'* (*Quality and Fairness, p.71*)
- The functions of the Agency are also likely to impact on a number of other service providers (including voluntary agencies) involved in the provision of support services for women in crisis pregnancies
- The functions of the Agency would appear to overlap with those of the Women's Health Council — which is responsible for looking at policy development and research into any areas impacting on women's health

Role identified in *Quality and Fairness*
- Action 28 — a comprehensive strategy to address crisis pregnancy agency to be prepared — has been assigned directly to the Crisis Pregnancy Agency on establishment

Drug Treatment Centre Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Centre was established in 1969 and is the longest established treatment service in the country — it provides focused treatment for the population it serves. In 1988, THE DRUG TREATMENT CENTRE BOARD (ESTABLISHMENT) ORDER, 1988 established the Drug Treatment Centre Board	**Statutory functions (*Source: Section 4 Establishment (Amendment) Order, 1992*)** (a) to organise and administer at the Centre such out-patient drug treatment service as may from time to time be approved by the Minister (b) to organise and administer at the Centre a toxicology laboratory service including the processing of blood samples, liver function tests and urine analyses (c) to refer patients who attend the Centre for appropriate in-patient treatment when necessary (d) to provide an ante-natal and post-natal service for female drug abusers (e) to communicate, co-operate and co-ordinate with other bodies in promoting the prevention of drug abuse (f) to communicate, co-operate and co-ordinate with other bodies providing services for drug abusers (g) to provide a counselling and advisory service for those who attend the Centre (h) to organise and administer a counselling and advisory service for former patients of the Centre (I) to organise and provide or to arrange for the provision of relevant occupational rehabilitation programmes for drug misusers in association with the relevant statutory agencies (j) to provide and organise training programmes for personnel involved in the treatment of drug misusers in association with the appropriate statutory and non-statutory agencies (k) to provide advice, information and guidance to personnel involved in the treatment and/or care of drug misusers (l) to make any necessary provision for publicity in relation to the Centre (m) to make such charges as the Board thinks fit for the services provided and, where the Minister gives any direction in relation to such charges, to comply with such direction (n) to furnish advice, information and assistance in relation to its services to the Minister In the discharge of its functions, the Board shall have regard to such general aims and objectives as the Minister may from time to time determine and convey to the Board	**Assigned responsibility** • N/A **Indirect responsibility/impact** • P.69 — Action 22 • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- It is noted that no other providers of this type of service appear to be under the direct responsibility of the Department of Health and Children

Role identified in *Quality and Fairness*

- There are no specific actions assigned to the Drug Treatment Centre Board
- However, as a service provider, a number of actions are likely to both impact upon, and require a response from, the agency (e.g. Action 49 — introduction of best practice models of customer care including a statutory system of complaint handling)

Food Safety Authority of Ireland

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Prior to its establishment in 1998 under the FOOD SAFETY AUTHORITY OF IRELAND ACT, 1998, food control in Ireland was fragmented with a multitude of official agencies with separate responsibilities for different parts of the food chain — the concept of developing one agency to oversee and co-ordinate the activities of those agencies was realised with the establishment of the FSAI Essentially it has a dual role: • Enforcement of food safety legislation • Development of a food safety culture The FSAI is supported by the following two agencies established under the 1998 Act: • **Food Safety Consultative Council** — to enable the FSAI to consult representatives of consumers, producers, retailers, distributors, caterers and manufacturers and, where appropriate, official agencies about the activities or other measures to be undertaken for the purpose of establishing and maintaining the highest level of standards of food hygiene and safety reasonably available in the interests of public health and consumer protection • **Scientific Committee of the Food Safety Authority of Ireland** — to assist and advise the board in relation to matters of a scientific nature	**Statutory functions (*Section 18 (1) 1998 Act*)** • The principal function will be to take all reasonable steps to ensure: a. Food produced in the State (whether or not distributed or marketed in the state) and b. Food distributed or marketed in the State Meets the highest standards of food safety and hygiene reasonably attainable • It shall in particular, take all steps to ensure that food complies: a. With any relevant food legislation in respect of food safety and hygiene standards or b. In the absence of any legislation, with the provisions of generally recognised standards or codes of good practice aimed at ensuring the achievement of the highest standards of food hygiene and food safety • The Authority shall at the request of the Food Safety Promotion Board co-operate with it in its performance of its functions • In order to achieve the highest level of protection, in the interests of public health and consumer protection the Authority shall foster all stages of food production, from primary production through to its final use by the consumer, the establishment and maintenance of high standards of food hygiene and safety • Undertake or arrange to have such activities as it deems appropriate or carry out/arrange to have food inspections to ensure compliance with the legislation • Activities and food inspections (above) shall be directed towards bringing a general acceptance amongst producers, manufacturers, distributors, retailers and caterers of the principle that all food placed on the market, the primary responsibility for safety and suitability of food is borne by them • Authority shall endeavour to consult with representatives of consumers, producers, retailers, distributors, caterers and manufacturers, where appropriate, official agencies about the activities or other measure to be undertaken ***British Irish agreement, 1999 part iii (replacing section 11/12 in 1998, Act)*** • The Authority may undertake, commission or collaborate in research projects	**Assigned responsibility** • N/A **Indirect responsibility/ impact** • P.66 — Action 17 • General actions relevant to service providers

Food Safety Authority of Ireland — *continued*

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Food Safety Authority coordinates 46 agencies involved in the production, distribution, marketing and promotion of food, including the work of Government departments and other state agencies that historically comprised the nation's food control and enforcement system — these agencies now operate under the FSAI
- The following additional functions would appear to be conducted solely by the Agency
    - Enforcement of food safety legislation

Overlap with/impact on functions of other agencies audited

- The functions of the Food Safety Promotion Board are interlinked with the FSAI
    - Communications & Information — transferred to Food Safety Promotion Board — the FSAI now concentrates on key sectors of the food chain to highlight the risks of food borne disease, provide information on outbreaks and advise on how these risks should be prevented and controlled
- FSAI works in strategic partnership with the following agencies on food safety policies and initiatives (based on service agreements)
    - Department of Agriculture, Food & Rural Development — responsible for the enforcement and compliance in relation to meat hygiene (over 200 premises), milk and milk products (180 plants) and egg/egg products (220 premises)
    - Health Boards — 37,000 inspections were carried out by the Environmental Health Officers
    - Local Authority Veterinary Service — 600 premises/96 abattoirs inspected 18 were found to be non-compliant/164 audits of butcher outlets 13 were non-complaint with the regulations
    - Department of Marine and Natural Resources — 28 sea fisheries officers supervised almost 350 premises, engaged in the processing, handling and storage of fish under service contract to the Authority
    - Office of the Director of Consumer Affairs — 296 retail units were visited and 1,401 products were examined under the Food Labelling Regulations

Role identified in *Quality and Fairness*

- While the Agency has no direct assigned responsibility for any actions, Action 17 provides for preparation of legislation in the area of food safety to take account of developments in food safety regulation at national and EU level by the Department of Health and Children

Food Safety Promotion Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Board was set up under the Belfast Agreement as one of the six all-island implementation bodies. It provides advice and guidance on food safety but the enforcement of food safety regulations are handled separately in the North and South	**Statutory functions *(British Irish Agreement 1999)*** • Promotion of food safety • Research into food safety • Communication of food alerts • Surveillance of food-borne diseases • Promotion of scientific co-operation and linkages between laboratories • Development of cost effective facilities for specialised laboratory testing **Other stated functions *(Corporate Plan)*** • Engage in a comprehensive advertising campaign using broadcast and print media • Convene an all-island Food Safety Training Council • Begin the development of a database on food-borne illness • Facilitate training events for public health professionals • Commission research projects to enhance food safety knowledge • Work with other agencies to develop an all-island food strategy	**Assigned responsibility** • N/A **Indirect responsibility/impact** • P.66 — Action 17 • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Food Safety Promotion Board is one of the six North-South implementation bodies, and as such is responsible for some of the following functions:
  - Development of an all-island food strategy
  - Promotion of cooperation and coordination on an all-island basis

Overlap with/impact on functions of other agencies audited

- The functions of the Food Safety Promotion Board are closely interlinked with the FSAI
  - Communications & Information — transferred to Food Safety Promotion Board
  - Research projects
  - Monitoring of food safety
- Potential overlap with FSAI on the development of information, advice, promotion of food safety and surveillance of outbreaks
- Potential overlap with the National Disease Surveillance Centre in relation to food borne outbreak surveillance

Role identified in *Quality and Fairness*

- While the Agency has no direct assigned responsibility for any actions, Action 17 provides for preparation of legislation in the area of food safety to take account of developments in food safety regulation at national and EU level by the Department of Health and Children

General Medical Services (Payments) Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Board was established under the GENERAL MEDICAL SERVICES (PAYMENTS) BOARD (ESTABLISHMENT) ORDER, 1972. Areas of responsibility were extended under the GENERAL MEDICAL SERVICES (PAYMENTS) BOARD (ESTABLISHMENT) ORDER, 1972, (AMENDMENT) ORDER, 1990 and the GENERAL MEDICAL SERVICES (PAYMENTS) BOARD (ESTABLISHMENT) ORDER, 1972 (AMENDMENT) ORDER, 1994. The Board makes payments on behalf of the Health Boards for: • GP services for GMS cardholders • Prescriptions for GMS cardholders • Payments for other prescriptions under the Long Term Illness scheme and Drug Payments Scheme • Payments for Dental Care • Payments for Optical Services • High tech drugs (HTD) • Primary childhood immunisation • Methadone treatment	**Statutory functions *(Amendment to the 1972 Establishment Order, 1994)*** The health boards shall arrange jointly for the performance of the following functions in relation to:— (i) The provision of services under section 58 and section 59 of the Act, and (ii) The provision of dental services under section 67 (i) of the Act:— (*a*) the calculation of payments to be made for such services or arising from the provision of such services; (*b*) the making of such payments; (*c*) the verification of the accuracy and reasonableness of claims in relation to such services; (*d*) the compilation of statistics and other information in relation to such services and the communication of such information to persons concerned with the operation of such services	**Assigned responsibility** • N/A **Indirect responsibility/impact** • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The GMS Payments Board was established to provide a common payments service for the Health Boards for a number of national schemes

Overlap with/impact on functions of other agencies audited

- The communication of statistics and other information in relation to its services has an impact on the following:
  - Agencies involved in the planning of primary care services
  - Agencies involved in research of primary care services

Role identified in *Quality and Fairness*

- The Board has no direct assigned responsibility for any actions under the Strategy. However, actions 36,37,38 refer to eligibility and medical cards — although it is unclear if GMS Board are being included in this work
- The structure and governance arrangements of the GMS Payments Board are currently the focus of an independent review, running in parallel with this Audit

Health Boards Executive (HeBE)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
HEALTH ACT 1996 brought new obligations and opportunities for Health Boards to work collectively in pursuit of strategic objectives The Executive was established under THE HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT 1999 (HEALTH BOARDS EXECUTIVE) (ESTABLISHMENT) ORDER, 2002 to facilitate conjoint working between Health Boards, including the following: • To further improve the efficiency and effectiveness of health and personal social services (VFM) • Progress a national health agenda	**Statutory Functions (Health (Eastern Regional Health Authority) Act, 1999)** **21**—(4) The Executive shall perform, on behalf of the health boards— (*a*) such executive functions of the health boards as may be specified, from time to time, by the members of the Executive, and (*b*) such other executive functions in relation to improving the efficiency and effectiveness of the health and personal social services as the Minister may, from time to time, direct. **Other stated functions *(HeBE position document October 2001)*** Established to further improve the efficiency and effectiveness of health and personal social services. The Executive will achieve this by undertaking: • Conjointly, activities falling within the executive remit of the Health Boards, Area Health Boards and the ERHA. The HeBE work programme will reflect the Executive's commitment to a modernisation agenda for the state's health delivery system • A number of devolved functions from the Department of Health and Children. These functions include a spectrum of operational activities currently being undertaken by the Department and which will on a phased basis and following negotiation be transferred to HeBE	**Assigned responsibility** • Page 80 — Action 48 • Page 81 — Action 52 • Page 81 — Action 53 • Page 82 — Action 54 • Page 129 — Action 112 **Indirect responsibility/impact** • General actions relevant to Health Boards

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- It is noted that the role of HeBE is to be strengthened under Quality and Fairness to contribute to the change agenda

Overlap with/impact on functions of other agencies audited

- HeBE has close operational links with the ERHA, Health Boards and the Department of Health and Children in the identification and delivery of a number of devolved functions
- Its assigned role in the change agenda will require close working and consultation with the Office for Health Management

Role identified in *Quality and Fairness*

- A strengthened role for HeBE as a key instrument in the change agenda is identified in Action 112
- The Executive is assigned joint responsibility for a number of executive actions with the Health Boards under Quality and Fairness, for example:
  - The introduction of a national standardised approach to the measurement of patient satisfaction
  - Review of charges under Action 53
  - Streamlining of funding arrangements for national community and voluntary bodies (Action 54)

Health Information and Quality Authority (HIQA)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Action 111 of *Quality and Fairness* provides for the establishment of a Health Information and Quality Authority to • Ensure the services provided in the health system meet nationally agreed standards, both at clinical and managerial level • Assess whether the health and personal social services are managed and delivered to ensure the best possible outcomes within the resources available	**Stated functions (*Action 111 — Quality and Fairness*)** • Provide the lead on information development, in line with the forthcoming National Health Information Strategy • Develop information standards, definitions and data dictionaries • Develop and agree minimum datasets • Quality-assure data and information • Assess proposed information developments relating to data and technical standards • Promote education, training and skills development for information staff • Promote and co-ordinate national research and development on e-health • Develop a national e-library to guide decision-making • Promote a common approach to security, privacy and confidentiality • Develop and agree guidelines governing access to information from health agencies • Assist efficient and effective procurement of health information technology for the health system	**Assigned responsibility** • Page 65 — Action 13 • Page 65 — Action 14 • Page 71 — Action 29 • Page 83 — Action 56 • Page 87 — Action 63 • Page 88 — Action 68 • Page 98 — Action 77 • Page 132 — Action 116 • Page 132 — Action 117 • Page 133 — Action 118 • Page 133 — Action 119 *Primary Care Strategy* • Actions 7, 8, 10, 11, 14 & 18 **Indirect responsibility/impact** • Page 127 — Action 111 • General actions relevant to service providers • Actions relevant to information agencies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- Critical driver of a number of goals and frameworks in *Quality and Fairness*, including better health, high performance, organisational reform and information
- Lead role in relation to system-wide monitoring and evaluation, development and implementation of information standards and systems

Overlap with/impact on functions of other agencies audited

- The functions of HIQA will impact on the functioning of a range of bodies especially DoHC, Health Boards, service providers
    - Coordination and development of quality initiatives and standards (e.g. professional bodies, training bodies, service providers)
    - Development and implementation of information standards and systems (national information agencies including National Disease Surveillance Centre, the National Cancer Registry, the Health Research Board, the Economic and Social Research Institute etc; Health Boards, ERHA and HeBE)
    - Monitoring and evaluation of health and personal social services (other agencies involved in monitoring and evaluation and inspection — ERHA, SSI, IHSAB, etc)

Role identified in *Quality and Fairness*

- The Authority is assigned joint responsibility for a number of actions under *Quality and Fairness*, for example:
    - Monitoring and evaluation of implementation of national strategies (e.g. Action 13)
    - Development of service and quality standards, disease protocols etc (e.g. Action 14, 29)
    - Development and expansion of services (e.g. Action 56, Action 7 Primary Care Strategy)
    - Integration and expansion of quality systems (e.g. Action 63)
    - Definition and collection of health information (e.g. Action 68)
    - Commissioning and development of health information systems (e.g. Actions 77, 116, Action 8 Primary Care Strategy)
- Action 1 of the Primary Care Strategy lists the coordination of quality initiatives as a key role of the Primary Care Task Force

Health Research Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*

Established under the HEALTH (CORPORATE BODIES) ACT, 1961 by S.I. NO. 279 OF 1986. Its functions are to promote, assist, commission or conduct medical, health, epidemiological and health services research; to liaise and co-operate with other research bodies in Ireland or elsewhere in the promotion, commissioning or conduct of relevant research; to undertake such other cognate functions as the Minister for Health and Children may from time to time determine. The HRB carries out these functions through competitive funding of research and maintaining research databases.	**Statutory functions (Section 4 (1) HRB Consolidated Order, 2002)**
	• To promote, assist, commission, or conduct:
	  • Medical research
	  • Epidemiological research (national level)
	  • Health research
	  • Health services research
	• To liase and co-operate with other research bodies in Ireland or elsewhere in the promotion, commissioning or conduct of research
	• To undertake such other cognate functions as the Minister may from time to time determine
	
	Other stated functions (Making Knowledge Work For Health)
	• A lead role in support for research projects, programmes, research careers and infrastructure
	• An agency role on behalf of the DoHC in building R&D for health by awarding funding from proposals for R&D programmes from Health agencies
	• A key role in contributing through Intra-Mural Research and information activities to building a research culture and the evidence base for decision-making
	• A role in developing expertise in research ethics and good research practice
	• A role in developing guidelines for the Health Services on the commissioning of research
	• A role in building all-island research capacity
		Assigned responsibility
		• Page 90 — Action 73
		Primary Care Strategy
		• Action 18
		
		Indirect responsibility/impact
		• General actions relevant to service providers
		• Actions relevant to information agencies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Board fulfils a lead role in supporting research, and acts as a funding agency for the Department to distribute funds
- Making Knowledge Work for Health — the recent national strategy setting the objectives for health research stated the following:
  - Research is a key factor in promoting health, combating disease, reducing disability and improving quality of care
  - Research is vital if the health services are to becomes more efficient and effective
  - More health research can help achieve other government objectives such as implanting the healthcare industry in Ireland

Overlap with/impact on functions of other agencies audited

- The functions of the HRB impact on the following:
  - Research activities of other agencies (Health Boards, other service providers, educational bodies etc)
  - Information gathering by information agencies (National Disease Surveillance Centre, the National Cancer Registry, the Health Research Board, the Economic and Social Research Institute)
- Unclear as to how much overlap there is between health board and service provider commissioning of external research and the work of HRB
- Role of HIQA in research into e-Health etc

Role identified in *Quality and Fairness*

- The Board is assigned joint responsibility along with the Department and service providers for the implementation of the Health Research Strategy, with the aim of continually developing health research to support information and quality initiatives (Action 73)
- Action 18 of the Primary Care Strategy identifies a role for the Board (along with the Primary Care Task Force, the education sector and HIQA) in developing academic practice and research
- The Board also has a key role in supporting the overall goal of the provision of information and evidence-based decision making

Health Service Employers Agency (HSEA)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Established under THE HEALTH SERVICE EMPLOYERS AGENCY (ESTABLISHMENT) ORDER, 1996.	**Statutory functions *(The Health Service Employers Agency (Establishment) Order, 1996)*** • To promote value for money in pay cost management • To promote and support efficiency and effectiveness in employment practices consistent with changing service and operational requirements • To support, and where appropriate, represent Health Service Employers in the management of industrial relations with particular reference to national level issues relating to pay and conditions of employment • To develop appropriate research, educational and informational initiatives to assist personnel management **Other stated functions (Corporate Objectives)** *HRM Advisory Service* • To provide a comprehensive employer advisory service designed to foster modern approaches to devolved management and dynamic staff management • To pool resources and expertise in developing policies designed to improve HRM • To provide effective guideline documentation to employers on new or amended employment legislation and related practices, procedures and policies • To provide a comprehensive advisory information and research service on HR and IR issues *Innovation and Change Management* • To improve cost effectiveness in the pay costs of service delivery in the health service • To analyse and review current employment practices and related operational issues in order to identify opportunities for improvement • To develop innovative approaches to change in a participative manner respecting the contribution of staff at all levels and their representative bodies *Industrial Relations* • To represent health service employers in national negotiations on pay and conditions of employment for all categories of staff • To support and/ or represent, as appropriate, health service employers on local issues • To align pay negotiations with improvements in service delivery • To work in partnership with the staff representative bodies to achieve change, particularly in improving delivery service and achieving value for money	**Assigned responsibility** • Page 98 — Action 77 • Page 119 — Action 103 • Page 121 — Action 108 *Primary Care Strategy* • Actions 3 & 14 **Indirect responsibility/impact** • General actions relevant to service providers • Actions relevant to employing bodies

Health Service Employers Agency (HSEA) — *continued*

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Agency has primary responsibility for the following functions in the Irish health system:
  - Support to health service employers
  - Representation at national agreements
  - Develop research into employment practices and personnel management
- The recent report on the Audit of the Irish Health System for Value for Money suggested that HSEA would be seen as a leader in addressing IR and change management issues. Employers would look to this agency for leadership in terms of tackling IR and change management issues. There are major issues from an employer/employee perspective discussed above and in the ensuing sections which will impact on employment practice, where employers on the ground will require significant levels of additional support. The report identifies the need for the HSEA to be properly resourced to allow it to be more proactive in terms of promoting and supporting VFM in employment practice at all levels in the system

Overlap with/impact on functions of other agencies audited

- The Agency has strong links to member organisations, including senior management representing the interest of the Health Boards, Voluntary Hospitals, Mental Handicap Agencies and other health bodies which make up the membership of the Agency, HRM professionals in the member organisations and line management in member organisations (where HRM and other management functions are more devolved)
- The functions of the Agency have an impact on the following:
  - Role of OHM and health boards in the change agenda
  - Activities of the Department, health boards and other employers in relation to employment practices and industrial relations
  - Involvement of the Department in cost effectiveness, pay costs etc
- The Agency has strong linkages with a variety of bodies, including:
  - IBEC
  - Training and professional bodies
  - Labour Court and Labour Relations Committee
  - Other public sector employers
  - The staff representative bodies

Role identified in *Quality and Fairness*

- The Agency is assigned joint responsibility along with the Department and service providers for the implementation of a number of actions, including:
  - Promotion of best practice in recruitment and retention (Action 103)
  - Publication of a detailed Action Plan for People Management (in conjunction with Department) — Action 108
- The Agency is likely to have a key role in supporting health service employers in the management of industrial relations arising from the change agenda outlined by *Quality and Fairness*
- The Agency has also been assigned responsibility for two actions under the Primary Care Strategy (alongside the Primary Care Task Force and the health boards)
  - The production of a primary care human resource plan
  - Arrangements for the increases in personnel for primary care teams and networks on a national basis

Note: Prospectus understands that an examination of the role and functions of the HSEA is in progress against the background of the Labour Relations Commission review of industrial relations in the health system.

Hospital Bodies Administrative Bureau

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Bureau was established under the HEALTH (CORPORATE BODIES) ACT, 1961 and the HOSPITAL BODIES ADMINISTRATIVE BUREAU ESTABLISHMENT ORDER, 1972 to provide administrative, analytical, clerical and ancillary services and other facilities for Comhairle na nOspidéal and the regional hospital boards This was further to an independent report in 1972 which recommended a single staff unit to cater for the servicing needs of the newly established Comhairle na nOspidéal, Dublin Regional Hospital Board, Cork Regional Hospital Board and Galway Regional Hospital Board	**Statutory functions *(Hospital Bodies Administrative Bureau (Establishment) Order, 1973)*** • To provide such administrative, analytical, clerical and ancillary services and such facilities, including office accommodation and equipment, as may, from time to time, be required to assist Comhairle na nOspidéal and the regional hospital boards in discharging their functions • To provide such other services and facilities as may, from time to time, be approved by the Minister after consultation with Comhairle na nOspidéal and the regional hospital boards	**Assigned responsibility** • N/A **Indirect responsibility/impact** • N/A

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Regional Hospital Boards ceased to function in 1976/1977. The functions of the Bureau have related solely to Comhairle na nOspidéal since then, and is de facto the executive arm of Comhairle
- The Department of Health and Children makes an annual allocation to Comhairle na nOspidéal in response to a joint estimate of expenditure

Overlap with/impact on functions of other agencies audited

- The impact of the proposed National Hospitals Agency on the current functions of Comhairle na nOspidéal are likely to have a similar impact on the Bureau

Role identified in *Quality and Fairness*

- There are no specific actions assigned to the Hospital Bodies Administrative Bureau

Hospitals Trust Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Hospitals Trust Board was established to distribute the funds from the Hospitals Sweepstakes — a lottery set up to contribute towards the refurbishment of Irish hospitals The PUBLIC HOSPITALS ACT, 1933 provided for National Hospital Trustees and the definition of functions. The PUBLIC HOSPITALS (AMENDMENT) ACT, 1938 (Hospitals Trust Board) established the Hospitals Trust Board, to which the functions from National Hospital Trustees were transferred	**Statutory functions (Public Hospitals Act, 1933)** • To dispose and apply the funds raised • To keep in such form as shall be approved by the Minister for Health and Children all proper and usual accounts of all moneys received or expended by them • To make provision for the general improvement and coordination of the facilities made available to the public by such institutions and organisations as aforesaid, and to provide for divers matters connected with the matters aforesaid and to make such amendments of the law as may be necessary. • Pay bank fees	**Assigned responsibility** • N/A **Indirect responsibility/impact** • N/A

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The functions of the Board appear to be no longer relevant as there are no longer funds for distribution from the sweepstakes

Role identified in *Quality and Fairness*

- There are no specific actions assigned to the Hospitals Trust Board

Institute of Public Health

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Institute of Public Health was established on an all-Ireland basis under the Good Friday Agreement. It originated from an agreement by the Department of Health and Social Services in Northern Ireland and the Department of Health and Children in the Republic of Ireland to establish an institute in conjunction with the Royal College of Physicians in Ireland which would offer practical benefits through promoting cooperation in the area of public health A report on the role of an Institute of Public Health prepared by a working group set up by the two Chief Medical Officers (1996) outlined ways in which co-operation could achieve benefits in the areas of information, research, training and policy advice It is concerned with tackling health inequalities, strengthening partnerships and networking nationally and internationally, contributing to public health information and surveillance and strengthening public health capacity	**Stated functions *(Strategic Objectives)*** The Institute will promote cooperation in research, training, information and policy advice in order to achieve the following Strategic Objectives: • Contributing to policies which tackle inequalities in health • Strengthening partnerships for improving the health of society • Maximising the potential for international collaboration to contribute to the surveillance of population health • Producing information on health and inequalities and contribute to the surveillance of population health • Contributing to the capacity (information, skills and resources) of those who work to improve the health of society	**Assigned responsibility** • N/A **Indirect responsibility/impact** • Actions related to service providers • Actions related to information agencies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- In the area of environmental health, the Institute of Public Health in Ireland is supporting co-operation across boundaries to sustain and develop public health work. The role of the Institute is vital in providing public health leadership which can cut across sectors and contribute to the reduction/elimination of health inequalities. There is a need to provide a comprehensive plan to support the Institute in enjoining the partners in environmental action and health planning (*Quality and Fairness*)
- The Institute is solely responsible for the following functions:
  - Promotion of cooperation in the area of public health between the Republic of Ireland and Northern Ireland

Overlap with/impact on functions of other agencies audited

- The proposed development of population health units at Department and health board level need to take account of the role of the Institute to ensure optimal cooperation and coordination of work
- The following function in particular carried out by the Institute will impact directly on the proposed Health Information and Quality Agency:
  - Working to strengthen information skills

Role identified in *Quality and Fairness*

- There are no specific actions assigned to the Institute of Public Health
- Research carried out by the Institute was used to inform key policy in Quality and Fairness (e.g. men's health etc)

Irish Health Services Accreditation Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Irish Health Services Accreditation Board was established under the IRISH HEALTH SERVICES ACCREDITATION BOARD (ESTABLISHMENT) ORDER, 2002 to ensure quality in the provision of healthcare	**Statutory functions *(Establishment Order, 2002)*** • To operate hospital accreditation programmes and to grant accreditation to hospitals meeting standards set or recognised by the Board • To operate accreditation programmes in respect of such providers of other health services as may, from time to time, be deemed appropriate by the Minister after consultation with the Board, and to grant accreditation to such providers meeting standards set or recognised by the Board • To operate such other schemes aimed at ensuring quality in the provision of health services as may, from time to time, be deemed appropriate by the Minister after consultation with the Board • To do such other things as are incidental or conducive to carrying out the functions as set out above • The Board may promote its functions through provision of information to the public	**Assigned responsibility** • N/A **Indirect responsibility/impact** • Action 63 (p. 87) • Actions related to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Board has been established to operate a scheme of accreditation to promote continuous quality improvement and safety in acute hospitals. The accreditation programme has already been introduced in a number of the major acute teaching hospitals
- *Quality and Fairness* identifies the extension of the Hospital Accreditation Programme as a key requirement for the integration and expansion of quality systems throughout the health system (Action 63)
- Provision has been made under the Board's Establishment Order to operate accreditation programmes for other providers as deemed appropriate by the Minister

Overlap with/impact on functions of other agencies audited

- The establishment of HIQA will require close working relationships between it and the Accreditation Board to ensure efficient collaborative practice
  - *'One of HIQA 's functions is 'to introduce and oversee accreditation processes across the health system. This will include, in relation to acute hospitals area, working closely with the Hospitals Accreditation Body which will soon be established'* (p. 128)
- Links/will link with hospitals and other health care providers in relation to accreditation of their programmes
- As the accreditation programme extends to service providers outside of the hospital system, the functions of the Board are likely to impact on the following:
  - Other agencies involved in the inspection or monitoring of service quality or standards — e.g. Social Services Inspectorate
  - Other agencies involved in the setting of professional and professional standards — e.g. professional bodies

Role identified in *Quality and Fairness*

- There are no specific actions assigned to the Board, however the extension of the health accreditation programme is cited as a key deliverable

Irish Blood Transfusion Service Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Service was established under the THE BLOOD TRANSFUSION SERVICE BOARD (ESTABLISHMENT) ORDER, 1965 to provide blood transfusion and related services, a continued availability of a safe and adequate supply of blood and blood products THE BLOOD TRANSFUSION SERVICE BOARD (ESTABLISHMENT) (AMENDMENT) ORDER, 1988 allows for the establishment of an eye bank to facilitate corneal transplantation	**Statutory functions *(Establishment Order, 1965, Amendment Order, 1994)*** • To organise and administer a blood transfusion service including the processing or supply of blood derivatives or other blood products and including blood group and other tests in relation to specimens of blood received by the Board • To make available blood and blood products • To make available equipment or re-agents suitable for use in relation to the service • To furnish advice, information and assistance in relation to the service to the Minister, any health authority or any hospitals • To publicise the service, as necessary • To organise, provide, assist or encourage research and the training and teaching of persons relating to blood transfusion and the preparation of blood products • To co-operate with other bodies with analogous functions • To establish an eye bank to facilitate corneal transplants	**Assigned responsibility** • Page 88 — Action 66 **Indirect responsibility/impact** • Actions related to service providers • Actions related to research and information agencies

Commentary on findings based on available evidence

Relevance and distribution of function(s)
- The Board provides a national service in relation to the organisation and administration of a blood transfusion service

Overlap with/impact on functions of other agencies audited
- The Board provides a key service to hospitals
- Links with ongoing education, training and development work of National Haemovigilance Office in relation to transfusion practice, in partnership with hospitals
- Dependency on Irish Medicines Board with regard to licensing and product authorisation of blood products
- Certain of its technical functions are inspected by the Irish Medicines Board

Role identified in *Quality and Fairness*
- The Board has been assigned joint responsibility (alongside the Department and the Irish Medicines Board) for the setting and adherence to the highest international standards of safety in transfusion medicine (Action 66)

Irish Medicines Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Board was established under the IRISH MEDICINES BOARD ACT, 1995 Supported by the following advisory committees also established under the same legislation: • Advisory Committee for Human Medicines to assist and advise the Board in relation to any matters pertaining to the safety, quality or efficacy of medicinal products for human use as are referred to it by the Board and to perform the functions assigned to it by subsection (8) • Advisory Committee for Veterinary Medicines to assist and advise the Board in relation to any matters pertaining to the safety, quality or efficacy of medicinal products for animal use as are referred to it by the Board and to perform the functions assigned to it by subsection (8)	**Statutory functions *(Irish Medicines Board Act, 1995)*** • The licensing of the manufacture, preparation, importation, distribution and sale of medicinal products • Subject to subsection (4), to exercise the powers conferred on the competent authority by Council Directive No. 65/65/EEC of 26 January 1965, as amended, and any regulations under the Health Act, 1947, giving effect to that Directive as amended • To exercise the powers conferred on the supervisory authority by Council Regulation (EEC) No. 2309/93 of 22 July 1993(3) • To exercise the powers conferred on the competent authority by Council Directive No. 81/851/EEC of 28 September 1981(4) • To exercise the powers specified in the Control of Clinical Trials Acts, 1987 and 1990, and conferred on the Board by section 35 • To establish and administer a service for obtaining and assessing information as regards the safety, quality and efficacy of medicinal products • To establish and administer a service for obtaining and assessing reports on any adverse effects of medicinal products in use in the State • To advise the Minister and others concerned as to the precautions or restrictions, if any, subject to which medicinal products may be marketed or continued in use in the State • To arrange for the collection and dissemination of information relating to medicinal products including, in particular, information concerning the pharmacological classification and therapeutic efficacy of such products • To furnish, whenever it is so requested by the Minister, advice to the Minister in relation to the licensing of the manufacture, importation, distribution and sale of medicinal products and in relation to the standards of manufacturing practice (including quality control) of medicinal products • To furnish, whenever it is so requested by the Minister, advice to the Minister in relation to the certification for export or any other purpose of medicinal products manufactured in the State • To establish and administer a service for the inspection of any service for the collection, screening, processing and quality control facilities and procedures in respect of human blood, blood components, blood products and plasma derivatives for the purpose of ensuring the safety and quality of blood, blood components, blood products and plasma derivatives and to advise the Minister in relation to such general or particular matters arising out of the administration of such a service as the Minister may refer to the Board • If so requested, to advise the Minister or others concerned on such matters relating to medical devices as may be referred to it and are connected with the functions or activities of, or the services provided by, the Board • To furnish, whenever it so thinks fit or is so requested by the Minister, advice to the Minister in relation to any matter connected with the functions or activities of, or the services provided by, the Board The Minister may, if he or she so thinks fit or, if so requested by the Minister for Agriculture, Food and Forestry, by order: • Confer on the Board such additional functions connected with the functions for the time being of the Board or the services or activities that the Board is authorised for the time being to provide or carry on (including functions for the purpose of giving effect to any directive, regulation or other act adopted by an institution of the European Communities in relation to medicinal products) as he or she considers appropriate • Make such provision as he or she considers necessary or expedient in relation to matters ancillary to or arising out of the conferral on the Board of functions under this section or the performance by the Board of functions so conferred	**Assigned responsibility** • Page 87 — Action 65 • Page 88 — Action 66 Indirect responsibility/impact • Page 87 — Action 64 • Actions related to service providers • Actions related to research and information agencies

Irish Medicines Board — *continued*

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*

	Other stated functions *(Guide to Information held by Irish Medicines Board)*
	• Assessment of applications for authorisation to market medicinal products for Human and Veterinary use. Issue of product authorisations (PA/VPA) to market each medicinal product, or rejection of such applications
	• Assessment of applications to carry out clinical trials in humans in Ireland. Issue of permission/refusal of permission to carry out clinical trials
	• Inspections of manufacturers of medicines for human or veterinary use. Inspection of wholesalers of medicines for human use. Issue of manufacturing and wholesale licences or refusal of such licences.
	• Post marketing surveillance including
	  • Pharmacovigilance
	  • Quality defect monitoring
	  • Sampling and testing
	  • Product recalls
	• Issue of certificates to companies wishing to export their medicinal products to countries outside of the EU
	• Servicing of a number of EU Committees and Schemes related to authorisation of medicines. Servicing of the Pharmaceutical Inspection Co-Operation Scheme dealing with harmonisation of inspections standards. Participation in the WHO Collaborating Programme for International Drug Monitoring to increase the opportunities for review and evaluation of drug safety issues originating from outside the EU	

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Board provides a national service in relation to the following:
  - Licensing of medicinal products and devices
  - Facilitate availability of safe and effective human and veterinary medicines on the Irish market
  - Keep unsafe or ineffective human and veterinary medicines off the market
  - Ensure that clear easily understandable information for safe and effective use of all approved medicines is available
  - Ensure that medicines on the market continue to fulfil their expectations, by monitoring of reports of suspected adverse reactions and new scientific information
  - Approve and monitor clinical research
  - Ensure that withdrawal periods for veterinary medicinal products are adequate to protect consumers from harmful residues in foodstuffs of treated animals
  - Ensure products are manufactured in compliance with Good Manufacturing Practices and the requirements of the product authorisations
  - Effectively participate in the European Medicines Regulatory System

Overlap with/impact on functions of other agencies audited

- The Board provides a key service to hospitals, health care professionals, license holders and applicants, pharmaceutical and medical devices industry
- Inspects technical functions of Irish Blood Transfusion Board, as well as licensing and product authorisation of blood products

Role identified in *Quality and Fairness*

- The Board has been assigned joint responsibility (alongside the Department and the Blood Transfusion Services Board) for the setting and adherence to the highest international standards of safety in transfusion medicine (Action 66); as well as responsibility for the examination of the licensing of alternative medicines (in conjunction with the Department) — Action 65
- In addition, Action 64 provides for the complete review of medicines legislation by the Department

Medical Council

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*

The Service was established under the MEDICAL PRACTITIONERS ACT, 1978 (currently under review) to act as the statutory body for the medical profession. Its functions include administering the General Register of Medical Practitioners, ensuring that the standards of medical training are maintained and inquiring into the fitness of a doctor to practise on specific grounds
 	
The Act was amended by the MEDICAL PRACTITIONERS (AMENDMENT) ACT, 1993, the MEDCIAL PRACTITIONERS (AMENDMENT) ACT 2OOO, and the MEDICAL PRACTITIONERS (AMENDMENT) ACT 2002
	Statutory functions *(1978 Medical Practitioners Act) — Overview*
	
	Establishment of the Register
	• As soon as may be after the establishment of the Council the Council shall prepare and establish a register of medical practitioners (in this Act referred to as the register) to be known as the General Register of Medical Practitioners
	
	Education and training
	It shall be the duty of the Council from time to time to satisfy itself—
	• As to the suitability of the medical education and training provided by any body in the State recognised by the Council for such purpose
	• As to the standards of theoretical and practical knowledge required for primary qualifications
	• As to the clinical training and experience required for the granting of a certificate of experience, and
	• As to the adequacy and suitability of postgraduate education and training provided by bodies recognised by the Council for the purposes of medical specialist training
	• The Council shall ensure that the requirements relating to education and training for a formal qualification shall satisfy the minimum standards specified in any Directive adopted by the Council of the European Communities relating to that qualification
	• The Council shall ensure that the requirements relating to education and training in specialised medicine in the State shall satisfy the minimum standards specified in any Directive adopted by the Council of the European Communities relating to such education and training
	
	Fitness to Practice
	• The Council or any person may apply to the Fitness to Practise Committee for an inquiry into the conduct of a registered medical practitioner on the grounds of—
	  • His alleged professional misconduct, or,
	  • His fitness to engage in the practice of medicine by reason of physical or mental disability,
	and the application shall, subject to the provisions of this Act, be considered by the Fitness to Practise Committee
		Assigned responsibility
		• N/A
		
		Indirect responsibility/impact
		• Actions relevant to training bodies
		• Actions relevant to professional bodies

Commentary on findings based on available evidence

Relevance and distribution of function(s)
- It is noted that the statutory base for the Medical Council, the Medical Practitioners Act, 1978, is currently under review
- The following functions are solely carried out by the Medical Council (however similar functions in respect of different professions are carried out by other agencies)
  - Maintenance of a register of medical practitioners
  - Promotion and setting of educational and training standards for recognised training bodies (for both undergraduate and postgraduate education and training)
  - Conduct of fitness to practice inquiries

Overlap with/impact on functions of other agencies audited
- There would appear to be an overlap between the Postgraduate Medical and Dental Board in relation to postgraduate education and training
  - Both agencies are involved in the accreditation or review of suitability of postgraduate professional education for medical practitioners

Role identified in *Quality and Fairness*
- While there are no specific actions assigned directly to the Medical Council, a number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104)
- Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions

Mental Health Commission

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Mental Health Commission was established under the MENTAL HEALTH ACT, 2001 The Commission's primary function is to promote and foster high standards and good practices in the delivery of mental health services and to ensure that the interests of persons detained under the terms of the Act are protected. The Commission is be responsible for overseeing the process of review of detention by mental health tribunals and will also employ the new inspector of mental health services, who will have wide-ranging powers. The Commission was appointed in late 2001, to enable it to commence the implementation of the new Act as quickly as possible	**Statutory functions *(Mental Health Act, 2001)*** **33.**—(1) The principal functions of the Commission shall be to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act (2) The Commission shall undertake or arrange to have undertaken such activities as it deems appropriate to foster and promote the standards and practices referred to in subsection (1) (3) Without prejudice to the generality of the foregoing, the Commission shall — (*a*) appoint persons to be members of tribunals and provide staff and facilities for the tribunals (*b*) establish a panel of consultant psychiatrists to carry out independent medical examinations under section 17 (*c*) make or arrange for the making, with the consent of the Minister and the Minister for Finance, of a scheme or schemes for the granting by the Commission of legal aid to patients (*d*) furnish, whenever it so thinks fit or is so requested by the Minister, advice to the Minister in relation to any matter connected with the functions or activities of the Commission (*e*) prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services (4) The Commission shall have all such powers as are necessary or expedient for the purposes of its functions **34.**—(1) The Minister may, if he or she so thinks fit, by order — (*a*) confer on the Commission such additional functions connected with the functions for the time being of the Commission or the services or activities that the Commission is authorised for the time being to provide or carry on as he or she considers appropriate, and (*b*) make such provision as he or she considers necessary or expedient in relation to matters ancillary to or arising out of the conferral on the Commission of functions under this section or the performance by the Commission of functions so conferred (2) The Minister may by order amend or revoke an order under this section (including an order under this subsection)	**Assigned responsibility** • Page 70 Action 25 **Indirect responsibility/impact** • N/A

Commentary on findings based on available evidence

Relevance and distribution of function(s)

The Commission has been established to implement the Mental Health Act 2001

Overlap with/impact on functions of other agencies audited

- It will have strong links with service providers in the mental health area
- It will have links with agencies such a HIQA with a role in quality assurance and dissemination of best practice

Role identified in *Quality and Fairness*

- Action 25 — a new programme for mental health will be developed — this programme intends to build on the recent initiatives in mental health — one of the key actions to improve mental health services and promote awareness of mental health is the establishment of the Mental Health Commission

National Cancer Registry Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Board was established under THE NATIONAL CANCER REGISTRY BOARD (ESTABLISHMENT) ORDER, 1991 and the THE NATIONAL CANCER REGISTRY BOARD (ESTABLISHMENT) ORDER, 1991 (AMENDMENT) ORDER, 1996 to collect and analyse data and to report on cancer incidence and mortality in Ireland	**Statutory functions *(The National Cancer Registry Board (Establishment) Order, 1991)*** • To identify, collect, classify, record, store and analyse information relating to the incidence and prevalence of cancer and related tumours in Ireland • To collect, classify, record and store information in relation to each newly diagnosed individual cancer patient and in relation to each tumour which occurs • To promote and facilitate the use of the data thus collected in approved research and in the planning and management of services; • To publish an annual report based on the activities of the Registry • To furnish advice, information and assistance in relation to any aspect of such service to the Minister	**Assigned responsibility** • N/A **Indirect responsibility/impact** • Page 65 — Action 12 • Actions relevant to information agencies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Registry Board provides a national data set critical for epidemiological and research purposes and valuable information on cancer rates that were included in the National Health Strategy. A key priority is to increase the level of international collaboration in data collection and analysis
- The Registry has at present 33 staff members, both full-time and part-time. Most of these (18) are employed as tumour registration officers throughout the country (based primarily in health boards), while the remainder are based at the Registry's headquarters in Cork
- The Registry claims to make a significant contribution to health gain by:
    - Identifying current cancer risks to the Irish population
    - Monitoring temporal and geographical trends in these risks
    - Identifying populations at risk
    - Providing data for researchers on cancer
    - Providing an evidence base for the assessment of Irish cancer services

Overlap with/impact on functions of other agencies audited

- The functions of the Board impact on the following:
    - Other agencies involved in cancer services and cancer research — general public and their representatives, health services planners and administrators, health professionals, epidemiology and cancer research community
    - The National Cancer Strategy and the National Cancer Forum
- Receives a grant from the Health Research Board to develop expertise in survival methods
- The establishment of a Health Information and Quality Authority to lead the development of health information is likely to impact significantly on the functioning of the Cancer Registry

Role identified in *Quality and Fairness*

- While there are no specific actions assigned directly to the National Cancer Registry Board, Action 12, a revised implementation plan for the National Cancer Strategy will be published by the National Cancer Forum, is likely to have implications for the National Cancer Registry Board in terms of implementation requirements

National Children's Advisory Council

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Set up under the National Children's Strategy to • Advise the Minister of State for Children • Contribute to monitoring and evaluation of implementation of the National Children's Strategy, • Undertake and advise on research • Advise on the development of mechanisms to consult with children	**Stated functions (National Children's Strategy)** • Advising the Minister on all aspects of children's lives • Advising the Minister on the better coordination and delivery of services to children • Contributing to monitoring and evaluation of the implementation of the Strategy at national and local level • Undertaking and advising on research • Advising on training in relation to the Strategy • Advising on the development of mechanisms to consult with children	**Assigned responsibility** • N/A **Indirect responsibility/impact** • Action 14 — Initiatives will be taken to improve children's health • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The National Children's Advisory Council has been established to support the implementation of the National Children's Strategy and to contribute to the on-going development of policy in relation to children

Overlap with/impact on functions of other agencies audited

- It has a strong link with the National Children's Office, as it contributes to the monitoring of the implementation of the National Children's Strategy and also because the former have representatives on the Council. In this way, a strong linkage is created within the Council between the Government and non-government sectors
- It links with the National Research Dissemination Unit
- Responsibility for advising the Minister on the better coordination and delivery of services to children impacts on, and potentially overlaps with, the following:
    - Policy and advisory role of other bodies such as Review Group on Child and Adolescent Psychiatric Services
    - Planning role of health boards and other service providers in developing and delivering services for children (including the Special Residential Services Board)
    - Inspection function of the Social Services Inspectorate

Role identified in *Quality and Fairness*

- There are no actions directly assigned to the National Children's Advisory Council. However, Action 14 provides for initiatives to improve children's health

National Children's Office

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Set up under the National Children's Strategy for its implementation. It provides advice to the Minister of State for Children, develops measures to further the goals of the strategy and is responsible for reporting on Ireland's commitments under the United Nations Convention on the Rights of the Child	**Stated functions *(National Children's Strategy)*** • Preparing an annual work programme to translate the three National Goals and objectives into detailed plans for action and the preparation of progress reports for presentation by the Minister of State to the Cabinet Committee on Children on a six-monthly basis • Ensuring that coordinated and integrated action takes place by identifying priority cross-cutting issues to be progressed on a two to three-year cycle and supporting cross-departmental action by, inter alia, co-funding new and existing initiatives which are innovative and adaptable and which encourages cross-departmental actions • Monitoring implementation of the Strategy in departments and public agencies • Promoting capacity building through encouraging and supporting training initiatives	**Assigned responsibility** • Page 68 — Action 21 **Indirect responsibility/impact** • Page 65 — Action 14 • Page 64 — Action 8 • Page 71 — Action 27 • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Office has been established to implement the cross-departmental National Children's Strategy, and is a cross-departmental structure
- The following functions would appear to be conducted solely by the Office
    - Preparation of an annual work programme to address the National Goals under the National Children's Strategy
    - Monitor implementation of the Strategy in relevant agencies and Departments
    - Coordinate the activity of Government departments in this area

Overlap with/impact on functions of other agencies audited

- Formal link with Family Affairs Unit of the Department of Social and Family Affairs. Will be jointly responsible for management of the National Longitudinal Study.
- It has a strong link with the National Children's Advisory Council, as it is advised by it and has representatives on the Council. In this way, a strong linkage is created within the Council between the Government and non-government sectors
- It links with the National Research Dissemination Unit
- It has links to local-level public bodies

Role identified in *Quality and Fairness*

- The Office has been assigned joint responsibility under Action 21 for the implementation of the Youth Homelessness Strategy (with the Department and health boards)
- A number of other actions are likely to impact on the functions of the National Children's Office, for example:
    - Action 8 — Measures to promote healthy lifestyles in children
    - Action 14 — Initiatives take to improve children's health
    - Action 27 — Family support services will be expanded

National Council for the Professional Development of Nursing and Midwifery

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Council was set up under THE NATIONAL COUNCIL FOR THE PROFESSIONAL DEVELOPMENT OF NURSING AND MIDWIFERY (ESTABLISHMENT) ORDER, 1999 following a recommendation by the Commission on Nursing (1998). The purpose of its establishment is to provide a framework for continuing education and clinical career pathways, which will give guidance to the development of specialist nursing and midwifery posts and post-registration educational programmes for nurses and midwives	**Statutory functions *(Establishment Order,1999):*** • To monitor the on-going development of nursing and midwifery specialities, taking into account, changes in practice and service need • To formulate guidelines for the assistance of health boards and other relevant bodies in the creation of specialist nursing and midwifery posts • To support additional developments in continuing nurse education by health boards and voluntary organisations • To assist health service providers by setting guidelines for the selection of nurses and midwives who might apply for financial support in seeking opportunities to pursue further education; and • To publish an annual report on its activities, including the disbursement of monies by the Council ***Further functions to be assigned in new legislation (Annual report 2001):*** • The determination of the appropriate level of qualification and experience for entry into specialist nursing and midwifery practice • The accreditation of specialist nursing and midwifery courses for the purpose of Clinical Nurse Specialist/Clinical Midwife Specialist and Advanced Nurse practitioner/Advanced Midwife practitioner appointments • The accreditation of post-registration courses	**Assigned responsibility** • Page 118 — Action 101 **Indirect responsibility/impact** • Page 84 — Action 58 • Actions relevant to training bodies • Actions relevant to professional bodies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The following functions are solely carried out by the Council (however certain similar functions in respect of different professions are carried out by other agencies)
  - Formulation of guidelines in creation of specialist posts
  - Support of additional developments in continuing medical education
  - Determination of appropriate level of entry qualifications for specialist nursing and midwifery
  - Accreditation of specialist courses and post-registration courses
- It is noted that a number of the functions envisaged for the Council continue to be handled by An Board Altranais, pending the passing of new legislation. These are:
  - The determination of the appropriate level of qualification and experience for entry into specialist nursing and midwifery practice
  - The accreditation of specialist nursing and midwifery courses for the purpose of Clinical Nurse Specialist/Clinical Midwife Specialist and Advanced Nurse practitioner/Advanced Midwife practitioner appointments
  - The accreditation of post-registration courses

Overlap with/impact on functions of other agencies audited

- The agency's responsibility for the promotion and setting of educational and training standards for nurses at entry level impacts on the responsibility of the Nursing Board in relation to post-registration education and training
  - Both agencies are working together on aspects of standards for professional practice
- Working linkages set up with Nursing and Midwifery Planning and Development Units in health boards
- Partner with Bord Altranais on projects of mutual concern e.g. Nurse and Midwife Prescribing Project
- Wide range of linkages with the profession established
- Partner with Health Research Board in relation to research on projects relating to nursing/midwifery
  - Linkages with Nursing Policy Unit, DoHC with regard to research

Role identified in *Quality and Fairness*

- Responsibility for a key deliverable under Action 101 is assigned to the Council — the development of further clinical specialist and advanced practitioner posts in nursing and midwifery (p. 118)
- Action 58 — a plan to provide responsive, high quality maternity care by a specially established working group is likely to impact on the activities of the Council
- A number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104)
- Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions

National Council for Ageing and Older People

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*

Established by THE NATIONAL COUNCIL ON AGEING AND OLDER PEOPLE (ESTABLISHMENT) ORDER, 1997	**Statutory functions *(The National Council On Ageing And Older People (Establishment) Order, 1997)***
	• To advise the Minister for Health on all aspects of ageing and the welfare of older people, either on its own initiative or at the request of the Minister and in particular on:
	  • measures to promote the health of older people
	  • measures to promote the social inclusion of older people
	  • the implementation of the recommendations contained in policy reports commissioned by the Minister for Health
	  • methods of ensuring coordination between public bodies at national and local level in the planning and provision of services for older people
	  • means of encouraging greater partnership between statutory and voluntary bodies in providing services for older people
	  • meeting the needs of the most vulnerable older people
	  • means of encouraging positive attitudes to life after 65 years and the process of ageing
	  • means of encouraging greater participation by older people
	  • whatever action, based on research, is required to plan and develop services for older people
	• To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:
	  • undertaking research on the lifestyle and the needs of older people in Ireland
	  • identifying and promoting models of good practice in the care of older people and service delivery to them
	  • providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well being and autonomy of older people
	  • liasing with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people
	• To promote the health, welfare and autonomy of older people
	• To promote a better understanding of ageing and older people in Ireland
	• To liase with international bodies which have functions similar to the functions of the Council
	
	The Council may, in relation to the performance of its functions, publish documents, organise conferences, support initiatives and establish informal networks to promote healthy ageing
		Assigned responsibility
		• P. 70 — Action 26
		
		Indirect responsibility/impact
		• General actions relevant to service providers

National Council for Ageing and Older People — *continued*

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- A range of policies and legislative initiatives make provision for enhanced planning and services for older persons, including The Years Ahead: A Policy for the Elderly, A Health Promotion Strategy for Older People etc
- The establishment and funding of an advisory body to the Minister, namely the National Council on Ageing and Older People, with responsibility for policy development was cited as the first of four initiatives contributing to VFM in relation to the elderly as a care group, in the recent Audit of Value for Money
- The potential to mainstream the functions of the agency after a particular time period has been identified

Overlap with/impact on functions of other agencies audited

- Has links with a number of European and International Organisations for Older People from which it may share best practice guidelines
- Also has links with Older Peoples Organisations, health boards and the Eastern Regional Health Authority, Hospitals, Government departments, etc with which it may share information
- Functions of the Council impact on the following:
    - Planning role of health boards and other service providers in developing and delivering services for children (including the Special Residential Services Board)
    - Inspection function of the Social Services Inspectorate
    - Other policy makers for older people (health boards, voluntary agencies)

Role identified in *Quality and Fairness*

- While the Council has not been assigned direct responsibility for any actions, it is likely to input into Action 26 — an integrated approach to meeting the needs of ageing and older persons
    - Department of Health and Children in conjunction with the Department of the Environment and Local Government and the Department of Social, Community and Family Affairs and Public Enterprise to develop a coordinated action plan for older persons
    - An action plan for dementia, based on the recommendations of the National Council will be implemented

The National Disease Surveillance Centre

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Non-statutory organisation established in 1999 as Ireland's specialist centre for the surveillance of communicable diseases. On July 1st 2000 the Infectious Diseases (Amendment) Regulations came into force — under these regulations the NDSC was assigned responsibility for the collation and analysis of the weekly infectious diseases. These weekly reports are published on their website **Note:** It was proposed to establish the NDSC as an independent statutory body under the Health (Corporate) Bodies Act during 2002 and have legislation passed to this effect	***Stated functions (Service Plan, 2002)*** • Surveillance of some major communicable diseases, through the collection, collation and analysis of data • Operational support — providing expert advice to, responding to requests for support from, departments of public health or hospitals • Training for professionals working in communicable disease control • Research — identifying and developing best practice in communicable diseases • Policy advice — providing advice to government departments and appropriate agencies in relation to the development of standards, guidelines and practices, and promoting the adoption of best practice by different agencies • Public information — providing information on infectious diseases to the public and the media Focus is primarily on infectious disease control, environmental health hazards and food borne illness — at a later stage it might extend its sphere of operation to non-infectious disease — health issues such as accidents or congenital malformations	**Assigned responsibility** • N/A **Indirect responsibility/impact** • General actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Centre was established to co-ordinate the surveillance and control of infectious diseases and environmental hazards on a national basis

Overlap with/impact on functions of other agencies audited

- Has links with a number of bodies
  - Departments — the Department of Health and Children, Department of the Environment and Local Government, Department of Agriculture, Food and Rural Development, e.g. Zoonoses
  - Health boards through the Departments of Public Health, GP unit, clinicians
  - FSAI/FSPB — e.g. outbreak surveillance
  - Virus reference library
  - HIQA — through the CIDR (computerised infectious disease reporting)
  - National AIDS Strategy Group/Regional AIDS coordinators, e.g. AIDS surveillance
  - Maternity hospitals, e.g. routine testing for HIV
  - EU networks — participation in the EU R&D programme to strengthen preparedness in dealing with biological agents/The European Parliament decided (Decision 2199/98EC) to establish a network for the epidemiological surveillance control and control of communicable diseases in the Community.
  - Links to professional bodies for conferences e.g. RCPI, ICGP, FSAI, Universities, teaching hospitals etc
  - Local Authorities, e.g. water-borne cryptosporidiosis

Role identified in *Quality and Fairness*

- There are no functions assigned directly to the NDSC

The National Hospitals Agency

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Action 80 (p. 102) of Quality and Fairness states that a National Hospitals Agency will be established on a statutory basis under the aegis of the Department of Health and Children to provide expert, objective advice on relevant matters as they arise	**Stated functions *(Action 80 — Quality and Fairness)*** • To prepare a strategic plan for expanding the capacity of acute hospitals • To advise on the organisation and development of all acute hospital services • To advise on the designation and funding of national specialist services • To facilitate closer linkages with the private hospital sector • To liase with regulatory and professional bodies on matters affecting acute hospitals • To manage a new national waiting time database	**Assigned responsibility** • P. 102 — Actions 79 & 80 • P. 104 — Action 82 • P. 105 — Actions 83 — 84 **Indirect responsibility/impact** • P. 119 — Action 102

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- Critical driver in ensuring an objective, evidence-based means to determining specialties for extra beds identified, also to support co-operation between hospitals, plus specialist advice required on the priority that should be attached to the development of individual specialties and services in acute hospitals throughout the country

Overlap with/impact on functions of other agencies audited

A range of bodies as set out in *Quality and Fairness* including DoHC, ERHA, health boards, service providers (particularly hospitals) will be impacted by the functioning of the NHA:

- Advise on organisation and development of all hospital services
  - Acute Policy Unit, DoHC
  - ERHA — Eastern region
  - Comhairle na nOspidéal
  - Health boards
  - Statutory hospitals
- Advise on specialist services
  - Comhairle na nOspidéal
- Develop strategic relationship with private hospital sector
  - Existing relationships between health boards, statutory hospitals, voluntary hospitals and private hospitals
- Manage new national waiting time database
  - National Treatment Purchase Fund

Role identified in *Quality and Fairness*

- The Authority is assigned responsibility for a number of actions under *Quality and Fairness,* including:
  - The development of a strategic relationship with private hospital providers (Action 79)
  - The management and organisation of waiting lists (Action 82) in conjunction with health boards and Service providers

National Social Work Qualifications Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Up to 1995, social workers were accredited by the Central Council for Education and Training in Social Work in the United Kingdom. The National Social Work Qualifications Board, formerly known as the National Validation Body on Social Work Qualifications and Training was appointed by the Minister for Health in 1995. It was established for social work accreditation and education in Ireland	**Statutory functions *(Section 5 Establishment Order, 1997)*** a. Carry out any and all functions carried out by the National Validation Body on Social Work Qualifications and Training prior to the making of this Order b. Grant the NQSW to persons who have successfully completed recognised courses c. Advise on the equivalence of qualifications obtained otherwise than in an Irish third level institution d. Advise the Minister, health boards, other health agencies and voluntary hospitals, Government Departments, public sector employers and other employers as to which courses provided in the State have been recognised by the National Social Work Qualifications Board for the purpose of awarding the NQSW, should any of the above seek such advice e. Advise the Minister of the standards which should inform the education and training of Social Workers in the State f. Advise the Minister and other relevant Ministers of the specific content of recognised courses, having consulted with Government Departments who employ social workers g. Determine and agree, in consultation with third level institutions providing, or proposing to provide at any time in the future, academic and professional social work education and training, the development of course content for the education and training of Social Workers in the State h. Assess from time to time, as occasion may require, but in any event not less than once in every five year (i) The suitability of the social work education and training provided by any institution recognised by the Board for such purpose (ii) The standards of theoretical and practical knowledge required for social work qualifications (iii) whether the education and training of social workers meet the requirements as laid down in EU Directives and other legislation passed by the Council of the European Communities i. Maintain in accordance with rules made by the Board a record of NQSW certificates granted to social workers who have successfully completed recognised courses pursuant to paragraph (b) of this article j. Issue letters of accreditation to social workers with non-national qualifications k. Maintain in accordance with rules made by the Board a record of letters of accreditation issued to social workers with non-national qualifications l. Engage in research into the education and training of social workers including the formulation of experimental curricula and the evaluation of existing programmes and examinations and assessment procedures m. Maintain statistical records and make such records available for research and planning, including manpower planning purposes, and n. Undertake such other appropriate tasks and functions as may be assigned to the Board from time to time by the Minister	**Assigned responsibility** • N/A **Indirect responsibility/impact** • Actions relevant to training bodies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The following functions are solely assigned to the Board:
  - Monitoring of courses for social workers
  - Issue of letters of accreditation to social workers with non-national qualifications
  - Maintenance of statistical records and making such records available for research, planning, including manpower planning

Overlap with/impact on functions of other agencies audited

- Universities
- Health boards/service providers who employ social workers

Role identified in *Quality and Fairness*

- While there are no specific actions assigned directly to the National Social Work Qualifications Board, a number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104) collectively
- Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions

Office for Health Management (OHM)

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
A body established to implement the national strategy for management development for the health and personal and social services in Ireland. Its main function is to facilitate management development for the health services by acting as a central resource and commissioning body	**Stated functions (Annual Report 2001)** *Personal development* • Identification of management competencies and diagnostic tools — nursing, general managers and health and social care professionals • Personal development planning — number of pilot sites established each year • Mentoring programme — pilot programme launched in a number of health boards (including the commissioning of a series of training workshops to train mentors and brief mentees) • Provider database — provision of information to human resource personnel and health service staff on range of courses, programmes and providers of management and organisation development *Management development* • Leadership development programmes • Top and senior management development programmes • Top and senior executive coaching • Identify and promote best practice in management • Commissioned management development programmes *Organisation Development* • Clinicians in Management (CIM) — central role in supporting the CIM initiative through training and development interventions • OD Network — facilitation support to self-managing network of people working in organisational development and change management **Additional stated functions (*Quality and Fairness*)** • The brief of the Office for Health Management will be expanded to include organisation development as well as management development i.e. to drive and support the organisation development and the management and personal development agenda being pursued by health service employers • The OHM will work closely with the Department of Health and Children and health agencies to initiate organisation development programmes aimed at coordinating structures, strategy, culture, processes and people • Health agencies will be required to include in their annual service plans specific provision for advancing staff, management and organisation development	**Assigned responsibility** • P. 119 — Action 103 • P. 130 — Action 113 *Primary Care Strategy* • Action 16 **Indirect responsibility/impact** • P. 121 — Action 107 • P. 126 — Action 110

Commentary on findings based on available evidence

Relevance and distribution of function(s)
- Action 113 indicates that the role of the Office for Health Management will be expanded to include:
  - Organisation development as well as management development i.e. to drive and support the organisation development and the management and personal development being pursued by health service employers
  - Work closely with the Department of Health and Children and health agencies to initiate organisation development programmes aimed at coordinating structures, strategy, culture, processes and people
- The role of the Office is primarily enabling — commissioning management and development programmes on behalf of employers in the health and personal social services

Overlap with/impact on functions of other agencies audited
- Change management role overlaps with that of the HSEA
- Service providers/employing bodies

Role identified in *Quality and Fairness*
- The OHM is assigned joint responsibility for a number of actions under *Quality and Fairness*, including:
  - The promotion of best practice in recruitment and retention (alongside the HSEA) — Action 103
- Under the Primary Care Strategy, the OHM is assigned responsibility for:
  - The provision of continuing professional and personal development programmes to primary care professionals

Office of Tobacco Control

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*

A body established under the PUBLIC HEALTH (TOBACCO) ACT, 2002 to advise the Minister on tobacco control measures, to monitor and co-ordinate the implementation of such measures and to advise the Minister on the control and regulation of the manufacture, sale, marketing and smoking of tobacco products	**Statutory functions *(Public health (Tobacco) Act, 2002)***
	• Advise the Minister in relation to the formulation and assist in the implementation of policies concerning the control and regulation of the manufacturing, sale, marketing and smoking of Tobacco products
	• Consult with international bodies or agencies for the purpose of identifying measures designed to eliminate, reduce the incidence of, or discourage smoking
	• Make recommendations to the Minister in relation to measures that should be taken to reduce or eliminate smoking or its effects in the State
	• Undertake, sponsor, commission, provide financial assistance for research aimed at identifying measures that when adopted are likely to reduce the incidence of smoking
	• Prepare and publish reports on any research undertaken, sponsored or commissioned or for which financial assistance was given
	• Furnish advice to the Minister on matters relating to the control and regulation of the manufacture, importation, sale or supply of Tobacco products and on measures to reduce, eliminate smoking
	• Provide, and where appropriate exchange with the Garda Síochána and the Revenue Commissioners, information relating to the control and regulation of the manufacture, sale, importation and distribution of Tobacco products
	• Prepare and implement a plan for the coordination nationally of the activities of the office and of health boards in relation to this Act
	• Furnish advice to the Minister on
	  ◦ Strategies employed by manufacturers, importers, distributors or retailers of Tobacco products in the marketing, sale or promotion of such products
	  ◦ Technology used in the manufacture, production or marketing of Tobacco products
	  ◦ Any innovations on the part of manufacturers, importers, distributors or retailers of Tobacco products relating to the manufacture, production or marketing of those products
	• Coordinate and implement a programme for the inspection of all premises in which Tobacco products are manufactured etc
	• Collect or disseminate such information as may reasonably be necessary for the effective performance of its functions
	• Furnish advice to the Minister or government in relation to any matter connected with its functions
	• Regulation and control of sale, marketing and smoking of Tobacco products
	• Establish and maintain a register of retailers of Tobacco products
	• Minister can after consultation with the Minister for Finance or other relevant Ministers confer additional functions on the Office
		Assigned responsibility
		• P. 63 — Actions 5 & 6
		Indirect responsibility/impact
		• Actions relevant to service providers
		• Actions relevant to information agencies

Commentary on findings based on available evidence

Relevance and distribution of function(s)
- The Office was established to implement the provisions of the Public Health (Tobacco) Bill, 2001 which provides for a more comprehensive and strengthened legislative basis for regulating and controlling the sale, marketing and smoking of Tobacco products and for enforcing such controls

Overlap with/impact on functions of other agencies audited
- Health promoting agencies
- Research agencies
- Agencies involved in prevention/cure of cancers

Role identified in *Quality and Fairness*
- The Office is assigned responsibility for Action 6 — The Public Health (Tobacco) Bill will be enacted and implemented as a matter of urgency
- Links to Action 5 — Actions on major lifestyle factors targeted in the National Cancer, Cardiovascular and Health Promotion Strategies will be enhanced
- Links to Action 7 — a reduction in smoking will continue to be targeted through Government fiscal policies

Pharmaceutical Society of Ireland

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Established under the PHARMACY ACT, 1951 as the professional body for the pharmaceutical profession. Its chief functions relate to the education, examination and registration of pharmaceutical chemists	**Statutory functions (Pharmacy Act, 1951)** • The registrar shall maintain a register to be called the register of dispensing chemists and druggists. Any existing registered druggist who has received the certificate of the Society of his having passed, during the period for qualification, an examination of his qualifications held pursuant to section 3 of this Act shall, on making application in writing to the registrar, be entitled to be registered in the register of dispensing chemists and druggists • Where a person is registered in the register of dispensing chemists and druggists, his name shall be removed from the register of registered druggists in Ireland • The Council shall, during the period for qualification, cause the prescribed examinations to be held from time to time for the purpose of examining the qualifications for registration under this Act of existing registered druggists • The examinations shall be held at the prescribed times and in the prescribed manner by examiners appointed, with the approval of the Minister by the council **Statutory functions (Pharmacy Act, 1962)** The Council may, in accordance with regulations made by the Council with the approval of the Minister, provide or make provision for the courses of training and examinations to be taken by candidates for registration in any of the registers maintained by the Society and the regulations may specify the manner in which and the conditions under which training shall be provided and may, in particular, provide— (*a*) for the approval by the Council for the purposes of the regulations of lecturers, teachers and examiners (*b*) for the conditions of admission to the examinations (*c*) for the recognition and approval by the Council of courses of study and training and of examinations of institutions or bodies other than the Society where the Council are satisfied that the institutions or bodies are suitable for the provision of such courses or the holding of such examinations (*d*) that the institutions or bodies referred to in paragraph (c) of this subsection shall comply with requirements specified in the regulations before recognition of their courses or examinations is granted by the Council (*e*) for the granting of certificates to persons taking the courses and passing the examinations **Other stated functions (Annual report)** • Inspects pharmacies for minimum standards of practice • Supports the Benevolent Fund with administrative resources • Involved with other members of the Review Group on Pharmacy Regulation	**Assigned responsibility** • N/A **Indirect responsibility/impact** • Actions relevant to training bodies • Actions relevant to professional bodies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The following functions are solely carried out by the Pharmaceutical Society (however similar functions in respect of different professions are carried out by other agencies)
  - Maintenance of a register of dispensing chemists and druggists
  - Fitness to practice inquiries and sanctions
  - Standards on matters of professional conduct
  - Promotion and setting of educational and training standards, and accreditation of bodies and courses for pharmacists
  - Inspection of premises
- It is noted that the Society has been reorganised in the past few years to better meet the business demands that will be placed on it in the future
- The Society has been actively working with the Department of Health and Children in the development of a new Pharmacy Act, *'which will bring the existing legislation up to date and carry all the regulations relating to the profession into the 21st century.'* The Society believes that the only lasting and effective means of regulating the provision of a pharmacy service in terms of its standards, its accessibility and its accountability in the public interest is by means of a new Pharmacy Act. Its submission informed the Group in relation to a new Pharmacy Act and to articulate the Society's position as to what it believes should be provided for in a new Act and the most appropriate means, in the Society's view of providing for it *(Source: Blueprint for the Future Regulation of Pharmacy in Ireland)*

Overlap with/impact on functions of other agencies audited

- Medicines Board regulates the production and use of medicinal products for human and veterinary use
- Links with registered pharmaceutical chemists and pharmacies (community and hospital)

Role identified in *Quality and Fairness*

- While there are no specific actions assigned directly to the Pharmaceutical Society, a number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104)
- Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions

Postgraduate Medical and Dental Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Established under the MEDICAL PRACTITIONERS ACT, 1978 (currently under review) to promote and co-ordinate postgraduate medical and dental education and advise the Minister for Health and Children on all matters relating to such education	**Statutory Functions *(Section 40 — Medical Practitioners Act, 1978)*** • To promote the development of postgraduate medical and dental education and training and to co-ordinate such developments • To advise the Minister, after consultation with the bodies specified in sections 9 (1)(a), 9(1)(b), 9(1)(c), 9(1)(d), 9(1)(e) of this Act; and with such other bodies as the Board may consider appropriate, on all matters, including financial matters, relating to the development and coordination of postgraduate medical and dental education and training • To provide career guidance for registered medical practitioners and registered dentists **Other stated functions** • Fulfils 'lobbying/coordinating' role for individual professional medical and dental training bodies • Providing financial assistance and funding to individual training bodies and training initiatives • Conducting surveys (e.g. NCHD staffing) and evaluation of training • Meet with counterparts in other countries to discuss common policies/issues • Sectoral comment on related issues at national/system level — e.g. Health Research Board priorities for 2000-2003 • Contacting Department of Health, health boards and hospital authorities on matters impacting on postgraduate trainees and training bodies • Administers NCHD Postgraduate Allowances Scheme on behalf of Department of Health and Children and the Irish Medical Organisation	**Assigned responsibility** • N/A **Indirect responsibility/impact** • P. 85 — Action 62 • Actions relevant to training bodies • Actions relevant to professional bodies

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The following functions are solely carried out by the Postgraduate Medical and Dental Board (however similar functions in respect of different professions are carried out by other agencies)
  - Administration of NCHD Postgraduate Allowances Scheme (on behalf of Department of Health and Children and IMO)

Overlap with/impact on functions of other agencies audited

- The following agencies are also involved in functions common to the Board:
- Promotion & development of post-graduate courses
  - Medical Council, 10 main Irish professional bodies providing programmed training for doctors (ICGP, etc)
  - The Dental Council in relation to the promotion of professional education for dentists
- Continuing medical education (CME)
  - Employing health agencies
- Continuing dental education
  - Dental Council, Irish Dental Association, Dental Schools in Cork and Dublin
- Contribution to manpower planning policy
  - Irish Medical Council, RCSI, Royal College of Physicians of Ireland, ICGP, Irish Hospital Consultants Association, IMO, Association of Hospital chief executives
- There would appear to be an overlap with the Medical Council in relation to postgraduate education and training
  - Both agencies are involved in the accreditation or review of suitability of postgraduate professional education for medical practitioners

Role identified in *Quality and Fairness*

- While there are no specific actions assigned directly to the Board, a number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104)
- Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions

Pre-hospital Emergency Care Council

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
An advisory council was recommended in the 1993 review of the Ambulance Service to ensure delivery on the report. The National Ambulance Advisory Council was replaced by the Pre-hospital Emergency Care Council Responsible for the recognition of institutions for the education and training of emergency medical technicians	**Statutory functions *(Establishment Order, 2000)*** 1. Recognise, in accordance with the rules made by the Council, institutions for the education and training of emergency medical technicians 2. Conduct examinations leading to the award of the N.Q.E.M.T. at such levels of competence as may, with the consent of the Minister, be determined by the Council 3. Award the N.Q.E.M.T. to such persons as have completed a recognised course in a recognised institution and have passed the relevant examination conducted by the Council pursuant to paragraph (2) of this Article 4. Recognise the equivalence of professional qualifications in pre-hospital emergency care obtained outside the State 5. Upon request, advise the Minister, health boards, other Government Departments, public sector employers and other employers of recognised courses 6. Advise the Minister of the standards which should inform the education and training of emergency medical technicians in the State 7. Advise the Minister of the specific content of recognised courses 8. In consultation with recognised institutions providing, or institutions proposing to provide at any time in the future, education and training in pre-hospital emergency care, approve of the content of courses for such education and training 9. Assess from time to time, as occasion may require, but in any event not less than once in every three years — a. The suitability of the education and training in pre-hospital emergency care provided by an institution recognised by the Council for such purpose b. The standards of theoretical and practical knowledge required for qualifications in pre-hospital emergency care 10. Maintain, in accordance with the rules made by the Council, a record of holders of the N.Q.E.M.T. 11. Issue letters of accreditation to the holders of non-national qualifications 12. Maintain, in accordance with the rules made by the Council, a record of holders of non-national qualifications 13. Engage in research into pre-hospital emergency care, especially in regard to emerging technology and the education and training of emergency medical technicians including the formulation of experimental, curricula and the evaluation of existing courses and assessment and examination procedures 14. Subject to any data protection legislation in force, maintain statistical records and make such records available for research and planning, including manpower planning purposes 15. Make recommendations to the Minister on standard operational procedures and protocols for pre-hospital emergency care 16. Undertake such other appropriate tasks and functions as may, from time to time, be assigned to the Council by the Minister	**Assigned responsibility** • P. 83 — Action 57 **Indirect responsibility/impact** • Actions relevant to training bodies • Actions relevant to professional bodies

Pre-hospital Emergency Care Council— *continued*

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Council was established in part to ensure national coordination of all aspects of ambulance services, with a range of functions including standards, regulation, accreditation, training and research
- The following functions are solely carried out by the Council (however similar functions in respect of different professions are carried out by other agencies)
    - Recognition of training bodies
    - Conduction and certification of relevant courses
    - Maintenance of register of course holders
    - Research into pre-hospital emergency care

Overlap with/impact on functions of other agencies audited

- There would appear to be no direct overlap with other agencies audited. However, the proposed establishment of the Health and Social Care Professional Council is seen to provide the opportunity to rationalise the educational standard setting for a range of health and social care professionals.
- Link into health boards, Dublin Fire Brigade, training institutions

Role identified in *Quality and Fairness*

- The Council has been assigned responsibility (along with the Department and service providers) to advance measures to provide the highest standard of pre-hospital emergency care and ambulance services (Action 57)
- A number of actions are assigned to training bodies (Actions 50 & 51) and professional bodies (Actions 50, 51, 86 & 104)
- Action 105 recognises the role of statutory registration and requirement of professions by providing for the strengthening and expansion of statutory provisions

Social Services Inspectorate

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Established in 1999 by the Department of Health and Children as an independent body to inspect social services provided by health boards. To date the SSI has focused on child care services **Note: SSI to be established on a statutory basis (Action 63, *Quality and Fairness*)**	**Statutory functions (Child Care Act, 1991)** • Inspection of health board residential homes for children & special care units under the Child Care Act 1991 under 23K, (7)(f)(ii) (inserted by section 16 of the Children Act 2001) • Advising the DoHC on the formulation of standards for child care services • Monitoring of the organisation, operation and management of child care services • Evaluating the quality and responsiveness of services as experienced by users and carers • Providing professional advice and expertise to Departments • Formulating, implementing and reviewing child care policy and the effective and efficient delivery of services • Developing strategies to give effect to recommendations of relevant enquiries and reports • Supporting the DoHC in developing standards for fostering and other areas of social services The Inspectorate does not directly investigate complaints from the public or consider appeals against health board decisions	**Assigned responsibility** • N/A **Indirect responsibility/impact** • P. 87 — Action 63

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- Established to provide for the Inspection of health board residential homes & special care units
- 'A systematic process review of the quality of childcare nationally is lacking both as regard management of childcare services and clinical practice review. It is expected that the Social Services Inspectorate will have an ongoing role in the review of quality in childcare services. There are concerns that significant variances exist in the quality of childcare services being provided by different health boards' (p227 VFM report)
- Remit extended under *Quality and Fairness* to include residential care for people with disabilities and older people (p. 87)

Overlap with/impact on functions of other agencies audited

- The functions of the Inspectorate would appear to overlap with the following:
  - The National Children's Office in relation to advice on childcare
  - The Special Residential Services Board in relation to inspection of residential services
- Close links to health boards, ERHA, HIQA and other Service Providers in relation to inspection of health board residential homes and special care units
- The SSI suggests that active consideration should be given to coordinating inspections with the Department of Education and Science where there is a joint responsibility

Role identified in *Quality and Fairness*

- Action 63 provides for the establishment of the Social Services Inspectorate on a statutory basis to contribute to the integration and expansion of quality systems, and expands its remit to include residential care for people with disabilities and older persons

Special Residential Services Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Established in 2001 to advise the Ministers for Health and Children and Education and Science on matters relating to children in respect of whom child detention or special care orders have been made by the courts 'The Board will play a vital role in ensuring that all of these services are put in place and are maintained to the appropriate standards' (Mary Hanafin, TD)	**Statutory functions (*Part 11 of the Children Act, 2001):*** (1) The Board shall advise the Ministers on policy relating to the remand and detention of children and ensure the efficient, effective and coordinated delivery of services to children in respect of whom children detention orders or special care orders are made and, without prejudice to the generality of the foregoing, shall — a. Coordinate the delivery of residential accommodation and support services to children detained in children detention schools and special care units b. Ensure the appropriate and efficient utilisation of such schools and units, having particular regard to the principle that detention of children in children detention schools or special care units is a measure of last resort c. Liaise with courts in relation to the level and nature of services available for children who are charged with offences or in need of special care or protection d. In particular, assist the courts, on request, in identifying suitable places in children detention schools for children found guilty of offences and for that purpose liaise with the directors of those schools e. Give its views on any proposal of a health board, pursuant to section 23A(2)(b) (inserted by section 16) of the Act of 1991, to apply for a special care order under Part IVA of that Act f. Monitor and regularly review the level and nature of such residential accommodation and support services, having regard to the current and anticipated demand for them, and recommend to the Ministers any adjustments in the provision of such accommodation or services which the Board considers to be necessary g. Promote, organise or take part in seminars, conferences, lectures or demonstrations (whether in the State or elsewhere) relating to the detention of children or delinquent behaviour by children h. Collect, maintain, research and evaluate statistics and other data relating to the detention of children, and i. Ensure a coordinated approach to — (i) The development and provision of educational, cultural and linguistic, child care and other programmes for children detained in such schools and units (ii) The development and provision of the physical infrastructure necessary to support the programmes and services provided by those schools and units, and (iii) The training of the staff of children detention schools and special care units (2) Where the Board considers that there is a lack of coordination in the provision of residential accommodation to children detained in children detention schools and special care units or that the support services to such children are not being utilised in an appropriate or efficient manner, it shall make appropriate recommendations to the Ministers for the improvement of such coordination or utilisation (3) The Board, in performing its functions, shall have regard to the policies and objectives of the Government or any Minister of the Government in so far as they may affect or relate to those functions (4) The Board shall have all such powers as are necessary or expedient for the exercise of its functions	**Assigned responsibility** • N/A **Indirect responsibility/impact** • Actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- Fundamental to ensuring a coordinated approach to the remand and detention of children — the Board was established to address the need for strengthened coordination between the relevant Government Departments and State Agencies
- The Board has adopted the following priorities
  - Conduct an analysis of the use of residential accommodation
  - Promote the development of procedures and criteria for assessment, admission and discharge amongst others

  Overlap with/impact on functions of other agencies audited
- The functions of the Board would appear to overlap with the following:
  - Social Services Inspectorate in relation to the inspection of residential services for children
- Coordinating role between relevant Government Departments, health boards and service providers

Role identified in *Quality and Fairness*

- The Board has no actions directly assigned to it under Quality and Fairness

Women's Health Council

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
A Plan for Women's Health 1997 — 1999 set out four key objectives: • To maximise the health and social gain of Irish women • To create a woman-friendly health service • To increase consultation and representation of women in the health service • To enhance the contribution of the health services to promoting women's health in the developing world The Council was set up under the THE WOMEN'S HEALTH COUNCIL (ESTABLISHMENT) ORDER, 1997 to evaluate progress towards meeting the objectives above and advising the Minister for Health and Children on women's health issues generally	**Statutory functions *(Section 4 /5 SI 278 of (Establishment) Order, 1997)*** a) To advise the Minister for Health on all aspects of women's health, either on its own initiative or at the request of the Minister and in particular on: • The implementation of the recommendations on women's health contained in policy reports commissioned by the Minister for Health • Measures to promote women's health • Action, based on research, required to plan and develop services to improve women's health • Methods of increasing coordination between public bodies at national and local level in the planning and provision of health services for women • Means of encouraging greater partnership between statutory and voluntary bodies in providing health services for women • Means by which the health services could assist the improvement of women's health in the developing world b) To assist the development of national and regional policies and strategies designed to increase health gain and social gain for women by: • Undertaking research on the health needs of women in Ireland • Identifying and promoting good practice in the provision of health services for women • Providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health and well being of women • Liasing with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for women c) To develop expertise on women's health within the health services d) To liase with international bodies which have functions similar to the functions of the Council e) The Council may also advise other Ministers, at their request, on aspects of women's health which are within the functions of the Council	**Assigned responsibility** • N/A **Indirect responsibility/impact** • Actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The following functions would appear to be conducted solely by the Council
  - To evaluate progress towards the achievement of objectives under the Women's Health Plan

Overlap with/impact on functions of other agencies audited

- The functions of the Women's Health Council impact on the following:
  - Other agencies involved in research in the area of women's health
  - Agencies involved in planning services for women
  - Women's health policy unit in the Department of Health and Children
  - Women's health advisory committees
- Crisis Pregnancy Agency now established to look at policy development and research into crisis pregnancy area

Role identified in *Quality and Fairness*

- No specific actions assigned to the Women's Health Council, although a range of measures are contained in relation to women's health generally

Regional Health Boards

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Health boards were established under the HEALTH ACT, 1970 for the administration of the health services in the State. health boards replaced local authorities in fulfilling this role There are currently ten health boards established: three area health boards located in the eastern region under the aegis of the ERHA and seven regional health boards covering the rest of the country	**Statutory functions *(Health Act, 1970)*** **6.**—(1) Subject to section 17, a health board shall perform the functions conferred on it under this Act and any other functions which, immediately before its establishment, were performed by a local authority (other than as a sanitary authority) in the functional area of the health board in relation to the operation of services provided under, or in connection with the administration of, the enactments specified in subsection (2) (2) The enactments referred to in subsection (1) are — (*a*) the Health Acts, 1947 to 1966 (*b*) the Mental Treatment Acts, 1945 to 1966 (*c*) the Births and Deaths Registration Acts, 1863 to 1952 (*d*) the Notification of Births Acts, 1907 and 1915 (*e*) the Acts relating to the registration of marriages (*f*) the Sale of Food and Drugs Acts, 1875 to 1936 (*g*) Part I of the Children Act, 1908, and *sections 2* of the *Children (Amendment) Act, 1957* (*h*) the Rats and Mice (Destruction) Act, 1919 (*i*) the Blind Persons Act, 1920 (*j*) the *State Lands (Workhouses) Act, 1930* and the *State Lands (Workhouses) Act, 1962* (*k*) the Registration of Maternity Homes Act, 1934 (*l*) the *Midwives Act, 1944,* as amended by the Nurses Act, 1950 (*m*) the Adoption Acts, 1952 and 1964 (*n*) *the Poisons Act, 1961* (3) A reference in any enactment (other than the *Health Services (Financial Provisions) Act, 1947*) or any statutory instrument to a health authority shall be construed as a reference to a health board or, if the Minister by order so determines, the chief executive officer of a health board (4) Section 10 (1) (*a*) of the *Vital Statistics and Births, Deaths and Marriages Registration Act, 1952,* is hereby amended by the substitution of 'the health board' for 'the public assistance authority under the *Public Assistance Act, 1939* (No. 27 of 1939) ***Other relevant sections*** Section 13 — Chief executive officers of health boards (appointment of) Section 16 — Delegation by chief executive officer Section 17 — Performance of duties of officers Section 25 — Arrangements between health boards and local authorities Section 26 — Arrangements by health boards for provision of services Section 45/46 — Eligibility provisions **Reserved functions (HEALTH (AMENDMENT) (NO. 3) ACT, 1996)** **3.**—(1) A health board shall perform the following functions: (*a*) a function of a health board specified in a section mentioned in *column (3)* of the *First Schedule,* of the Act mentioned in *column (2)* of that Schedule opposite the mention aforesaid (*b*) a function (if any) as maybe declared to be a reserved function by order made by the Minister, and (*c*) a function which is specified as a reserved function in this Act (2) Every function of a health board that is required to be performed pursuant to *subsection (1)* shall be a reserved function and 'reserved function' shall be construed and have effect accordingly (3) The chief executive officer shall assist a health board in the performance of its reserved functions, in such manner as the health board may require	**Assigned responsibility** • P. 62-73: Actions 4, 5, 8, 11, 14-15, 19-23, 25-27, 31, & 34 • P. 77-85: Actions 40, 44, 48, 52-54, 61-62 • P. 87-89: Actions 63, 69-72 • P. 97-98: Actions 74, 76-78 • P.104-108: Actions 81-87, 90-91 • P. 113-114: Actions 93-94, 98-99 • P. 116-120: Actions 100-102 • P. 126-130: Actions 110, 112 • P. 132-133: Actions 116-120 *Primary Care Strategy* • Actions 2-6, 8-11, 13, 14, 16, 17, 19 **Indirect responsibility/impact** • Actions relevant to service providers

Regional Health Boards — *continued*

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
	(4) The Minister shall not make an order under *subsection (1) (b)* in relation to any function or class of functions that is or are specifically conferred on a chief executive officer under this Act or any other enactment (5) The Minister may by order amend or revoke an order under this section (6) A health board shall not take any decision or give any direction in relation to any function of a health board that is not a reserved function **4.**—(1) A function of a health board that is not a reserved function shall be a function of the chief executive officer unless otherwise provided for, whether in this Act or in any other enactment, and a function that is required to be so carried out shall be an executive function and 'executive function' shall be construed and have effect accordingly (2) A chief executive officer shall furnish the health board with such information (including financial information) in relation to the performance of his or her executive functions as the board may from time to time require (3) A chief executive officer shall furnish the Minister with such information (including financial information) in relation to the performance of his or her executive functions as the Minister may from time to time require ***Joint action by health boards*** **11.**—(1) The Minister may by order provide for and authorise joint action by two or more health boards in the performance of any of their functions either in relation to the whole or part of their respective functional areas (2) An order under this section may provide for the manner in which the expenses incurred in carrying out the joint action are to be met and for the establishment of a joint board for the purposes of the order (3) The following provisions shall have effect in relation to a joint board established under this section: (*a*) the board shall be a body corporate with perpetual succession by the name given to it by the order (*b*) the board may sue and be sued in its corporate name (*c*) the board shall have power to hold and dispose of land (*d*) the board shall provide and have a common seal which shall be authenticated by the signature of the chairman or some other member authorised to act in that behalf and the signature of an officer of the board authorised to act in that behalf (*e*) judicial notice shall be taken of the seal of the board and every document purporting to be an order or other instrument made by it and to be sealed with its seal (purporting to be authenticated in accordance with paragraph (*d*)) shall be received in evidence and be deemed to be that order or instrument without further proof unless the contrary is shown (*f*) the Minister may by order apply to the board any provisions of this Act or of any regulations there under, with such modifications or limitations as he thinks fit and specifies by order	

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The health boards, established under the Health Act, 1970 are the statutory bodies responsible for the delivery of health and personal social services in their functional areas. They are also the main providers of health and personal social care at regional level (p. 39 *Quality and Fairness*)

Overlap with/impact on functions of other agencies audited

- Health boards link to a wide range of agencies in the health system, including:
- Voluntary service providers
- Information and research agencies
- Professional bodies
- Agencies involved in the coordination and implementation of national services and strategies
- Other public service providers outside of health and personal social services (e.g. local authorities, educational bodies etc)

Role identified in *Quality and Fairness*

- The Health boards are seen as key implementers of the National Health Strategy, with a considerable proportion of actions assigned directly or jointly to them
- In particular, Action 110 identifies the role of the health boards for driving change, including a stronger focus on accountability linked to service plans, outputs and quality standards
- The Primary Care Strategy assigns responsibility for 14 of the 20 actions to the health boards

Area Health Boards

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
Area health boards were established under the HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT, 1999 Health Authority, to replace the former Eastern Health Board The three area health boards in the region are responsible for the provision of health and personal social services in their area. These are the Northern, South Western and East Coast Area Health Boards	**Statutory Functions — Health (ERHA) Act, 1999** **15.**—(1) An Area Health Board shall perform, with respect to its functional area and on behalf of the Authority, such functions as are specified by the Authority in accordance with *section 9(1)* and shall carry out such other functions as provided by this Act or as may from time to time be conferred on it by the Authority (2) An Area Health Board shall, with respect to its functional area— a) provide, or arrange for the provision of, such services as may be specified in any arrangements entered into with the Authority in accordance with *section 10(2)* b) plan and co-ordinate the provision of services, in co-operation with persons providing services in the area and with such other persons as it may see fit, and c) advise the Authority on the provision of services generally (3) An Area Health Board shall— a) carry out its functions subject to any general directions which may be given by the Authority, and b)co-operate with the Authority and with other Area Health Boards in the coordination of services in such manner as the Authority may from time to time determine (4) Where an Area Health Board makes an arrangement with a person for the provision of services, it shall put in place systems, procedures and practices to enable it to monitor and evaluate the services so provided (5) An Area Health Board shall, notwithstanding that it is exercising functions on behalf of the Authority under this section, be entitled to enforce any rights acquired and shall be liable in respect of any liabilities incurred (including liabilities in tort) in the exercise of those functions in all respects as if it were acting as a principal, and all proceedings for the enforcement of such rights or liabilities shall be brought by or against the Area Health Board in its own name (6) Sections 3 and 4 of the No. 3 Act of 1996 (as amended by *section 24*) shall apply to an Area Health Board as if it were a health board and references in those sections to a chief executive officer shall be construed for the purposes of this subsection as including references to an area chief executive	**Assigned responsibility** • P. 62-73: Actions 4, 5, 8, 11, 14-15, 19 23, 25-27, 31, & 34 • P. 77-85: Actions 40, 44, 48, 52-54, 61-62 • P. 87-89: Actions 63, 69-72 • P. 97-98: Actions 74, 76-78 • P.104-108: Actions 81-87, 90-91 • P. 113-114: Actions 93-94, 98-99 • P. 116-120: Actions 100-102 • P. 126-130: Actions 110, 112 • P. 132-133: Actions 116-120 *Primary Care Strategy* • Actions 2-6, 8-11, 13, 14, 16, 17, 19 **Indirect responsibility/impact** • Actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- Similar to the regional health boards, the area health boards are the statutory bodies responsible for the delivery of health and personal social services in their functional areas. They are also the main providers of health and personal social care at regional level (p. 39 *Quality and Fairness*)

Overlap with/impact on functions of other agencies audited

- Area health boards link to a wide range of agencies in the health system, including:
  - Voluntary service providers
  - Information and research agencies
  - Professional bodies
  - Agencies involved in the coordination and implementation of national services and strategies
  - Other public service providers outside of health and personal social services (e.g. local authorities, educational bodies etc)

Role identified in Quality and Fairness

- The Area health boards are seen as key implementers of the National Health Strategy, with a considerable proportion of actions assigned directly or jointly to them
- In particular, Action 110 identifies the role of the health boards for driving change, including a stronger focus on accountability linked to service plans, outputs and quality standards
- The Primary Care Strategy assigns responsibility for 14 of the 20 actions to the health boards

Eastern Regional Health Authority

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Eastern Regional Health Authority was established under the HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT, 1999 . The Authority plans, commissions, monitors and evaluates health and personal social services in the eastern region, covering counties Dublin, Wicklow and Kildare, from the three area health boards and other providers located in the region. The three area health boards in the region are responsible for the provision of health and personal social services in their area. These are the Northern, South Western and East Coast Area Health Boards	**Statutory Functions — Section 9, Health (ERHA) Act, 1999** (1) The Authority shall perform the functions conferred on it, under this Act and any other functions which are performable by a health board and such other functions as may be provided for by law (2) The Authority shall, having regard to the resources available and as it sees fit, plan, arrange for and oversee the provision of services in its functional area (3) In performing its functions under this section, the Authority shall — a) make arrangements under section 10 with persons for the provision of services b) co-ordinate the provision of services c) put in place systems, procedures and practices to enable it to monitor and evaluate services provided in accordance with arrangements made under section 10 d) provide in its annual report an account of measures taken to monitor and evaluate services and an account of the outcomes of such measures e) have regard to the advice (if any) tendered to it by each of the three Area Health Boards, and f) have regard to the right of voluntary bodies who provide services in accordance with arrangements made under section 10 to manage their own affairs in accordance with their independent ethos and traditions (4) Nothing in this Act shall be construed as prejudicing the performance by the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital of its functions under its Charter **Delegation of functions of Authority.** **9.**—(1) The Authority shall provide in writing for such of its reserved functions in relation to the provision of services which, immediately before the establishment day, were performed by the Eastern Health Board, to be exercisable on its behalf, in relation to the functional area of an Area Health Board, by that Area Health Board (2) Notwithstanding *subsection (l),* the Authority may, from time to time, and where it considers such action would secure the most beneficial, effective and efficient use of resources, provide in writing for such of its reserved functions as it may determine to be exercisable on its behalf, in relation to the whole or part of its functional area, by a specified Area Health Board and where the Authority does so, any provision made under *subsection (1)* in relation to those functions shall cease to have effect (3) The performance of its functions under *subsections (1)* and *(2)* shall be a reserved function of the Authority **Arrangements by Authority for provision of services.** **10.**—(1) Subject to *subsections (2)* and *(4),* the Authority shall, having regard to the resources available to it, make one or more arrangements with one or more persons for the provision of services within its functional area (2) (*a*) Subject to *section 9(2)* and *subsection (3),* the Authority shall, having regard to the resources available to it, make and carry out an arrangement with each Area Health Board for the provision within the Area Health Board's functional area of services which, immediately before the establishment day, were provided by the Eastern Health Board (3) The Authority may determine an arrangement or any part thereof made under *subsection (2) (a)* in relation to the provision of a service and make and carry out an arrangement in lieu thereof with a voluntary body for the provision of the service (4) An arrangement made under this section shall include the following: a) a written agreement between the Authority and the person who proposes to provide the services, covering a period of not less than 3 years and not more than 5 years and specifying— (i) the principles by which both parties agree to abide for the duration of the agreement, and (ii) such standards relating to the efficiency, effectiveness and quality of the services to be provided as may be agreed between the parties and b) a written agreement, to be renewed annually, between the Authority and the person who proposes to provide the services specifying— (i) the services to be provided, and (ii) the funds to be made available therefore	**Assigned responsibility** • P. 104 — Action 82 • P. 105 — Actions 83 & 84 • P. 108 — Action 91 And other actions assigned to health boards generally **Indirect responsibility/impact** • Actions relevant to service providers

Eastern Regional Health Authority — *continued*

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
	(5) The Authority may delegate its power to make an arrangement under subsection (1) to an Area Health Board, other than where: a) the arrangement is with any one of the persons specified in the *Second Schedule,* or b) the arrangement is with another Area Health Board ***Other functions (outlined in Annual Report)*** • Co-ordinate and plan services across the Eastern region • Commissioner and funder of services from 3 area health boards and 36 other agencies • Monitor and evaluate services • Provision of information across Eastern region (e.g. public health report) • Development of strategies or policy for the Eastern region (e.g. HR) • Ensure standardisation of services across the Eastern region	

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The ERHA currently commissions and funds services from the 3 area health boards and 36 other agencies
- The ERHA has sole statutory responsibility for monitoring and evaluating services in the Eastern region
- Eastern Health Shared Services provides a number of shared services on behalf of the ERHA and the three area health boards

Overlap with/impact on functions of other agencies audited

- The ERHA links to a wide range of agencies in the health system, including:
- Voluntary service providers
- Information and research agencies
- Professional bodies
- Agencies involved in the coordination and implementation of national services and strategies
- Other public service providers outside of health and personal social services (e.g. local authorities, educational bodies etc)
- The functions of the ERHA impact or overlap with the following:
    - Monitoring and evaluation role of HIQA
    - Planning role of NHA in relation to hospital services
    - Coordination role of HeBE

Role identified in *Quality and Fairness*

- The ERHA is assigned responsibility for a number of actions to improve acute services (in conjunction with NHA and health boards), including:
    - Management of waiting lists — Action 82
    - Maximum use of one day procedures — Action 83
- The improvement of the organisation and management of acute services — Action 84
    - Health boards and the ERHA will optimise the use of operating theatres by extending their hours of work at evenings and weekends. The details of this initiative will be discussed with staff and unions in the context of partnership and IR structures
    - Health boards and the ERHA will work to integrate more fully the planning and provision of services between acute hospitals and primary care providers.
    - *'Despite the development of hospital services around the country, many patients are referred outside their own region, mostly to Dublin, for treatment even though the procedure required is available locally'.* The National Hospitals Agency will work with the health boards, the ERHA and clinicians to encourage patients to use services within their regions where the necessary treatment is available locally

Beaumont Hospital Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Beaumont Hospital Board was established under the BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1977 BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER 1977, (AMENDMENT) ORDER 1988 (Functions) BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER 1977, (AMENDMENT)(NO.2) ORDER, 1988	**Statutory functions: Establishment (Amendment) Order, 1988 section 4** • To conduct, maintain, manage and develop at the hospital built by the Board at Beaumont, Dublin, such hospital services as may, from time to time, be approved by the Minister • To provide such facilities for the teaching of medical, nursing and para-medical students as may, from time to time, be determined by the Minister after consultation with the Board • To provide such other services and facilities as may, from time to time, be determined by the Minister, after consultation with the Board	**Assigned responsibility** • P. 104 — Action 82 • P. 105 — Actions 83 & 84 • P. 106 — Actions 85 & 86 • P. 108 — Action 91 **Indirect responsibility/impact** • Actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- Beaumont Hospital delivers a range of acute care services, including regional and national specialist services as well as providing teaching and training facilities

Role identified in *Quality and Fairness*

- There are no actions directly assigned to Beaumont Hospital
- Actions relating to the Framework for Change for acute services will impact on all acute hospitals

Board of the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
A corporate body was established under THE HEALTH ACT, 1970 (SECTION 76) (ADELAIDE AND MEATH HOSPITAL, DUBLIN, INCORPORATING THE NATIONAL CHILDREN'S HOSPITAL) ORDER, 1996 (S.I. NO. 228 OF 1996) following an agreement between the hospital boards of the Adelaide Hospital, Dublin, the Meath Hospital and the National Children's Hospital that the activities of each of those hospitals should be combined and carried on by one corporate body	**Statutory Functions: Source: S.I. No. 228/1996** (a) To operate the hospital premises that are to be built by the Tallaght Hospital Board at Tallaght, County Dublin, (hereafter in this Charter referred to as the 'Hospital Premises') as a public voluntary teaching hospital and, in particular, to carry on at those premises when the building of them is completed and, pending such completion, at the respective premises of the hospitals hereafter mentioned in this provision, the activities carried on by the Adelaide Hospital, Dublin, the Meath Hospital and the National Children's Hospital immediately before the commencement of the Health Act, 1970 (Section 76) (Adelaide and Meath Hospital, Dublin, Incorporating the National Children's Hospital) Order, 1996 (hereafter in this Charter referred to as 'the transfer day') and, for those purposes, to assume responsibility for— (i) the hospital services and equipment provided and held by each of the said hospitals immediately before the transfer day (ii) ensuring that persons who retired as members of the staff of the Adelaide Hospital, Dublin, the Meath Hospital or the National Children's Hospital before the transfer day (whether they are persons who held contracts of service or contracts for service) and in respect of whom any of the said hospitals provided entitlements to pensions and other rights continue to enjoy the said entitlements (iii) any surplus or deficit arising from the annual financial determinations by the Minister on behalf of the Eastern Health Board which pertain to the hospital boards of the said hospitals in respect of services rendered by each of the said hospitals prior to the transfer day but excluding the property and capital assets (including private funds) of the Adelaide Hospital Society, any body which for the time being assumes the functions of, or acts as successor to, the Meath Hospital and any body which for the time being assumes the functions of, or acts as successor to, the National Children's Hospital, and (iv) all rights and liabilities in respect of contracts and other choses-in-action and legal proceedings enjoyed by each of the said hospitals, or to which each of them was subject, immediately before the transfer day (and, accordingly all such rights and liabilities shall stand vested in the Hospital upon the transfer day without any assignment and it shall not be necessary for the Hospital or any of the said hospitals to give notice to the person bound by any such chose-in-action of the transfer effected by this provision) (b) On and after such day or days as may be determined by the Minister, to perform the functions conferred on and assume the responsibilities and liabilities of the Tallaght Hospital Board established by the Tallaght Hospital Board (Establishment) Order, 1980 (S.I. No. 38 of 1980), and to perform the functions (in particular as respects teaching agreements, employment contracts of staff and all other contracts) performed in relation to the Adelaide Hospital, Dublin, the Meath Hospital and the National Children's Hospital by the Central Council of the Federated Dublin Voluntary Hospitals under the Hospitals Federation and Amalgamation Act, 1961. (c) To promote and secure the availability, . . . of such medical and surgical procedures as may lawfully be provided within the State from time to time within the Hospital Premises and any other hospital or medical establishment operated by the Hospital or for the purposes of services otherwise provided by it; the Hospital will ensure the availability of an adequate range of staff . . . including medical and consultant staff with a contract for medical or surgical services to the Hospital, staff transferred from the Adelaide Hospital, Dublin, the Meath Hospital, the National Children's Hospital and the Central Council of the Federated Dublin Voluntary Hospitals, and staff appointed by the Board (d) To provide for the treatment of diseases and illnesses requiring medical and surgical relief for persons, whether adults or children, and to provide such relief either gratuitously or otherwise (e) To provide as far as possible for the health, happiness and welfare of children and adults accepted as patients (f) To manage the Hospital Premises and services provided by it in the interests of patients	**Assigned responsibility** • P. 104 — Action 82 • P. 105 — Actions 83 & 84 • P. 106 — Actions 85 & 86 • P. 108 — Action 91 **Indirect responsibility/impact** • Actions relevant to service providers

Board of the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital — *continued*

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
	(g) To provide and maintain instruction in medicine and surgery in connection with the treatment of diseases and illnesses and the promotion of health, and so far as conveniently may be to encourage, undertake and promote medical research and education at both the undergraduate and postgraduate levels and the investigation of diseases and illnesses by means of lectures and demonstrations delivered in the Hospital Premises or elsewhere and by the preparation and publication of records and reports or otherwise as may seem desirable (h) To establish and support a Faculty of Health Sciences within which there shall be a single College of Nursing, a School of Postgraduate Medical Studies and schools for such other medical and health science disciplines as may be required . . . (i) To accept students of such medical schools as it recognises for the purposes of this paragraph for training in general and paediatric medicine, surgery, and other relevant disciplines upon such terms as it may think fit and generally to act as an institution for the training of medical personnel at both undergraduate and postgraduate levels (j) To maintain the Fundamental Principle upon which the Adelaide Hospital, Dublin was established, namely, that it should be an essentially Religious and Protestant Institution, by maintaining the Hospital as a focus for Protestant participation in the health services and thereby preserving its particular denominational ethos . . . (k) To employ or hire by means of contracts of service or contracts for services such persons as may be required to enable the objects of the Hospital to be achieved . . . (l) To develop the tradition of voluntary support groups for the activities of the Hospital, in particular through the bodies referred to in subparagraphs (a), (b) and (c) of Clause (12)(3) (m) To continue close co-operation with the health boards or other health agencies in whose area of operation the establishments operated by the Hospital are situate in providing complementary services in the interests of the patients of the Hospital and of the health of the population served by the Hospital (n) To solicit and receive subscriptions and gifts of all kinds whether absolute or conditional for the purposes of the Hospital (o) To take over, acquire, administer, manage, maintain or make appropriate provision for the working of any other hospital or any convalescent home, or medical institution or residence for nurses or residence for students or institution or college for training nurses and the provisions of this Charter shall apply to such hospital, convalescent home, or medical institution or residence for nurses or residence for students or institution or college for training nurses so taken over, acquired, administered, managed, maintained, or in relation to which provision is so made, as if it were part of the Hospital Premises (p) To promote and develop paediatric medicine and surgery in the State by developing the work heretofore carried out by the National Children's Hospital and to associate all paediatric services with the name of the National Children's Hospital (q) To maintain and develop sick children's nursing within the College of Nursing and to associate such sick children's nursing with the name of the National Children's Hospital (s) Generally to do all things necessary or expedient for the proper and effective carrying out of any of the objects aforesaid	

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- The Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital delivers a range of acute care services, including regional specialities as well as providing teaching and training facilities

Role identified in *Quality and Fairness*

- There are no actions directly assigned to the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital
- Actions relating to the Framework for Change for acute services will impact on all acute hospitals

Dublin Dental Hospital

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Hospital is established under DUBLIN DENTAL HOSPITAL (ESTABLISHMENT) ORDER, 1963 DUBLIN DENTAL HOSPITAL (ESTABLISHMENT) ORDER,1963,(AMENDMENT) ORDER,1985	**Statutory functions: Section 4 Establishment Order, 1963** • To conduct, maintain and manage a hospital for the affording of dental treatment and appliances to persons • To co-operate with the authorities of University College, Dublin, Trinity College, Dublin, and the Royal College of Surgeons in Ireland in the teaching and training of students of dentistry and dental surgery • To provide courses of study and training for post-graduate students of dentistry and dental surgery • To teach and train dental auxiliaries and technicians **Other Goals of the Dental Hospital as laid out in the FOI Section 15 Manual** • Educate and train dentists in specialist and consultant postgraduate programmes to meet the needs of the community • Provide continuing education opportunities for all members of the dental team • Conduct research in education, basic and clinical sciences which builds on our strengths and individual talents at national and international level • Provide clinical services at reasonable fees appropriate to the needs of the community in ways which ensure that the requirements of high quality teaching and research were met • Provide a referral and consultant resource to healthcare providers and also provide appropriate clinical services at secondary care level focusing on multidisciplinary care and the development of centres of excellence	**Assigned responsibility** • P. 104 — Action 82 • P. 105 — Actions 83 & 84 • P. 106 — Actions 85 & 86 • P. 108 — Action 91 **Indirect responsibility/impact** • Actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- **The Dublin Dental Hospital delivers a range of dental treatment services, as well as providing teaching and training facilities**
- **The Hospital has service agreements with a range of agencies to provide specialist care services. These services play an important role in specialist/consultant training programmes, as well as delivering specialist care for patients**

Role identified in *Quality and Fairness*

- There are no actions directly assigned to the Dublin Dental Hospital
- Actions relating to the Framework for Change for acute services will impact on all acute hospitals

Leopardstown Park Hospital

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Hospital is established under LEOPARDSTOWN PARK HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1979 Organisation originally established to care for British ex-service personnel. In 1979, Leopardstown Park Hospital Board took over full responsibility for the management of the hospital. Since then the Board has worked to develop and improve the facilities of the hospital to cater for its traditional role in the care and treatment of War Pensioners, and in its new role to develop a hospital which can meet the needs of the Irish Health Services, and in particular the needs of elderly persons from South East Dublin	**Statutory Functions (Section 4 Establishment Order, 1979)** The functions of the Board are, on being permitted by the Trustees to use the hospital in accordance with the terms of such permission, • To conduct and manage the hospital • To provide such services and facilities at the hospital as may, from time to time, be approved by the Minister, after consultation with the Board • To provide for the maintenance of the hospital **Stated functions (Service principles)** • To maintain older people in the dignity and independence at home in accordance with the wishes of older people • To restore to independence at home those older people who become ill or dependent • To encourage and support the care of older people in their own community by family, neighbours and voluntary bodies in every possible way • To provide high quality hospital or residential care for older persons when they can no longer be maintained in dignity and independence at home	**Assigned responsibility** • P. 104 — Action 82 • P. 105 — Actions 83 & 84 • P. 106 — Actions 85 & 86 • P. 108 — Action 91 **Indirect responsibility/impact** • Actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- Leopardstown Park Hospital provides a range of services for older persons in close association with neighbouring acute hospitals, in particular St Vincent's University Hospital

Role identified in *Quality and Fairness*

- There are no actions directly assigned to Leopardstown Park Hospital
- Actions relating to the Framework for Change for acute services will impact on all acute hospitals and the associated non-acute units

St James's Hospital Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Hospital is established under ST JAMES'S HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1971 The amalgamation of some of the smaller voluntary hospitals in the city into a new hospital at St. Kevin's later formed St. James's Hospital. The board of St. James's Hospital met for the first time in 1971 to plan the current hospital. St. James's Hospital is now a major teaching hospital for Trinity College	**Statutory Functions: (Section 4, Establishment Order, 1971)** • To conduct, maintain, manage and develop at the hospital heretofore known as St. Kevin's Hospital, Dublin, such hospital services as may, from time to time, be approved by the Minister • To provide such facilities for the teaching of medical, nursing and para-medical students and for the conduct of medical research as may from time to time be determined by the Minister after consultation with the Board • To provide such other services and facilities, as may, from time to time, be approved by the Minister, after consultation with the Board	**Assigned responsibility** • P. 104 — Action 82 • P. 105 — Actions 83 & 84 • P. 106 — Actions 85 & 86 • P. 108 — Action 91 **Indirect responsibility/impact** • Actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- St James's Hospital delivers a range of acute care services, including regional and national specialities as well as providing teaching facilities

Role identified in *Quality and Fairness*

- There are no actions directly assigned to St James's Hospital
- Actions relating to the Framework for Change for acute services will impact on all acute hospitals

St Luke's and St Ann's Hospital Board

Rationale for establishment	Stated functions	Responsibility in *Quality and Fairness*
The Hospital is established under ST LUKE'S AND ST ANNE'S HOSPITAL BOARD (ESTABLISHMENT) ORDER 1988 following an agreement with the Daughters of Charity of St Vincent de Paul in Ireland for the integrated operations of St Luke's Hospital and St Anne's Hospital	**Statutory functions (Section 4, Establishment Order, 1998)** • Provide a service for the diagnosis and treatment of malignant diseases, diseases of the skin • Encourage measures which may lessen the incidence of such diseases and conditions • Educate and train 7 persons engaged or to be engaged on duties in connection with the diagnosis, treatment and prevention of diseases referred to above • Engage in research or arrange for the conduct of research associated with diseases referred to at (a) above • Maintain and administer hospitals, institutions, and other premises necessary for the performance of the functions of the Board • Furnish advice, information and assistance in relation to the service referred to at (a) above to the Minister, to health boards or to other hospitals **Additional stated functions (Statement of Priority Objectives)** • To consolidate the service following the major redevelopment commenced in 1994 • Further develop patient support services, including palliative care, complementary therapies, information services and psychiatric and counselling services for patients and their families • Continue to develop linkages where possible with other service providers • Develop quality initiatives and general education and information initiatives for patients, relatives and staff • Provide Cytology services to the First Phase of the National Cervical Screening Programme • Recruitment, retention and training of staff	**Assigned responsibility** • P. 104 — Action 82 • P. 105 — Actions 83 & 84 • P. 106 — Actions 85 & 86 • P. 108 — Action 91 Indirect responsibility/impact • Actions relevant to service providers

Commentary on findings based on available evidence

Relevance and distribution of function(s)

- St Luke's and St Ann's Hospital delivers a service for the diagnosis and treatment of malignant diseases, diseases of the skin and such benign conditions as are amenable to treatment provided for malignant diseases; and to provide training to medical staff for the diagnosis and treatment of the above. The hospital is the major national centre for radiotherapy

Role identified in *Quality and Fairness*

- There are no actions directly assigned to St Luke's and St Ann's Hospital
- Actions relating to the Framework for Change for acute services will impact on all acute hospitals

Appendix 7

Governance: Analysis of the individual agencies reviewed

Appendix 7

Governance: Analysis of the individual agencies reviewed

This appendix outlines the current governance arrangements for 56[1] of the 58 Agencies examined.

Presentation of findings

The following tables have been organised according to:

1. The legislation/establishment order for the Agency:

- **Agencies established under individual Acts**
  - An Bord Altranais (Nursing Board)
  - Adoption Board
  - Opticians Board
  - Dental Council
  - Food Safety Authority of Ireland
  - Hospitals Trust Board
  - Irish Medicines Board
  - Medical Council
  - Mental Health Commission
  - Postgraduate Medical And Dental Board
  - Office of Tobacco Control
  - Poisons Council
  - Pharmaceutical Society of Ireland
  - Special Residential Services Board

- **Agencies established under the Health (Corporate Bodies) Act 1961**
  - National Breast Screening Board
  - Crisis Pregnancy Agency
  - Drug Treatment Centre Board

[1] *Note: The Health Information and Quality Authority and the National Hospitals Agency are excluded as their governance arrangements are not finalised.*

- Health Service Employers Agency
- Irish Health Services Accreditation Board
- Irish Blood Transfusion Services Board
- National Cancer Registry Board
- National Council for the Professional Development of Nursing and Midwifery
- National Council on ageing and older people
- National Social Work Qualifications Board
- Pre-hospital Emergency Care Council
- Women's Health Council
- Beaumont Hospital Board
- Dublin Dental Hospital Board
- Lepardstown Park Hospital Board
- St James' Hospital Board
- St Luke's and St Ann's Hospital Board

- **Agency established under the British Irish Agreement**
  - Food Safety Promotion Board

- **Agencies established under the Health Acts 1970-2001**
  - Comhairle na nOspidéal; Hospital Bodies Administration Bureau
  - Board of the Adelaide and Meath Hospitals, Dublin, incorporating the National Children's Hospital
  - General Medical Services (Payments) Board
  - Health Boards Executive (HeBE)
  - Health Boards (7)
  - Eastern Regional Health Authority
  - Area Health Boards (3)

- **Non-statutory agencies[2]**
  - Board for the Employment of the Blind
  - The Institute of Public Health
  - The National Disease Surveillance Centre
  - Social Services Inspectorate
  - Office for Health Management
  - National Children's Office; National Children's Advisory Council

This analysis allows us to establish if common governance arrangements apply across the Agencies established under similar legislation and the extent to which they meet other criteria of best practice.

[2] In the case of non-statutory agencies, material received has been used to comment on reporting arrangements

2. Evidence provided obtained from the Establishment Order or relevant piece of legislation, in relation to principal governance features:

- Size of the Board
  - Number of Board members
- Composition of the Board
  - Make up of the Board described in the Establishment Order
- Source of appointment to the Board/replacement
  - How are Board members appointed to the Board?
    - Direct Ministerial appointment
    - Nomination through election and direct Ministerial appointment
    - Nomination and then Ministerial appointment
  - How often the Board is replaced
- Frequency of meetings
  - How often the Board is required to meet
- Reporting to
  - Who the Board reports to
- Accountability/reporting arrangements
  - What reporting arrangements are in place

3. Best practice — review of available evidence on each Agency against best practice criteria

From our review of governance arrangements in other health systems a set of best practice principles were developed. Each of the Agencies is benchmarked against this set best practice principles. The following principles were applied:

- Size: Best practice indicates that Board size should be between 9 and 17 (unless there are exceptional circumstances)
- Board Membership, Appointment, Independence and Capability: there should be clear rules for the composition of the board, for criteria of eligibility, and for the selection and appointment of Board members
- Scope of Role: this refers specifically to interfaces between the Board and the rest of the organisation. Each Board should have clear statements of authority and accountability for itself and for management, in the areas of strategy and planning, financial control and oversight, risk management and people management, and others, which seem appropriate.
  - It is critical to maintain a balance such that
    1. The chief executive reports to and seeks authority for (major) decisions from the Board, and not the other way round,
    2. Apart from these and the overall policy framework (usually set by the Government) he/she has full freedom on operating decisions; and
    3. The Board reserves broad oversight of the main areas and the right to take certain key decisions — whose nature and type (e.g. budget approval) should be clearly defined.

- Monitoring Processes: there should be processes in place for regular monitoring of management performance, financial control and organisational outcomes, and these processes should be clearly specified and communicated.
    - If management are to be given operating freedom, yet held accountable, the board must ensure that it is aware in broad terms of management actions, and regularly monitors both financial and other indicators of performance against objectives — whether these are set by itself or by a higher level. Only the board can do this, and good management will expect it.
    - Management must also have the necessary support in terms of development, information etc to execute their responsibility.
    - There should be processes in place for the Boards to monitor their performance during the year
- Reporting Arrangements: there should be arrangements for periodic reporting to all stakeholders on management's and the board's plans, actions, results, and general stewardship.

References:

- Material provided by individual agencies for the purpose of the audit, including:
    - Statutory Instruments/legislative bases
    - Relevant corporate documentation — e.g. annual reports, corporate strategies, service plans, provider plans etc
- Material used by Prospectus Strategy Consultants and Watson Wyatt Worldwide to develop best practice guidelines includes the following reports on corporate governance arrangements:
    - Laking, R (2001); 'The Governance of the Wider State Sector: Principles for Control and Accountability of Delegated and Devolved Bodies' Presentation at the *'OECD Global Forum on Governance'* Bratislava 22-23 November 2001
    - IFAC (2001); 'Corporate Governance Review by the Standing Committee on Company Law Reform;' *A Consultation Paper on proposals made in Phase I of the Review,* 20 November 2001
    - The Hampel Report on Corporate Governance (1998) Hampel Committee
    - Cadbury Report (1992) 'Report of the Committee on the Financial Aspects of Corporate Governance,' chaired by Sir Adrian Cadbury
    - Sendt, B (2001); 'Best Practice Standards for Public Sector Corporate Governance,' Presentation at Annual Company Secretaries Conference, 20 November 2001

Agencies established under individual Acts

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
An Bord Altranais (Nursing Board) NURSES ACT, 1985	29	17 from the nursing profession 12 from branches of the medical profession, education, nurse training bodies, the Department of Health and Children, and the general public	**17 appointed through elections from the nursing profession** • Five nurses resident in the State and who are engaged in training nurses of whom— 1 in general nursing, 1 in paediatric nursing, 1 in psychiatric nursing, 1 in the care of mentally handicapped persons, and 1 in midwifery, elected by nurses • Five nurses resident in the State and who are engaged in nursing administration of whom— 1 in general nursing administration, 1 in the administration of public health nursing, 1 in the administration of psychiatric nursing, 1 in the administration of midwifery, and 1 in the administration of nursing of mentally handicapped persons, elected by nurses • Seven nurses resident in the State who are engaged in clinical nursing practice of whom— 2 in general nursing, 2 in psychiatric nursing, 1 in midwifery, 1 in public health nursing, and 1 in the nursing of mentally handicapped persons, elected by nurses • **Twelve persons appointed by the Minister,** after consultation with such bodies or organisations as he considers suitable to advise him, of whom— (i) one shall be a registered medical practitioner engaged in the practice of medicine in a hospital approved of by the Board for the training of general nurses (ii) one shall be a registered medical practitioner engaged in the practice of medicine in a hospital approved of by the Board for the training of psychiatric nurses (iii) one shall be a registered medical practitioner engaged in the practice of obstetrics in a hospital approved of by the Board for the training of midwives, (iv) one shall be a person representative of the management of health boards (v) one shall be a person representative of the management of hospitals, other than hospitals administered by health boards	A minimum of 4 meetings per annum	Minister for Health and Children Houses of the Oireachtas	*Accounts:* The accounts of the Board shall be audited at least once in every year by an auditor appointed for that purpose by the Minister and the fees of such auditor and the expenses generally of such audit shall be paid by the Board as soon as may be after each such audit As soon as may be after each audit under this section, the Board shall cause such accounts and the auditor's certificate and report thereon to be printed, published and put on sale, and immediately after each such publication, a copy of such accounts and such certificate and report thereon as so printed and published shall be laid before each House of the Oireachtas *Report:* The Board shall as soon as may be after the end of each year prepare and publish a report of its proceedings under this Act during the preceding year

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
			(vi) two shall be persons representative of the Department of Health (vii) one shall be a person who is experienced in the field of education (viii) one shall be a person representative of third level educational establishments which are involved in the education and training of nurses (ix) one shall be a nurse, and (x) two shall be persons representative of the interest of the general public Every member of the Board shall hold office, unless he sooner dies, resigns or becomes disqualified, for a period of five years No person shall hold office as a member of the Board for more than two consecutive terms of five years			

An Bord Altranais (Nursing Board)

Comments against best practice principles based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 29

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by nominations through elections and direct Ministerial appointment
  - The Board is competency based with 17 Members elected from the various branches within nursing, e.g. *'5 from nursing training, 5 from nursing administration'*
  - The remaining 12 members are appointed by the Minister for Health and Children
  - There are clear criteria laid out in the legislation for the Ministerial appointments, e.g. *'one shall be a registered medical practitioner engaged in the practice of medicine in a hospital approved of by the Board for the training of general nurses'*
  - The criteria for Ministerial appointments ensures that public interest is represented on the Board, e.g. *'two shall be persons representative of the interest of the general public'*

Scope of role:

- There are no clear statements of authority and accountability within the legislation for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
An Bord Uchtála (Adoption Board) ADOPTION ACT, 1952 (Principal Act) ADOPTION ACT, 1988 (Adoption of children whose parents have failed in their duty to them, powers given to the board) ADOPTION ACT, 1991 (Register of Foreign Adoptions)	9	1 Chairman — he/she is or has been a Judge of the Supreme Court, the High Court or the Circuit Court or a Justice of the District Court or is a barrister or solicitor of at least ten years standing. 8 Ordinary Members	Appointed by Government Term of office is 5 years	Board met 45 times in 2000	Minister for Health and Children Houses of the Oireachtas Notices to be published in *Iris Oifigiúil*	*Annual report:* 13. (1) The Board shall, after the expiration of each year, publish a report giving the following information in relation to that year— (*a*) the number of applications for adoption and the decisions of the Board thereon (*b*) the names of the registered societies concerned in the applications (*c*) the number of applications for registration of societies and the decisions of the Board thereon (*d*) the name and address of each society which is registered or the registration of which is cancelled during the year (2) The Board shall present a copy of the report to the Minister who shall cause it to be laid before each House of the Oireachtas Notices to be published in *Iris Oifigiúil* 14.—(1) The Board shall cause to be published in *Iris Oifigiúil* a notice in the prescribed form of the making of every adoption order and of every registration and cancellation of registration in the Adoption Societies Register (2) A notice in regard to an adoption order shall not refer to the child's natural parents, former surname, place of birth or otherwise to his origin

An Bord Uchtála (Adoption Board)

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 9

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Government appointment
  - The legislation clearly outlines the competency based criteria for the Chairperson of the Board e.g. *'he/she is or has been a Judge of the Supreme Court, the High Court or the Circuit Court or a Justice of the District Court or is a barrister or solicitor of at least ten years standing'*
  - There are no guidelines outlining the competencies or nomination criteria for ordinary Board members
  - Public interest is not explicitly represented on the Board e.g. stakeholders, members of the public, elected public representatives

Scope of role:

- This is an executive Board and its functions are clearly laid out in the legislation.

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the Registrar/management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas
  - Clearly identified requirements for the Annual Report
  - Notices have to be published in *Iris Oifigiúil*
- There are no financial reporting requirements in the legislation
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Bord na Radharcmhastóirí (Opticians Board) OPTICIANS ACT, 1956	11	Election will be held every fifth year Before the 1st December • 6 people will be elected by registered opticians • 5 registered ophthalmic opticians • 1 registered dispensing optician	Appointed by Minister for Health and Children Term of office is 5 years	At least 1 meeting in each quarter of the year	Minister for Health and Children	*Accounts:* The accounts of the Board shall be audited by an auditor appointed from time to time by the Board for that purpose Publication of the Register of Ophthalmic/Dispensing Opticians

Bord na Radharcmhastóirí (Opticians Board)
Comments against best practice based on available evidence

Size:
- Best practice recommends a Board size between 9 and 17. The Board size is 11

Board Membership, Appointment, Independence and Capability:
- Board members are appointed by nomination and then Ministerial appointment
  - The legislation outlines the election criteria/competencies for nomination to the Board, e.g. *'5 registered ophthalmic opticians'*
  - All Board members are appointed by the Minister for Health and Children
  - Public interest is not explicitly represented on the Board, e.g. stakeholders, members of the public, elected public representatives

Scope of role:
- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:
- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the officers of the Board
  - The Board reviewing its own performance

Reporting arrangements:
- There are clear requirements for the auditing of accounts e.g. Board appoints an Auditor to examine the accounts
- No formal requirement to publish the accounts of the Board
- Publication of The register of Ophthalmic/Dispensing Opticians is set at intervals of five years
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
An Comhairle Fiacloireachta (Dental Council) DENTISTS ACT, 1985 THE DENTAL COUNCIL (ELECTION OF MEMBERS) REGULATIONS, 1985	19	• 2 UCC and UCD • 1 RCSI • 7 fully registered dentists • 2 Medical Council • 1 Minister for Education • 2 registered dentists • 2 other	19 members: • 2 persons appointed by UCC and UCD • 1 member by RCSI • 7 fully registered dentists resident in the State appointed by election by fully registered dentists • 2 persons appointed by the Medical Council • 1 person appointed by the Minister for Education • Four persons appointed by the Minister, at least two of whom— (i) shall not be registered dentists, and (ii) shall, in the opinion of the Minister, after consultation with the Minister for Industry, Trade, Commerce and Tourism, represent the interests of the general public as consumers of dental services Term of office is 5 years. No person shall hold membership of the Board for more than 2 consecutive terms	Council shall hold meetings at least 4 times a year	Minister for Health and Children	*Accounts:* The accounts of the Council shall be audited at least once in every year by an auditor appointed for that purpose by the Minister and the fees of such auditor and the expenses generally of such audit shall be paid by the Council as soon as may be after each such audit As soon as may be after each audit under this section, a copy of such accounts and the auditor's certificate thereon shall be laid before each House of the Oireachtas and as soon as may be after such accounts have been so laid, the Council shall cause such accounts and the auditor's certificate thereon to be printed, published and put on sale Publish the Register of Dentists *Report:* The Council shall as soon as may be after the end of each year in which it is in office prepare and publish a report of its proceedings under this Act during the preceding year

An Comhairle Fiacloireachta (Dental Council)

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 19

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by nominations through elections and direct Ministerial appointment
  - The Board is competency based with 7 members elected by fully registered dentists
  - 5 members are appointed by the Universities and Medical Council, e.g. 2 members appointed by UCC and UCD
  - 1 member is appointed by the Minister for Education
  - The remaining 4 members are directly appointed by the Minister for Health and Children
  - There are clear criteria laid out in the legislation for 2 of the Ministerial appointments, e.g. *'Four persons appointed by the Minister, at least two of whom (i) shall not be registered dentists, and (ii) shall, in the opinion of the Minister, after consultation with the Minister for Industry, Trade, Commerce and Tourism, represent the interests of the general public as consumers of dental services.'*
  - The criteria for Ministerial appointments ensures that *'public interest'* is represented on the Board

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the Registrar of the Council/management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas in the legislation with regard to:
  - Accounts
  - Annual report
- Publication of The Register of Dentists
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Food Safety Authority of Ireland • ***Food Safety Consultative Council*** • ***Scientific Committee of the Food Safety Authority of Ireland*** FOOD SAFETY AUTHORITY OF IRELAND ACT, 1998 BRITISH IRISH AGREEMENT ACT, 1999 (amends above act in relation to functions) HEALTH AND CHILDREN (DELGATION OF MINISTERIAL FUNCTIONS) ORDER, 2000 (delegates the powers under Section 20 of the Principal Act [conferral of additional functions on the Authority])	**FSAI** 10 **FSCC** 24 **SCFSAI** 15	**FSAI** Chairperson and 9 ordinary members 1 ordinary member is the Chairperson of the SCFSAI **FSCC** The Council shall consist of not more than 24 members, broadly based and representative	The FSAI is supported by the following two agencies established under the 1998 act: • Food Safety Consultative Council — to enable the FSAI to consult representatives of consumers, producers, retailers, distributors, caterers and manufacturers and, where appropriate, official agencies about the activities or other measures to be undertaken for the purpose of establishing and maintaining the highest level of standards of food hygiene and safety reasonably available in the interests of public health and consumer protection • Scientific Committee of the Food Safety Authority of Ireland — to assist and advise the board in relation to matters of a scientific nature **FSAI** Minister will make appointments to the Board The Minister, when appointing an ordinary member of the Board, shall fix such member's period of membership which shall not exceed 5 years and, subject to this section, membership shall be on such terms as the Minister determines. Four of the ordinary members of the Board appointed under *subsection (2)* shall hold office for a period not exceeding three years from the date of their appointment as determined by the Minister **FSCC** 12 members nominated by the Minister for Health and Children 2 nominated by the Minister for Agriculture and Food 1 nominated by Minister for the Marine and Natural Resources 1 nominated by Minister for the Enterprise, Trade and Employment 1 nominated by Minister for the Environment and Local Government Remainder appointed by the Board **SCFSAI** Appointed by the Minister for Health and Children after consultation with the Board	FSAI may hold as many meetings as may be necessary to carry out its functions	Minister for Health and Children House of the Oireachtas C&AG	**FSAI** *Annual Report:* As soon as may be after the end of the financial year of the Authority in which the establishment day falls and of each subsequent financial year of the Authority, but not later than 6 months thereafter, the Authority shall make a report to the Minister of its activities during that year and the Minister shall cause copies of the report to be laid before each House of the Oireachtas *Accounts:* The accounts of the Authority for each financial year shall be prepared in such form and manner as may be specified by the Minister. The accounts shall be prepared by the chief executive and approved by the Board as soon as practicable but not later than three months after the end of the financial year to which they relate for submission to the Comptroller and Auditor General for audit. A copy of the accounts and the auditor's report thereon shall be presented to the members of the Board and to the Minister as soon as practicable and the Minister shall cause a copy of these documents to be laid before each House of the Oireachtas The chief executive shall be the accountable person in relation to the accounts of the Authority and shall, whenever he or she is so required by a Committee of Dáil Éireann established under Standing Orders of Dáil Éireann to examine and report to Dáil Éireann on the appropriation accounts and reports of the Comptroller and Auditor General

Food Safety Authority of Ireland

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17.
  - FSAI Board is 10
  - FSCC is 24
  - SCFSAI is 15

Board Membership, Appointment, Independence and Capability:

- FSAI
  - Board members are appointed by direct Ministerial appointment
    - The only criterion for Board membership states that one of the ordinary members of the Board must be the Chairperson of the SCFSAI
    - There are no competency based requirements for the remaining Board members laid out in the legislation
    - Public interest is not explicitly represented on the Board (e.g. stakeholders, members of the public, public representatives)
- FSCC
  - Board members are appointed by nomination and direct Ministerial appointment
    - 17 members are nominated by the relevant Ministers, e.g. Minister for Health and Children; Minister for Marine and Natural Resources
    - 7 Board members are appointed by the Board of the FSAI
    - There are no competency based requirements in the legislation for Consultative Council members
    - Public interest is not explicitly represented on the Consultative Council (e.g. stakeholders, members of the public, public representatives)
- SCFSAI
  - Board members are appointed by direct Ministerial appointment after consultation with the FSAI Board
    - There are no competency based requirements in the legislation for Scientific Council members
    - Public interest is not explicitly represented on the Scientific Council (e.g. stakeholders, members of the public, public representatives)

Scope of role:

- FSAI
  - The CEO prepares the accounts and they are approved by the Board
  - The CEO is accountable in relation to the accounts of the Authority e.g. *whenever he or she is so required by a Committee of Dáil Éireann established under Standing Orders of Dáil Éireann to examine and report to Dáil Éireann on the appropriation accounts and reports of the Comptroller and Auditor General*
  - There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, risk management and people management
- FSCC
  - The role of the FSCC is clearly laid out in the legislation e.g. *'12(4) For the purpose of promoting higher standards, the Authority shall endeavour to consult representatives of consumers, producers, retailers, distributors, caterers and manufacturers and, where appropriate, official agencies about the activities or other measures to be undertaken. The Authority shall for the purposes of the consultations referred to in section 12(4) or for consultations on any other matter relating to the functions of the Authority, establish a body to be known as the Food Safety Consultative Council'*
- SCFSAI
  - The role of the SCFSAI is clearly laid out in the legislation e.g. *'There shall be established, as soon as may be after the establishment day, by the Board a committee ('the Scientific Committee') to assist and advise the Board in relation to matters of a scientific nature referred to it by the Board and to perform the functions assigned to it by this section'*

Food Safety Authority of Ireland/*Food Safety Consultative Council/Scientific Committee of the Food Safety Authority of Ireland* — continued

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The FSAI Board reviewing the performance of the CEO/management team/FSCC/SCFSAI
  - The Board reviewing its own performance.

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas laid out in the legislation with regard to:
  - Annual report
  - Accounts
- There are arrangements in the legislation for periodic reports to be published on issues relating to Food Safety *'The Authority may seek reports on any matter which in its opinion concerns the safety or hygiene of food from the appropriate Minister of the Government or body established under statute that has overall responsibility for the area to which the matter pertains'*

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Hospitals Trust Board PUBLIC HOSPITALS ACT, 1933 (National Hospital Trustees established, functions defined) PUBLIC HOSPITALS (AMENDMENT) ACT, 1938 (Hospitals Trust Board established, transfer of functions from National Hospital Trustees to Hospitals Trust Board)	5	Not specified	Appointed by Minister for Health and Children Each member shall hold office as such member for a period of five years from such commencement but shall be eligible for reappointment	Not specified	Minister for Health and Children	*Accounts:* The accounts of the Hospitals Commission shall in each year be audited and be the subject of a report to the Minister by a duly qualified auditor appointed annually for the purpose by the Minister, and an amount fixed by the Minister as the fee of such auditor shall be paid by the Hospitals Commission to the Minister as part of their expenses *(transferred to Hospital Trust Board in 1938 legislation)*

Hospitals Trust Board

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 5

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
  - There are no competency based requirements laid out in the legislation for Board membership
  - Public interest is not explicitly represented on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the officers and management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts audited on an annual basis and subject to a report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Irish Medicines Board • **Advisory Committee for Human Medicines** • **Advisory Committee for Veterinary Medicines** IRISH MEDICINES BOARD ACT, 1995	IMB 9 2 Advisory Committees 12 members each	1 member shall be the Chairperson Person of the Advisory Committee for Human Medicines 1 member shall be the Chairperson of the Advisory Committee for Veterinary Medicines 7 other members	**Irish Medicines Board** 9 Members Appointed by the Minister for Health and Children. Term of office not to exceed 5 years. A board member chairs the advisory committees. The Irish Medicines Board is supported by the following advisory committees also established under the same legislation: • **Advisory Committee for Human Medicines** to assist and advise the Board in relation to any matters pertaining to the safety, quality or efficacy of medicinal products for human use as are referred to it by the Board and to perform the functions assigned to it by *subsection (8)* • **Advisory Committee for Veterinary Medicines** to assist and advise the Board in relation to any matters pertaining to the safety, quality or efficacy of medicinal products for animal use as are referred to it by the Board and to perform the functions assigned to it by *subsection (8)* Appointed by the Minister for Health and Children Term of office is 5 years	Board meets 10 times a year Advisory Committees meet 6 times a year	Minister for Health and Children Houses of the Oireachtas C&AG	*Accounts:* The accounts of the Board for each year shall be prepared in such form and manner as may be specified by the Minister. The accounts shall be submitted as soon as may be but not later than 3 months after the end of the financial year to which they relate by the Board to the Comptroller and Auditor General for audit. A copy of the accounts and the auditor's report thereon shall be presented to the members of the Board and to the Minister as soon as may be and the Minister shall cause a copy of the documents aforesaid to be laid before each House of the Oireachtas *Report:* As soon as may be after the end of each financial year, but not later than 6 months thereafter, the Board shall make a report to the Minister of its activities during that year and the Minister shall cause copies of the report to be laid before each House of the Oireachtas *(IMB ACT 1995) Assessment by Board of performance of certain of its functions.* **20.**—The Board shall, in each year, carry out such examinations as it considers appropriate for the purpose of ascertaining— (*a*) whether and to what extent the resources of the Board— (i) have been used, and (ii) if acquired or disposed of by the Board, have been so acquired or disposed of, economically and efficiently, and (*b*) whether any such disposal has been effected upon the most favourable terms reasonably obtainable

Irish Medicines Board/Advisory Committee for Human Medicines/Advisory Committee for Veterinary Medicines

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17.
  - IMB size is 9
  - Advisory Committee for Human Medicine size 12
  - Advisory Committee for Veterinary Medicine size is 12

Board Membership, Appointment, Independence and Capability:

- IMB
  - Board members are appointed by direct Ministerial appointment
    - 1 Board member is the Chairperson of the Advisory Committee for Veterinary Medicines
    - 1 Board member is the Chairperson of the Advisory Committee for Human Medicines
    - There are no competency based requirements for the nomination or appointment to the Board
    - Public interest is not explicitly represented on the Board (e.g. stakeholders, members of the public, public representatives)
- Advisory Committee for Human Medicine
  - Advisory Committee members are appointed by direct Ministerial appointment
    - There are no competency based requirements for the nomination or appointment to the Advisory Committee
    - Public interest is not explicitly represented on the Advisory Committee (e.g. stakeholders, members of the public, public representatives)
- Advisory Committee for Veterinary Medicine
  - Advisory Committee members are appointed by direct Ministerial appointment, with the consent of the Minister for Agriculture
    - There are no competency based requirements for the nomination or appointment to the Advisory Committee
    - Public interest is not explicitly represented on the Advisory Committee (e.g. stakeholders, members of the public, public representatives)

Scope of role:

- IMB
  - There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, risk management and people management
- Advisory Committee for Human Medicine
  - The role is clearly laid out in the legislation
- Advisory Committee for Veterinary Medicine
  - The role is clearly laid out in the legislation

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/management team/Advisory Committees
- Section 20 of Establishment Order outlined above, provides for a self- appraisal by the Board of its use of resources. It is not clear from this whether it is the Board or the management team evaluating their performance
- Section 9(6) a. provides for the establishment of sub-committees under the Advisory Committees to advise them to range of functions including *'in relation to the performance of its functions.'*

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Medical Council MEDICAL PRACTITIONERS ACT, 1978 THE MEDICAL COUNCIL (ELECTION OF MEMBERS) REGULATIONS, 1978 (terms of office and manner of election) MEDICAL PRACTITIONERS (AMENDMENT) ACT, 1993 MEDCIAL PRACTITIONERS (AMENDMENT) ACT 2000 MEDICAL PRACTITIONERS (AMENDMENT) ACT 2002	25	(*a*) one person appointed by each of the following bodies— (i) University College Cork (ii) University College Dublin (iii) University College Galway (iv) the University of Dublin, and (v) the Royal College of Surgeons in Ireland (*b*) two other persons appointed by the Royal College of Surgeons in Ireland, of whom one shall be appointed to represent the surgical specialties, and the other shall be appointed to represent jointly the specialties of anaesthetics and radiology (*c*) two persons appointed by the Royal College of Physicians of Ireland, of whom one shall be appointed to represent the medical specialties, and the other shall be appointed to represent jointly the specialties of pathology, obstetrics and gynaecology (*d*) one person appointed by the Minister after consultation with such body or bodies as, in his opinion, represent psychiatry; (*e*) one person appointed by the Minister after consultation with such body or bodies as, in his opinion, represent general medical practice (*f*) ten fully registered medical practitioners engaged in the practice of medicine in the State of whom at least— (i) two shall be consultants in general hospitals not being consultant psychiatrists (ii) one shall be a consultant psychiatrist (iii) one shall be engaged in community medicine (iv) one shall be engaged in hospital practice, other than as a consultant, and (v) two shall be general practitioners appointed by election by fully registered medical practitioners; and (*g*) four persons appointed by the Minister, at least three of whom— (i) shall not be registered medical practitioners, and (ii) shall, in the opinion of the Minister, represent the interests of the general public	16 appointed by the Minister 9 appointed from the Universities/training colleges Term of office is 5 years. No person shall hold membership of the Board for more than 2 consecutive terms	At least 4 meetings a year	Minister for Health and Children Houses of the Oireachtas	*Accounts:* The accounts of the Council shall be audited at least once in every year by an auditor appointed for that purpose by the Minister and the fees of such auditor and the expenses generally of such audit shall be paid by the Council as soon as may be after each such audit. As soon as may be after each audit under this section, a copy of the accounts of the Council and the auditor's certificate and report thereon shall be given to the Minister As soon as may be after each audit under this section, the Council shall cause such accounts and the auditor's certificate and report thereon to be printed, published and put on sale, and immediately after each such publication, a copy of such accounts and such certificate and report thereon as so printed and published shall be laid before each House of the Oireachtas Publish medical practitioners register at intervals of 5 years

Medical Council

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 25

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by nominations through elections and direct Ministerial appointment
  - 5 members are appointed by the universities, e.g. UCD, UCG
  - 4 members are appointed by the RCSI, RCPI
  - 16 members are appointed by the Minister for Health and Children
  - There are clear criteria laid out in the legislation for Ministerial appointments, e.g. *'one person appointed by the Minister after consultation with such body or bodies as, in his opinion, represent psychiatry'*
  - The criteria for Ministerial appointments ensures that *'public interest'* is represented on the Board, e.g. *at least three of whom (i) shall not be registered medical practitioners, and (ii) shall, in the opinion of the Minister, represent the interests of the general public*

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the officers and management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Mental Health Commission MENTAL HEALTH ACT, 2001	13	(2) Of the members of the Commission— (*a*) one shall be a person who has had not less than 10 years' experience as a practising barrister or solicitor in the State ending immediately before his or her appointment to the Commission (*b*) 3 shall be representative of registered medical practitioners (of which 2 shall be consultant psychiatrists) with a special interest in or expertise in relation to the provision of mental health services (*c*) 2 shall be representative of registered nurses whose names are entered in the division applicable to psychiatric nurses in the register of nurses maintained by An Board Altranais under section 27 of the Nurses Act, 1985 (*d*) one shall be representative of social workers with a special interest in or expertise in relation to the provision of mental health services (*e*) one shall be representative of psychologists with a special interest in or expertise in relation to the provision of mental health services (*f*) one shall be representative of the interest of the general public (*g*) 3 shall be representative of voluntary bodies promoting the interest of persons suffering from mental illness (at least 2 of whom shall be a person who is suffering from or has suffered from mental illness) (*h*) one shall be representative of the chief executives of the health boards (*i*) not less than 4 shall be women and not less than 4 shall be men (3) The members of the Commission appointed pursuant to *subsection (2)(b)* shall be persons nominated for appointment thereto by such organisation or organisations as the Minister considers to be representative of such medical practitioners	13 members of the Commission appointed by the Minister for Health and Children Minister will appoint one member as the Chairperson Term of office is 5 years	N/A	Minister for Health and Children Houses of the Oireachtas C&AG	*Annual Report:* .—(1) As soon as may be after the end of each year beginning with the year in which the establishment day falls, but not later than 6 months thereafter, the Commission shall prepare and submit a report in writing to the Minister of its activities during that year and not later than one month after such submission, the Minister shall cause copies thereof to be laid before each House of the Oireachtas (2) A report under *subsection (1)* shall include the report of the Inspector under *section 51* and other information in such form and regarding such matters as the Minister may direct (3) The Commission shall, whenever so requested by the Minister, furnish to the Minister information in relation to such matters as he or she may specify concerning or relating to the scope of its activities, or in respect of any account prepared by the Commission or any report specified in *subsection (1)* or in *section 55* *Accounts:* The accounts shall be submitted as soon as may be but not later than 3 months after the end of the financial year to which they relate by the Commission to the Comptroller and Auditor General for audit (*c*) A copy of the accounts and the auditor's report thereon shall be presented to the members of the Commission and to the Minister as soon as may be after the end of the financial year to which they relate and the Minister shall cause a copy of the documents aforesaid to be laid before each House of the Oireachtas

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
		(4) The members of the Commission appointed pursuant to *subsection (2)(c)* shall be persons nominated for appointment thereto by such organisation or organisations as the Minister considers to be representative of such nurses (5) The member of the Commission appointed pursuant to *subsection (2)(d)* shall be a person nominated for appointment thereto by such organisation or organisations as the Minister considers to be representative of such social workers (6) The member of the Commission appointed pursuant to *subsection (2)(e)* shall be a person nominated for appointment thereto by such organisation or organisations as the Minister considers to be representative of such psychologists (7) The members of the Commission appointed pursuant to *subsection (2)(g)* shall be persons nominated for appointment thereto by such organisation or organisations as the Minister considers to be representative of such voluntary bodies				(6) The chief executive shall be the accountable person in relation to the accounts of the Commission and shall, whenever he or she is so required by a Committee of Dáil Éireann established under Standing Orders of Dáil Éireann to examine and report to Dáil Éireann on the appropriation accounts and reports of the Comptroller and Auditor General *Funding* The Minister may, in each financial year, after consultation with the Commission in relation to its proposed work programme and expenditure for that year, make grants of such amount as may be sanctioned by the Minister for Finance out of moneys provided by the Oireachtas towards the expenditure incurred by the Commission in the performance of its functions

Mental Health Commission

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Commission size is 13

Board Membership, Appointment, Independence and Capability:

- Commission members are appointed by direct Ministerial appointment
    - There are guidelines outlining the competencies, nomination criteria and gender breakdown for Commission members
    - Public interest, voluntary groups who work in this area are represented on the Commission

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management
- The CEO is the accounting officer of the Commission
- The Commission appoint the Inspector of Mental Health Services and the tribunals

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
    - The Board reviewing the performance of the management team
    - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas
    - There is also a requirement for the Minister after 5 years to carry out a review of this Act and shall make a report to the Houses of the Oireachtas of the findings and conclusions
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Postgraduate Medical and Dental Board MEDICAL PRACTITIONERS ACT, 1978	25	The Board shall consist of twenty-five members, appointed by the Minister, of whom— • Each shall be a person having practical experience or special knowledge of the matters relating to the functions of the Board • Not less than twenty shall either be registered medical practitioners or registered dentists Before making appointments to the Board, the Minister shall consult with— The Medical Council, the Dental Board, the appropriate bodies and any organisation, which . . . represents, in the State, registered medical practitioners or registered dentists	Appointed by the Minister for Health and Children Term of office is 5 years	At least 4 meetings a year	Minister for Health and Children Houses of the Oireachtas	*Accounts:* The accounts of the Council shall be audited at least once in every year by an auditor appointed for that purpose by the Minister and the fees of such auditor and the expenses generally of such audit shall be paid by the Council as soon as may be after each such audit As soon as may be after each audit under this section, a copy of the accounts of the Council and the auditor's certificate and report thereon shall be given to the Minister As soon as may be after each audit under this section, the Council shall cause such accounts and the auditor's certificate and report thereon to be printed, published and put on sale, and immediately after each such publication, a copy of such accounts and such certificate and report thereon as so printed and published shall be laid before each House of the Oireachtas

Postgraduate Medical and Dental Board

Comments against best practice based on available evidence

Size:
- Best practice recommends a Board size between 9 and 17. The Board size is 25

Board Membership, Appointment, Independence and Capability:
- Board members are appointed by direct Ministerial appointment
  - Some criteria for Board membership is clearly laid out in the legislation e.g. Not less than twenty shall either be registered medical practitioners or registered dentists
  - There are clear requirements in the legislation for consultations with particular groups before Ministerial appointments are made e.g. *Minister shall consult with — The Medical Council*
  - Public interest is not explicitly represented on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:
- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:
- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the officers and management team
  - The Board reviewing its own performance

Reporting arrangements:
- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Office of Tobacco Control PUBLIC HEALTH (TOBACCO) ACT, 2002	12	1 Chairperson and 11 ordinary members	Members appointed by the Minister Term of office is 5 years	Holds as many meetings as may be necessary to fulfil its functions	Minister for Health and Children C&AG Houses of the Oireachtas	*Annual Report:* not later than 3 months after the end of the year produce an annual report *Funding:* Minister issues grants as he/she sees fit *Accounts:* Prepare financial statement subject to audit of the C&AG and laid before the Houses of the Oireachtas

Office of Tobacco Control
Comments against best practice based on available evidence

Size:
- Best practice recommends a Board size between 9 and 17. The Board size is 12.

Board Membership, Appointment, Independence and Capability:
- Board members are appointed by direct Ministerial appointment
  - There are no competency based requirements for the nomination or appointment to the Board, e.g. Legislation states: *'The Office shall consist of 12 members, that is to say, a Chairperson and 11 ordinary members'*
  - Public interest is not explicitly represented on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:
- The legislation outlines the role of the CEO as to *'manage and control generally the administration of the office and perform such other functions (if any) as may be determined by the Office'*
- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:
- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:
- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- Maintain a register of retailers of tobacco products
- The legislation provides for regular reports to the stakeholders of the Board, e.g. *'Publish information and results of testing on tobacco products'*

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Comhairle na Nimheanna (Poisons Council) POISONS ACT, 1961 COMHAIRLE NA NIMHEANNA ORDER, 1962	17	• 3 registered medical practitioners • 5 registered pharmaceutical chemists • 1 registered dentist • 2 persons nominated by the Minister for Agriculture each of whom is a registered Veterinary surgeon • 1 person with special knowledge and experience of the use of poisonous substances in agriculture nominated by the Minister for Agriculture • 2 persons nominated by the Minister for Agriculture each of whom is a person whose main occupation is farming, and • 3 other persons (whether or not having any qualification referred to in the foregoing paragraphs)	Appointed by the Minister for Health and Children Term of office is 3 years	Holds as many meetings as may be necessary.	Minister for Health and Children Houses of the Oireachtas	Every regulation that is made needs to be laid before the Houses of the Oireachtas

Comhairle na Nimheanna (Poisons Council)

Comments against best practice based on available evidence

Size:
- Best practice recommends a Board size between 9 and 17. The Board size is 17

Board Membership, Appointment, Independence and Capability:
- Board members are appointed by direct Ministerial appointment
  - There are competency requirements for 10 members of the Board, e.g. *'1 registered dentist'*
  - Public interest is not explicitly represented on the Board however, the Minister select' *3 other persons'* on a random basis
  - 5 members are nominated by the Minister for Agriculture

Scope of role:
- There are no Officers assigned to this Board in the legislation

Monitoring Processes:
- The legislation does not provide for a 'monitoring process' with regard to The Board reviewing its own performance

Reporting arrangements:
- Rules made at the Board meetings need to be laid before the Houses of the Oireachtas
- There are no formal financial or other accountability arrangements outlined in the legislation
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
The Pharmaceutical Society of Ireland THE PHARMACY ACT (IRELAND), 1875 THE PHARMACY ACT (IRELAND), 1875 (AMENDMENT) ACT, 1890 PHARMACY ACT, 1951 (repeals and amends) PHARMACY ACT, 1962 (repeals and amends) MISUSE OF DRUGS ACT, 1977 (enforcement)	21	All 21 are Pharmacists and members of the Governing Council	Registration with the Pharmaceutical Society of Ireland is required before you can practice in Ireland. To be eligible to register as a pharmacist, a candidate must have completed a recognised degree in pharmacy and have undergone a year's training in practice Members of the Pharmaceutical Society are registered Pharmacists and they elect the 21 members to the governing council Every year by rotation, 7 members go out of office but can be re-elected	Meets monthly except in August	Minister for Health and Children	Not specified

The Pharmaceutical Society of Ireland

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 21

Board Membership, Appointment, Independence and Capability:

- The Board is appointed through elections in the Pharmaceutical Society
  - The Board is competency based, each member is a registered Pharmacist
  - Every year by rotation, 7 members go out of office but can be re-elected
  - No explicit public representation on the Board (e.g. stakeholders, members of the public, public representatives). It is noted that in its submission to the Review Group on Pharmacy Regulation (May 2002) the Society advocated that public interest should be represented on its Governing Council

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- Not specified in the legislation

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Special Residential Services Board (established under the Child Care Act 2001) CHILDREN ACT, 2001	13	Chairperson 12 other members (*a*) three representatives of the children detention schools, nominated by the Minister for Education and Science (*b*) three representatives of the chief executive officers of health boards (*c*) three experts in child care, (*d*) three experts in the educational needs of detained children, nominated by the Minister for Education and Science, of whom one shall be a member of the school attendance service, and (*e*) a probation and welfare officer nominated by the principal probation and welfare officer	Appointed by the Minister for Health and Children Term of office is 4 years, a member can be reappointed	Not Specified	Minister for Health and Children C&AG Houses of the Oireachtas	*Accounts:* Accounts kept in pursuance of this section shall be submitted by the Board to the Comptroller and Auditor General not later than 3 months after the end of each accounting year A copy of the income and expenditure account and of the balance sheet and of such other (if any) of its accounts as the Ministers may direct, together with a copy of the report of the Comptroller and Auditor General on the accounts, shall be presented to the Ministers as soon as may be The Minister shall cause copies of each of the documents aforesaid to be laid before each House of the Oireachtas *Annual Report:* The Board shall submit to the Ministers an annual report which shall include information on the performance of its functions during the year to which it relates and such other information in such form as the Board considers appropriate or the Minister may direct A report under *subsection (1)* shall be submitted to the Ministers not later than 6 months after the end of the year to which it relates The Minister shall cause copies of each report under *subsection (1)* to be laid before each House of the Oireachtas

Special Residential Services Board

Comments against best practice based on available evidence

Size:

- Best practice recommends the size of the Board between 9 and 17. The Board size is 13

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
  - 6 members are nominated by the Minister for Education and Science
  - 3 members are nominated by the chief executive officers of the health boards
  - There are basic competency requirements for some of the Board members, e.g. *'3 experts in child care'*
  - No explicit public representation on the Board (e.g. members of the public)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual Report
- The legislation does not prescribe any other reporting arrangements to stakeholders beyond the above

Agencies established under the Health (Corporate Bodies) Act 1961

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
An Bord Cioch Scrudaithe Naisiunta (National Breast Screening Board) NATIONAL BREAST SCREENING BOARD, (ESTABLISHMENT) ORDER, 1998 NATIONAL BREAST SCREENING BOARD (ESTABLISHMENT) ORDER, 1998 (AMENDMENT) ORDER, 1999 (Composition of the Board) NATIONAL BREAST SCREENING BOARD (ESTABLISHMENT) ORDER 1998 (AMENDMENT) (NO. 2) ORDER 2000	12 indicated in the legislation	CEOs of the health boards 4 people, at least two drawn from the disciplines involved in the early diagnosis and primary treatment of breast cancer in women	Members of the Board will be appointed by the Minister A member of the Board who is not a CEO of a health board, will have their term of office determined on appointment A CEO of an health board will remain on the Board until they cease to be a CEO	Board shall hold as many meetings as may be necessary to fulfil their functions	Minister for Health and Children C&AG	*Accounts:* The accounts of the Board for each year shall be prepared in such form and manner as may be specified by the Minister. The accounts shall be submitted as soon as may be but not later than three months after the end of the financial year to which they relate by the Board to the Comptroller and Auditor General for audit. A copy of the accounts and the auditor's report thereon shall be presented to the members of the Board and to the Minister as soon as may be and the Minister shall cause a copy of the documents aforesaid to be laid before each house of the Oireachtas The expenses generally of such audit shall be paid by the Board as may be after such audit Submission and presentation of the annual financial statements and auditor's report(s) thereon shall be carried out in accordance with *section 11* of the *Comptroller and Auditor General (Amendment) Act, 1993* *Annual Report:* The Board shall, in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the preceding year

An Bord Cioch Scrudaithe Naisiunta (National Breast Screening Board)

Comments against best practice based on available evidence

Size:

- Best practice recommends the size of the Board between 9 and 17. The size of the Board is 12

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
    - The CEOs of the health boards are all members of the Board
    - The competency requirements for 2 of the remaining members are laid out in the legislation e.g. *'at least two drawn from the disciplines involved in the early diagnosis and primary treatment of breast cancer in women'*
    - No explicit public representation on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
    - The Board reviewing the performance of the CEO/ management team
    - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas laid out in the legislation with regard to:
    - Accounts
    - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Crisis Pregnancy Agency CRISIS PREGNANCY AGENCY (ESTABLISHMENT) ORDER, 2001	9	Not specified Chairperson appointed by Minister from 9 members	Appointed by the Minister for Health and Children Term of office is 5 years	May hold as many meetings as may be necessary	Minister for Health and Children Houses of the Oireachtas C&AG	*Service plan:* Within 20 working days of having been notified by letter of its grant or grants for a financial year, the Agency shall submit to the Minister a service plan for the year in such terms as the Minister may determine *Accounts:* A statement of accounts of the Agency for each financial year shall be prepared and after such preparation be subject to audit by the Comptroller and Auditor General under section (5) of the Comptroller and Auditor General (Amendment) Act, 1993 *Annual Report:* The Agency shall in each year subsequent to its establishment, not later than 30th June, make a report to the Minister of its activities during the preceding year and the Minister shall cause copies of the Report to be laid before each House of the Oireachtas

Crisis Pregnancy Agency

Comments against best practice based on available evidence

Size:

- Best practice recommends the size of the Board between 9 and 17. The size of the Board is 9

Board Membership, Appointment, Independence and Capability:

- The Board is appointed by direct Ministerial appointment
  - There are no competency based requirements for the nomination or appointment to the Board, e.g. *'The Agency shall consist of 9 members appointed by the Minister'*
  - No explicit public representation on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation provides for the Agency to publish information as required, e.g. *'The Agency may, in relation to the performance of its functions, publish documents and organise conferences'*

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Drug Treatment Centre Board THE DRUG TREATMENT CENTRE BOARD (ESTABLISHMENT) ORDER, 1988 THE DRUG TREATMENT CENTRE BOARD (ESTABLISHMENT) ORDER 1988 (AMENDMENT) ORDER, 1992 (articles referring to functions amended)	10	(*a*) three shall be nominated by the Charitable Infirmary Charitable Trust (*b*) one shall be nominated by the regional Health Boards, other than the Eastern Health Board (*c*) one shall be nominated by the Eastern Health Board, (*d*) three shall be nominated by the Minister for Health (*e*) one shall be nominated by the Irish College of General Practitioners, and (*f*) one shall be nominated to represent the statutory training and occupational rehabilitation services	Appointed by the Minister for Health and Children Term of office is 5 years	The Board will hold as many meetings as may be necessary for the performance of its function	Eastern Regional Health Authority	*Accounts:* A statement of accounts of the Board for each financial year shall, as soon as may be after the end of such financial year be prepared and after such preparation be audited by and be subject to a report by an auditor appointed for the purpose by the Minister after consultation with the Board The expenses generally of such audit shall be paid by the Board as soon as may be after such audit A copy of the accounts and the auditor's certificate and report thereon shall be presented to the members of the Board and to the Minister *Annual report:* The Board shall in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the preceding year *Provider Plan agreement with the ERHA* *Legal and financial* — recognises that the ERHA has a legal accountability to the Minister for Health & Children and the Dáil on both financial and service issues *Service delivery accountability* — take responsibility for the achievement of agreed objectives as set out in the provider plan *Client related accountability* — has already initiated a consumer aspect to their service delivery and plans to continue this practice *Public accountability* — committed to ensuring systems are in place to provide responses to PQs and public representations

Drug Treatment Centre Board

Comments against best practice based on available evidence

Size:

- Best practice recommends the size of the Board between 9 and 17. The size of the Board is 10

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
    - The legislation clearly outlines the nomination criteria for Board members, e.g. *'one shall be nominated by the Irish College of General Practitioners'*
    - There are no competency based requirements for the nomination or appointment to the Board
    - No explicit public representation on the Board (e.g. members of the public)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a ' monitoring process' with regard to:
    - The Board reviewing the performance of the CEO/ management team
    - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
    - Accounts
    - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Health Research Board THE HEALTH RESEARCH BOARD (ESTABLISHMENT) ORDER, 1986. THE HEALTH RESEARCH BOARD (ESTABLISHMENT) (AMENDMENT) (NO.1) ORDER, 2002	16	8 members conjointly nominated by conference of Heads of Irish Universities, RCSI, RCPI — These 8 members shall be persons actively involved in medical epidemiological health or health services research — balanced representation of disciplines involved and of third level institutions in Ireland • 1 member actively involved in medical, epidemiological, health or health services research in Northern Ireland • 1 member nominated by the Minister for Enterprise, Trade & Employment • 1 member nominated by CEOs of the Health Boards • 1 member with specialist knowledge and experience of the voluntary research charity area • 1 member with specialist knowledge and experience of the conduct of research involving medicinal products and or medical devices • 3 remaining members at least 1 shall be an official of the DoHC	Appointed by the Minister for Health and Children Term of office is 5 years/a member cannot have more than 2 consecutive terms	Board will hold as many meetings as may be necessary for the performance of their function	Minister for Health and Children	*Accounts:* A statement of accounts of the Board for each financial year shall, as soon as may be after the end of such financial year be prepared and after such preparation be audited by and be subject to a report by an auditor appointed for the purpose by the Minister after consultation with the Board The expenses generally of such audit shall be paid by the Board as soon as may be after each audit A copy of the accounts and the auditor's certificate and report thereon shall be presented to the members of the Board and to the Minister *Annual report:* The Board shall in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the preceding year

Health Research Board

Comments against best practice based on available evidence

Size:

- Best practice recommends the Board size is between 9 and 17. The Board size is 16

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and then by Ministerial appointment
  - The legislation outlines the competency requirements for nomination to the Board, e.g. *8 members conjointly nominated by conference of Heads of Irish Universities, RCSI, RCPI*
  - No explicit public representation on the Board (e.g. members of the public)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts
  - Annual report

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Health Services Employers Agency (HSEA) THE HEALTH SERVICE EMPLOYERS AGENCY (ESTABLISHMENT) ORDER, 1996.	9	(i) two members shall be appointed on the nomination of the chief executive officers of the Health Boards (ii) two members shall be appointed on the nomination of the Voluntary Hospitals which are members of the Agency (iii) two members shall be appointed who shall be officers of the Department of Health	Board appointed by the Minister for Health and Children The term of office of a member of the Board shall be such period not exceeding three years as may be specified by the Minister when appointing him or her and he or she shall hold office for the period for which he or she is appointed unless he or she dies or resigns by letter addressed to the Minister or ceases to be a member in accordance with article 8 of this Order	Board may hold as many meetings as may be necessary for the performance of its function	Minister for Health and Children C&AG	*Accounts:* The annual financial statements of the Agency for each year shall be prepared in accordance with any accounting standards which may be laid down by the Minister The annual financial statements shall be prepared within three months of the end of the previous year for submission to the Comptroller and Auditor General and the audit of these annual financial statements shall be carried out by the Comptroller and Auditor General in accordance with section 5 of the Comptroller and Auditor General (Amendment) Act, 1993 The expenses generally of such audit shall be paid by the Agency as soon as may be after each audit *Annual report:* The Agency shall in each year, not later than such date as the Minister may direct, make a general report of its activities during the preceding year and shall submit a copy of the report to the Minister

Health Services Employers Agency (HSEA)

Comments against best practice based on available evidence

Size:

- Best practice recommends the Board size between 9 and 17. The Board size is 9

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and then Ministerial appointment
    - The legislation clearly lays out the nomination criteria for members of the Board, e.g. *2 members shall be appointed on nomination of the CEOS of the health boards*
    - There are no competency based requirements for the nomination or appointment to the Board
    - No explicit public representation on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
    - The Board reviewing the performance of the CEO/ management team
    - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
    - Accounts
    - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Irish Health Services Accreditation Board IRISH HEALTH SERVICES ACCREDITATION BOARD (ESTABLISHMENT) ORDER, 2002	11	Eleven (11) members drawn from nominations (*a*) one shall be a nominee of the Royal College of Surgeons in Ireland (*b*) one shall be a nominee of the Royal College of Physicians of Ireland (*c*) one shall be a nominee of the Irish College of General Practitioners (*d*) one shall be a nominee of an Bord Altranais (*e*) one shall be a nominee of the National Standards Authority of Ireland (*f*) one shall be a nominee of the Office for Health Management (*g*) one shall be a person with internationally recognised expertise in the field of quality in health care (*h*) one shall be a person with expertise in any of the areas of finance, strategy, business development or marketing (*i*) two shall be members of the general public, who shall not be employed in the health service (4) Not less than four members shall be female and not less than four members shall be male	Members appointed by the Minister Term of office is 3 years	Not less than 6 meetings annually	Minister for Health and Children C&AG	*Accounts:* The annual financial statements of the Board for each year shall be prepared in accordance with any accounting standards which may be laid down by the Minister. The annual financial statements shall be prepared within three months of the end of the previous year for submission to the Comptroller and Auditor General and the audit of these annual financial statements shall be carried out by the Comptroller and Auditor General in accordance with section 5 of the Comptroller and Auditor General (Amendment) Act, 1993 Submission and presentation of the annual financial statements and auditor's report(s) thereon, shall be carried out in accordance with section 11 of the Comptroller and Auditor General (Amendment) Act, 1993 *Annual report:* The Board shall, in each year, not later than the 30th day of April, make a report to the Minister of its activities during the preceding calendar year, and for the purposes of this provision the first annual report shall be submitted no later than the 30th of April 2003

Irish Health Services Accreditation Board

Comments against best practice based on available evidence

Size:

- Best practice recommends the Board size between 9 and 17. The Board size is 11

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and then Ministerial appointment
  - The Board is competency based with nominations across the various disciplines and areas of expertise, e.g. *'one shall be a nominee of an Bord Altranais; one shall be a person with expertise in any of the areas of finance, strategy, business development or marketing'*
  - The criteria for Ministerial appointments ensures that *'public interest'* is represented on the Board, e.g. *'two shall be members of the general public, who shall not be employed in the health service'*

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a ' monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts
  - Annual report

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Irish Blood Transfusion Service Board THE BLOOD TRANSFUSION SERVICE BOARD (ESTABLISHMENT) ORDER, 1965 THE BLOOD TRANSFUSION SERVICE BOARD (ESTABLISHMENT) (AMENDMENT) ORDER, 1988 (allows for the establishment of an eye bank to facilitate corneal transplantation) BLOOD TRANSFUSION SERVICE BOARD (ESTABLISHMENT) ORDER 1965 (AMENDMENT) ORDER, 1994 (provides for the remuneration of the chairperson)	12		Appointed by the Minister for Health and Children Term of office is 3 years	Board may meet as necessary	Minister for Health and Children C&AG Houses of the Oireachtas	*Accounts:* A statement of accounts of the Board for each financial year shall, as soon as may be after the end of such financial year, be prepared and after such preparation be audited by and be subject to a report by an auditor appointed for the purpose by the Minister after consultation with the Board The expenses generally of such audit shall be paid by the Board as soon as may be after each audit A copy of the accounts and the auditor's certificate and report thereon shall be presented to the members of the Board and to the Minister *Annual Report:* The Board shall, in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the preceding year It is noted that in its Reorganisation Plan (May 1996), the governance function of the Board was stated as being *'concerned primarily with strategic issues, evaluation of proposals submitted by executive management and monitoring of the implementation of Board decisions and policies and the determination of future strategy directions by the Board'*

Irish Blood Transfusion Service Board

Comments against best practice based on available evidence

Size:

- Best practice recommends the Board size between 9 and 17. The Board size is 12

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
  - There are no competency based requirements for the nomination or appointment to the Board, e.g. *'The Board shall consist of twelve members appointed by the Minister'*
  - No explicit public representation on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a ' monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts
  - Annual report
- It is noted that a number of reviews of the organisation, management and objectives of the Board have taken place in the recent past. The reorganisation plan approved in April 1996, drew heavily on these previous reviews including the Bain report and the Tribunal of Inquiry Report (Finlay). The critical problems identified included:
  - Ineffective organisational and management structures
  - Significant communication problems at all levels
  - Fragmentation of responsibility and split reporting lines
  - Absence of a definitive and single line of authority
  - Ineffective working relationships between the Dublin and Cork transfusion centres
  - Duplication of certain processes in Dublin and Cork
  - Lack of staff input in decision-making
  - Undue compartmentalisation of management, medical and scientific function
  - Weakness in responding to the need for change
- According to the material supplied by the IBTS, substantial progress has been made in implementing the Reorganisation Plan. The committee/team structure and management arrangements are now being put in place. The Lindsay Tribunal report (2002) made 8 recommendations dealing largely with operational issues. The Tribunal found that *'great changes had taken place in personnel, facilities and procedures since the occurrence of the events which were investigated by the Tribunal'.*

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
National Cancer Registry Board THE NATIONAL CANCER REGISTRY BOARD (ESTABLISHMENT) ORDER, 1991 THE NATIONAL CANCER REGISTRY BOARD (ESTABLISHMENT) ORDER, 1991 (AMENDMENT) ORDER, 1996 (appointment of staff, remuneration)	9	• One member shall be appointed on the nomination of the Irish Cancer Society • One member shall be appointed on the nomination of the President of University College, Cork • One member shall be appointed on the nomination of the Royal College of Surgeons in Ireland • One member shall be appointed on the nomination of the Royal College of Physicians of Ireland • One member shall be appointed on the nomination of the Faculty of Pathology at the Royal College of Physicians of Ireland • One member shall be appointed on the nomination of the Irish College of General Practitioners	Appointed by the Minister for Health and Children Term of office is 5 years	Board may hold as many meetings as may be necessary	Minister for Health and Children	*Accounts:* A statement of accounts of the Board for each financial year shall be prepared and after such preparation be audited by and be subject to a report by an auditor appointed for the purpose by the Minister with the consent of the Minister for Finance after consultation with the Board The expenses generally of such audit shall be paid by the Board as soon as may be after such audit A copy of the accounts and the auditor's certificate and report thereon shall be presented to the members of the Board and to the Minister within six months of the ending of the financial year to which they refer *Annual Report:* The Board shall in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the proceeding year

National Cancer Registry Board

Comments against best practice based on available evidence

Size:
- Best practice recommends that the size of the Board is between 9 and 17. The size of the Board is 9

Board Membership, Appointment, Independence and Capability:
- Board members are appointed through nomination and then Ministerial appointment
  - The legislation clearly lays out the nomination and competency requirements for members of the Board, e.g. *'One member shall be appointed on the nomination of the Royal College of Physicians of Ireland'*
  - No explicit public representation on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:
- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:
- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:
- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
National Council for the Professional Development of Nursing and Midwifery THE NATIONAL COUNCIL FOR THE PROFESSIONAL DEVELOPMENT OF NURSING AND MIDWIFERY (ESTABLISHMENT) ORDER, 1999	20	(*a*) seven shall be registered nurses, one from each of the following areas: general nursing, mental handicap nursing, psychiatric nursing, public health nursing, sick children's nursing, care of the elderly, and a nurse tutor, each of whom must be of high professional standing with experience of advanced practice (*b*) one shall be a registered midwife of high professional standing with experience of advanced practice (*c*) two shall be members of An Bord Altranais nominated by An Bord Altranais (*d*) one person shall be appointed following consultation with the Office for Health Management (*e*) one shall be a senior nurse manager appointed following consultation with the appropriate professional bodies (*f*) two persons shall be appointed following consultation with the Health Service Employers Agency (*g*) two shall be officers of the Department of Health and Children, one of whom shall be the Chief Nursing Officer at the Department (*h*) one shall be a medical practitioner appointed following consultation with the Royal College of Surgeons in Ireland, the Royal College of Physicians of Ireland, the Irish College of General Practitioners and the Royal College of Psychiatrists in Ireland (*i*) three shall be nurses or midwives appointed following consultation with third-level institutes, one of whom shall be the Head of a Department of Nursing in a NUI University, one shall be the Head of a Department of Nursing in a non- NUI University, and one shall be the Head of a Department of Nursing in an Institute of Technology or a Regional Technical College	Appointed by the Minister for Health and Children Term of office is 5 years, maximum 2 terms	Council may hold as many meetings as may be necessary	Minister for Health and Children C&AG	*Accounts:* A statement of accounts of the Council for each financial year shall be prepared and after such preparation be subject to audit by the Comptroller and Auditor General under Section *(5)* (First Schedule) of the Comptroller and Auditor General (Amendment) Act 1993 *Annual Report:* The Council shall not later than 30th June in each year, make a report to the Minister of its activities during the preceding year

National Council for the Professional Development of Nursing and Midwifery

Comments against best practice based on available evidence

Size:

- Best practice recommends the size of the Board is between 9 and 17. The Board size is 20

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and then Ministerial appointment
    - The Board is competency based across the various branches of nursing, midwifery and areas of expertise, e.g. *'seven shall be registered nurses, one from each of the following areas: general nursing, mental handicap nursing, psychiatric nursing, public health nursing, sick children's nursing, care of the elderly, and a nurse tutor, each of whom must be of high professional standing with experience of advanced practice'*
    - No explicit public representation on the Board (e.g. stakeholders, members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
    - The Board reviewing the performance of the CEO/management team
    - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
    - Accounts
    - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
National Council on Ageing and Older People THE NATIONAL COUNCIL ON AGEING AND OLDER PEOPLE (ESTABLISHMENT) ORDER, 1997	30	30 members at least 4 over 65	Appointed by the Minister for Health and Children Term of office is 4 years	Council will hold as many meetings as may be necessary	Minister for Health and Children C&AG	*Accounts:* A statement of accounts of the Council for each financial year shall be prepared and after such preparation be subject to audit by the Comptroller and Auditor General under Section (5) (First Schedule) of the Comptroller and Auditor General (Amendment) Act 1993 *Annual Report:* The Council shall in each year, not later than 30th June, of each year make a report to the Minister of its activities during the preceding year

National Council on Ageing and Older People

Comments against best practice based on available evidence

Size:

- Best practice recommends the size of the Board is between 9 and 17. The Board size is 30

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
  - The only requirement in the legislation is for four Board members to be over 65
  - There are no competency based requirements for the nomination or appointment to the Board, e.g. *'The Council shall consist of not more than thirty members appointed by the Minister. A minimum of four of the members shall be aged 65 years or over'*
  - No explicit public representation on the Board (e.g. members of the public, public representatives)
- However, the Council has a representational remit, which is reflected in both its size and composition

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
National Social Work Qualifications Board THE NATIONAL SOCIAL WORK QUALIFICATIONS BOARD (ESTABLISHMENT) ORDER, 1997	17	(*a*) two representative of social workers (*b*) two appointed on the nomination of a trade union, representative of the majority of social workers (*c*) one representative of practice teachers (*d*) three appointed from Colleges providing a recognised course leading to the NQSW that is to say University College Dublin, University College Cork and Trinity College Dublin; such members to be appointed on the nomination of the Head of the College and be employed in the College Department providing the recognised course (*e*) one representative of the management of health boards (*f*) one representative of the management of hospitals, other than hospitals administered by health boards, which employs social workers (*g*) one representative of the Probation and Welfare Service of the Department of Justice, nominated by the Minister for Justice (*h*) one appointed on the nomination of the Minister for the Environment, (*i*) one representative of the interest of the general public, and (*j*) three shall be persons with a special interest or expertise in social services	Appointed by the Minister for Health and Children Term of office is 4 years No person will serve for more than 2 consecutive terms	At least 4 meetings a year (as many as may be necessary after that)	Minister for Health and Children C&AG	*Accounts:* A statement of accounts of the Board for each financial year shall be prepared and after such preparation be subject to audit by the Comptroller and Auditor General under Section (5) (First Schedule) of the Comptroller and Auditor General (Amendment) Act, 1993 *Annual Report:* The Board shall in each year, not later than 30th April of each year, make a report to the Minister of its activities during the preceding year

National Social Work Qualifications Board

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 17

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by nomination and then Ministerial appointment
  - 3 members are appointed from the Universities
  - 2 members are appointed from the Trade Unions representing social workers
  - The remaining members are appointed by the Minister for Health and Children
  - There are clear criteria laid out in the legislation for the Ministerial appointments, e.g. *'one representative of the Probation and Welfare Service of the Department of Justice, nominated by the Minister for Justice'*
  - The criteria for Ministerial appointments ensures that public interest is represented on the Board, e.g. *'one representative of the interest of the general public'*

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Pre-hospital Emergency Care Council PRE-HOSPITAL EMERGENCY CARE COUNCIL (ESTABLISHEMENT) ORDER, 2000	17	• 1 nomination of a body recognised as being representative of emergency medical technicians • 3 nominated trade union • 2 nominated from the heads of the recognised institutions • 3 representative of the management of health boards • 3 registered medical practitioners • 1 registered nurse • 1 representative of the views of the public • 3 people with a special interest in pre-hospital emergency care	Appointed by the Minister for Health and Children Term of office is 4 years No person will serve for more than 2 consecutive terms	6 meetings a year (and as many others as may be necessary)	Minster for Health and Children C&AG	*Accounts:* A statement of accounts of the Council for each financial year shall be prepared and after such preparation be subject to audit by the Comptroller and Auditor General under section 5 of the Comptroller and Auditor General (Amendment) Act 1993 (No. 8 of 1993) *Annual Report:* The Council shall, not later than 30th day of April in each year, make a report to the Minister of its activities during the preceding year

Pre-hospital Emergency Care Council

Comments against best practice based on available evidence

Size:
- Best practice recommends a Board size between 9 and 17. The Board size is 17

Board Membership, Appointment, Independence and Capability:
- Board members are appointed through nomination and then Ministerial appointment
  - The Board is competency based, e.g. *'1 registered nurse, 3 people with a special interest in pre-hospital emergency care'*
  - The criteria for Ministerial appointments ensures that public interest is represented on the Board, e.g. *'one representative of the views of the public'*

Scope of role:
- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:
- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:
- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts
  - Annual report
- The legislation does not prescribe any other reporting arrangements to stakeholders

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Women's Health Council THE WOMEN'S HEALTH COUNCIL (ESTABLISHMENT) ORDER, 1997	23	Drawn from statutory and voluntary sectors and will reflect the widest range of interests pertaining to women's health	Appointed by the Minister for Health and Children Term of office is 3 years	Council may hold as many meetings as may be necessary	Minister for Health and Children C&AG	*Accounts: A statement of accounts of the Council for each financial year shall be prepared and after such preparation be subject to audit by the Comptroller and Auditor General under Section (5) (First Schedule) of the Comptroller and Auditor General (Amendment) Act 1993* *Annual Report:* The Council shall in each year, not later than 30th June of each year, make a report to the Minister of its activities during the preceding year

Women's Health Council

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 23

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
  - This is a representative Board e.g. members are drawn from the statutory and voluntary sectors
  - There are no competency based requirements for the nomination or appointment to the Board, e.g. *'Membership will be drawn from both the statutory and voluntary sectors and will reflect the widest possible range of interests pertaining to women's health'*
  - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the Director/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
  - Accounts
  - Annual report

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Beaumont Hospital Board BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1977 BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER 1977, (AMENDMENT) ORDER 1988 (Functions) BEAUMONT HOSPITAL BOARD (ESTABLISHMENT) ORDER 1977, (AMENDMENT)(NO.2) ORDER, 1988 (Number of board members 12-15)	15	Two on the nomination of the Eastern Health Board Three on the nomination of the Board of Governors of St. Laurence's Hospital, Dublin Three on the nomination of the Committee of Management of the Charitable Infirmary, Jervis Street, Dublin One on the nomination of the Royal College of Surgeons in Ireland	Appointed by the Minister for Health and Children Term of office is 3 years	Board will hold as many meetings as may be necessary	ERHA C&AG	*Accounts:* A statement of accounts of the Board for each financial year shall, as soon as may be after the end of such financial year, be prepared and after such preparation be audited by and be subject to a report by an auditor appointed for the purposes by the Minister after consultation with the Board The expenses generally of such audit shall be paid by the Board as soon as may be after each audit A copy of the accounts and the auditor's certificate and report thereon shall be presented to the members of the Board and to the Minister *Annual Report:* The Board shall, in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the preceding year *Provider Plan agreement with the ERHA* *Legal & Financial accountability* — The principle of accountability will be focused on the Hospital's sub-committee dealing with corporate governance. The Hospital recognises its legal and financial accountability in the context of its current Establishment Order *Service delivery accountability* — The Hospital notes that the ERHA requires it to take explicit responsibility for achieving the objectives set out in this provider plan in an environment that is needs driven and demands led by the A&E service *Patient related accountability* — The Hospital has a comprehensive system in place for dealing with comments and patient complaints, and maintains an ongoing database for review and follow-up *Public accountability* — In addition, the Hospital will continue to assist the ERHA in responding in a timely fashion to all PQs and public representations

Beaumont Hospital Board

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 15

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nominations and then by Ministerial appointment
  - Apart from the one representative from the Royal College of Surgeons there are no competency based requirements for the nomination or appointment to the Board, e.g. *'Three on the nomination of the Board of Governors of St. Laurence's Hospital, Dublin'*
  - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- Apparent ambiguity in reporting relationship to ERHA (under section 10 Health (Eastern Regional Health Authority) Act, 1999 — arrangements by the Authority for provision of services) given provisions in Establishment Order relating to direct report to Minister

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Dublin Dental Hospital Board DUBLIN DENTAL HOSPITAL (ESTABLISHMENT) ORDER, 1963 DUBLIN DENTAL HOSPITAL(ESTABLISHMENT) ORDER,1963,(AMENDMENT ORDER,1985 (additions to the selection board)	11	10 ordinary members, 1 chairperson Four of the members shall be appointed by the Minister as follows: Two on the nomination of University College, Dublin, One on the nomination of Trinity College, Dublin, and One on the nomination of the Royal College of Surgeons in Ireland	Appointed by the Minister for Health and Children for a determined term of office	Board will hold as many meetings as may be necessary	Minister for Health and Children Minister for Education and Science	*Accounts:* a financial statement be prepared and audited by an auditor appointed for the purpose by the Minister — a copy of the accounts and the auditor's certificate shall be presented to the members of the Board, to the Minister and to the Minister for Education and Science *Annual Report:* Minister shall direct a timescale for a report to be developed, this report will be presented to the Minister and the Minister for Education and Science

Dublin Dental Hospital Board

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 11

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and direct Ministerial appointment
  - 4 members of the Board have a competency requirement, e.g. *'Two on the nomination of University College, Dublin, one on the nomination of Trinity College, Dublin, and one on the nomination of the Royal College of Surgeons in Ireland*
  - There are no competency based requirements for the remaining Board members
  - No explicit public representation on the Board (e.g. members of the public, public representatives)
  - Board reports to the Minister for Education and Science and the Minister for Health and Children

Scope of role:

- The legislation does not clearly distinguish between the role of the Board and the role of its Officers, with the exception of appointments to senior teaching positions, where the Board shall make the recommendation of a selection board, consisting of the Chairman of the Board, if willing to act, and if not a person nominated by the Minister, and two persons nominated by the Board, two person nominated by TCD and two person nominated by the Minister for Education and Science (dentists)

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and the Minister for Education and Science laid out in the legislation with regard to:
  - Accounts
  - Annual report.
- Apparent ambiguity in reporting relationship to ERHA (under section 10 Health (Eastern Regional Health Authority) Act, 1999 — arrangements by the Authority for provision of services) given provisions in Establishment Order relating to direct report to Minister

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Leopardstown Park Hospital Board LEOPARDSTOWN PARK HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1979	9	9 members, two of whom shall be appointed on the nomination of the Secretary of State in the Department of Social Security U.K	Appointed by the Minister for Health and Children Term of office is 5 years	Hold as many meetings as necessary	Minister for Health and Children	*Accounts:* A statement of accounts of the Board for each financial year shall, as soon as may be after the end of each financial year, be prepared and after such preparation be audited by and be subject to a report by an auditor appointed for the purpose by the Minister after consultation with the Board The expenses of such audit shall be paid by the Board as soon as may be after each audit A copy of the accounts and the auditor's certificate and the report thereon shall be presented to the members of the Board and to the Minister *Annual Report:* The Board shall, in each year, not later than such date as the Minister shall direct, make a report to the Minister on its activities during the preceding year

Leopardstown Park Governance arrangements	• Leopardstown Park Hospital Board
	  • Appointed by the Minister for Health & Children under the terms of the Establishment Order, 1979
	  • 2 Board members are nominated by the Secretary of State in the Department of Social Security U.K
	  • Board operates under a licence agreed between the Leopardstown Park Hospital Trust, the Department of Social Security in the UK and the DoHC — under this licence specific obligations are placed on the Board
	  • Board appoints a chief executive and other staff to manage the day-to-day affairs of the hospital
	  • Board meet as often as necessary to oversee the management of the hospital and determine policy for the provision of services
	  • Chairman and chief executive meet regularly to discuss issues arising
	  • Board visits the hospital regularly to ensure good standards of care and maintenance
	  • Board maintains contact with various agencies through the management team, in the planning and delivery of services — this include ECAHB, consultations take place regularly with ECAHB officers to discuss matters relating to services provided within the catchment area
	• Leopardstown Park Hospital Trust
	  • Represents the British Government — has an obligation to ensure that proper development of the site maintains good quality services to ex-service personnel
	  • Trust does not play a role in the development of hospital services, services have been developed and enhanced since 1979 with the continued goodwill of the Trust
	  • The Board agreed with the Trust the development of new structural facilities on the site, which have enhanced services for war pensioners and older people in Dublin				

Leopardstown Park Hospital Board

Comments against best practice based on available evidence

Size:

- Best practice recommends the Board is between 9 and 17. The Board size is 9

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
    - 2 Board members are appointed upon nominations from the Secretary of State in the Department of Social Security U.K.
    - There are no competency based requirements for the Board members
    - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The Board operates under a license which places specific obligations on the Board, outlined above, for example:
    - Board appoints a chief executive and other staff to manage the day-to-day affairs of the hospital
    - Board meet as often as necessary to oversee the management of the hospital and determine policy for the provision of services
    - Chairman and chief executive meet regularly to discuss issues arising
    - Board visits the hospital regularly to ensure good standards of care and maintenance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children laid out in the legislation with regard to:
    - Annual report
    - Accounts
- Apparent ambiguity in reporting relationship to ERHA (under section 10 Health (Eastern Regional Health Authority) Act, 1999 — arrangements by the Authority for provision of services) given provisions in Establishment Order relating to direct report to Minister

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
St. James's Hospital Board ST JAMES'S HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1971 ST JAMES'S HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1971, (AMENDMENT) ORDER, 1998 (to reduce membership of the board from 18-15)	15	(2) two of the members shall be appointed by the Minister, one of whom shall be appointed by the Minister to be the Chairperson of the Board (3) four of the members, who shall be members of Dublin Corporation, shall be appointed by the Minister and the persons so appointed shall be representative of the local electoral areas, obtaining from time to time, which correspond with the geographic area served by the hospital (4) the remaining members of the Board shall be appointed by the Minister as follows:— (i) two members, one of whom shall be a Clinical Director, shall be appointed from amongst the consultant medical staff of the Hospital, on the nomination of the Medical Board of the Hospital (ii) two members, one of whom shall be a member of the nursing staff of the hospital, shall be appointed on the nomination of the group of trade unions representing the non-medical staff of the hospital (iii) two members shall be appointed on the nomination of the University of Dublin (iv) one member shall be appointed on the nomination of the Board of Directors of the St James's Hospital Foundation (v) two members shall be appointed on the nomination of the Chairman in consultation with the chief executive officer (5) In the case of members nominated under sub-articles (4)(iii) and (4)(iv) of this article the University of Dublin and the Board of Directors of the St James's Hospital Foundation shall consult with the Chairman and chief executive officer before making nominations to the Minister	*Term of office* 6. The term of office of a member of the Board shall, unless s/he sooner dies, resigns, or ceases to be a member under article 8 of this Order, terminate:— (1) in the case of a member appointed under sub-article (2) of article 5 of this Order, — at the end of six years or at the end of such period not exceeding six years as may be determined by the Minister when appointing him/her (2) in the case of a member appointed under sub-article (3) of article 5 who, on appointment was a member of Dublin Corporation — on the day of the first meeting of the said Corporation after the appointment of members following a local authority election of members to the said Corporation (3) in the case of members appointed under sub-articles (4)(i) and (4)(ii) of Article 5 — at the end of three years or at the end of such period not exceeding three years as may be determined by the body nominating such members (4) in the case of members appointed under sub-articles (4) (iii) and (4)(iv) of Article 5 — at the end of six years or at the end of such period not exceeding six years as may be determined by the body nominating such members (5)(*a*) in the case of one of the members first appointed under sub-article (4)(v) of article 5 — at the end of three years or at the end of such period not exceeding three years as may be determined by the person nominating such a member	Board will hold as many meetings as may be necessary	Eastern Regional Health Authority	*Accounts:* A statement of accounts of the Board for each financial year shall, as soon as may be after the end of such financial year, be prepared and after such preparation be audited by and be subject to a report by an auditor appointed for the purposes by the Minister after consultation with the Board The expenses generally of such audit shall be paid by the Board as soon as may be after each audit A copy of the accounts and the auditor's certificate and report thereon shall be presented to the members of the Board and to the Minister *Annual Report:* The Board shall, in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the preceding year *Provider Plan agreement with the ERHA* *Legal & Financial accountability* — The Hospital recognises that the ERHA has a legal accountability to the Minister for Health & Children and the Dáil in both financial and services issues and agrees to assist the ERHA in discharging this obligation. In addition, the Hospital, in conjunction with the other DATH's has commissioned a report from its Legal Advisors pertaining to prevailing Legal & Accountability Compliance requirements *Service delivery accountability* — The Hospital commits to meeting its service delivery targets subject to qualifications contained in this Agreement and provision of funding by the ERHA in the order specified by and agreed with the Hospital as required

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
			(*b*) In the case of the second member first appointed under sub-article (4)(v) of Article 5 — at the end of six years or at the end of such period not exceeding six years as may be determined by the person nominating such a member (*c*) in the case of all subsequent appointments under paragraph 4(a) of this Article — at the end of six years or at the end of such period not exceeding six years as may be determined by the person nominating such a member			*Patient related accountability* — The Hospital recognises its accountability to users of its services and provides therefore *Public accountability* — Both parties recognise that they each hold respective and complementary accountability to the Public and agree to co-operate and support each other in discharge of related obligations

St. James's Hospital Board

Comments against best practice based on available evidence

Size:
- Best practice recommends a Board size between 9 and 17. The Board size is 15

Board Membership, Appointment, Independence and Capability:
- Board members are appointed through nomination and direct Ministerial appointment
  - Board members have different rules regarding term of office depending on their nomination to the Board, e.g. *'in the case of a member appointed under sub-article (2) of article 5 of this Order, — at the end of six years or at the end of such period not exceeding six years as may be determined by the Minister when appointing him/her'*
  - The Board is competency based across the disciplines, e.g. *two members, one of whom shall be a Clinical Director, shall be appointed from amongst the consultant medical staff of the Hospital, on the nomination of the Medical Board of the Hospital; two members, one of whom shall be a member of the nursing staff of the hospital, shall be appointed on the nomination of the group of trade unions representing the non-medical staff of the hospital.*
  - The criteria for Ministerial appointments ensures that public interest is represented on the Board, e.g. *'four of the members, who shall be members of Dublin Corporation, shall be appointed by the Minister and the persons so appointed shall be representative of the local electoral areas, obtaining from time to time, which correspond with the geographic area served by the hospital'*

Scope of role:
- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:
- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:
- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- Apparent ambiguity in reporting relationship to ERHA (under section 10 Health (Eastern Regional Health Authority) Act, 1999 — arrangements by the Authority for provision of services) given provisions in Establishment Order relating to direct report to Minister

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
St Luke's and St Ann's Hospital Board SAINT LUKE'S AND SAINT ANNE'S HOSPITAL BOARD (ESTABLISHMENT) ORDER, 1988.	10	5 nominated by the Provincial Council and appointed by the Minister, and 5 appointed by the Minister	Nominated by the Minister for Health and Children Term of office is 4 years	Board will hold as many meetings as may be necessary	Eastern Regional Health Authority	*Accounts:* A statement of accounts of the Board for each financial year shall, as soon as may be after the end of such financial year, be prepared and after such preparation be audited by and be subject to a report by an auditor appointed by the Board with the approval of the Minister The expenses generally of such audit shall be paid by the Board as soon as may be after each audit A copy of the accounts and the auditor's certificate and report thereon shall be presented to the members of the Board and to the Minister *Annual Report:* The Board shall, in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the preceding year

St. Luke's and St. Ann's Hospital Board

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is 10

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and direct Ministerial appointment
  - 5 members of the Board are nominated by the Provincial Council, e.g. *5 nominated by the Provincial Council and appointed by the Minister*
  - There are no competency based requirements for the Board members
  - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a ' monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- Apparent ambiguity in reporting relationship to ERHA (under section 10 Health (Eastern Regional Health Authority) Act, 1999 — arrangements by the Authority for provision of services) given provisions in Establishment Order relating to direct report to Minister

Agency established under the British Irish Agreement Act 1999

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Food Safety Promotion Board BRITISH IRISH AGREEMENT ACT, 1999	Not fewer than 8, not more than 12 members Scientific Advisory Committee 16 members	Not specified	North/South Ministerial Council will appoint the members Term of office is 5 years	Not specified	North/South Ministerial Council	*Report:* The Body will prepare annually a corporate plan, subject to the approval of NSMC, including Finance Ministers. The Plan will include a description of the proposed activities of the Body and the funding implications The Body will submit a report on its activities in each year to NSMC at such date and in such form as NSMC may direct A copy of the report will be laid before the Northern Ireland Assembly and both Houses of the Oireachtas *Accounts:* The Body will submit copies of the above statement to NSMC as well as to the Comptroller and Auditor General for Northern Ireland and the Irish Comptroller and Auditor General who will in co-operation examine and certify the accounts The statement will be laid before the Northern Ireland Assembly and both Houses of the Oireachtas. Any report concerning the Body by the Comptroller and Auditor General for Northern Ireland will be laid before the Northern Ireland Assembly and any such report by the Irish Comptroller and Auditor General will be laid before both such Houses

Food Safety Promotion Board

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size between 9 and 17. The Board size is between 8 and 10
- The Scientific Advisory Committee size is 16

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by the North South Ministerial Council
    - There are no competency based requirements for the Board members
    - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
    - The Board reviewing the performance of the CEO/ management team
    - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the North South Ministerial Council laid out in the legislation with regard to:
    - Accounts
    - Annual report

Agencies provided for under the Health Act (1970) and Health (Eastern Regional Health Authority) Act 1999

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Comhairle na nOspidéal Hospital Bodies Administration Bureau HEALTH ACT, 1970 HEALTH (HOSPITAL BODIES) REGULATIONS, 1972 (S.I. No. 164 of 1972) Health (Hospital Bodies) Regulations, 1972, (Amendment) Regulations 1978 (S.I. No. 338 of 1978)	27 *Bureau* 6	Including not less than 14 persons who are registered medical practitioners engaged in a consultant capacity in the provision of hospital services Members of the Department of Health and Children *Bureau* (*a*) the Chairman, for the time being, of Comhairle na nOspidéal, who shall be Chairman of the Bureau (*b*) the Vice-Chairman, for the time being, of Comhairle na nOspidéal (*c*) the Chairman, for the time being, of the Dublin Regional Hospital Board (*d*) the Chairman, for the time being, of the Cork Regional Hospital Board (*e*) the Chairman, for the time being, of the Galway Regional Hospital Board (*f*) an officer of the Department of Health nominated by the Minister	Appointed by the Minister for Health and Children Term of office is 5 years	Monthly meetings Bureau meets twice a year	Minister for Health and Children	Not specified

Comhairle na nOspidéal

Comments against best practice based on available evidence

Size:

- Best practice recommends the Board size between 9 and 17.
    - Comhairle na nOspidéal — the Board is 27
    - The Bureau had a Board of 6

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and direct Ministerial appointment
    - Board is based on competency from one discipline only e.g. *not less than 14 person who are registered medical practitioners engaged in a consultant capacity in the provision of hospital services*
    - There are no competency based requirements for the remaining Board members
    - Members of the Department of the Health and Children are appointed to the Board
    - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
    - The Board reviewing the performance of the CEO/management team
    - The Board reviewing its own performance

Reporting arrangements:

- There are no specified reporting arrangements in the legislation, although periodic reports are produced and submitted to the Department of Health and Children

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Board of the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital THE HEALTH ACT, 1970(SECTION 76) (ADELAIDE AND MEATH HOSPITAL, DUBLIN,INCORPORATING THE NATIONAL CHILDREN'S HOSPITAL) ORDER, 1996	23	• 6 from The Adelaide Hospital Society • 6 from The Meath Hospital • 3 from The National Children's Hospital • 6 members among the persons nominated by the President under Clause (13) • 2 members shall be appointed by the Minister, one of whom shall have been nominated by the Eastern Health Board (or any successor to its functions) for such appointment and the other of whom shall have been nominated by the Board of Trinity College, Dublin, for such appointment	6 members shall be appointed by The Adelaide Hospital Society 6 members shall be appointed by The Meath Hospital 3 members shall be appointed by The National Children's Hospital, remainder appointed by the Minister for Health and Children Term of office is 3 years	Not specified	The Eastern Regional Health Authority	*Accounts:* The Hospital shall keep all proper and usual accounts — submitted annually to an auditor for audit and as soon as may after the audit, such of those accounts as, in the opinion of the Board, may be conveniently published for the information of members of the public *Annual report:* as soon as may after the end of each year the Hospital shall prepare and publish a report in relation to its activities during that year *Provider Plan agreement with the ERHA* *Legal & Financial Accountability* The Hospital accepts that it is accountable to the ERHA for the use of resources provided by them for patient care. The Hospital accepts that the ERHA has a legal accountability to the Minister and will assist in any way possible in fulfilling that obligation *Service Delivery Accountability* The Hospital will accept explicit responsibility for the achievement of agreed objectives as set out in its agreed Provider Plan etc *Patient related accountability* The Hospital accepts its obligations under the Patients' Charter *Public Accountability* An FOI Officer has been appointed

Board of the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital

Comments against best practice based on available evidence

Size:

- Best practice recommends the size of the Board between 9 and 17. The Board size is 23

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and direct Ministerial appointment
  - There are no competency based requirements for appointment to the Board
  - The legislation outlines the requirements for the nominations to the Board, e.g. *6 from The Adelaide Hospital Society; 6 from The Meath Hospital*
  - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual report
- Apparent ambiguity in reporting relationship to ERHA (under section 10 Health (Eastern Regional Health Authority) Act, 1999 — arrangements by the Authority for provision of services) given provisions in the Establishment Order relating to direct report to Minister

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
General Medical Services (Payments) Board GENERAL MEDICAL SERVICES (PAYMENTS) BOARD (ESTABLISHMENT) ORDER, 1972 GENERAL MEDICAL SERVICES (PAYMENTS) BOARD (ESTABLISHMENT) ORDER, 1972, (AMENDMENT) ORDER, 1990	14	• One officer of each health board designated by the CEO of the Health Board • One officer of each area health board established by section 14 of the ERHA Act, 1999, designated by the Area CEO • 3 other persons appointed by the members referred to above	Appointed by the Minister for Health and Children Health board CEOs Area health board CEOS A member will remain on the Board for a period determined by the relevant CEO	Board will hold as many meetings as may be necessary to fulfil their functions	Minister for Health and Children	Annual report which contains Financial and statistical analysis of claims and payments

General Medical Services (Payments) Board

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size of between 9 and 17. The Board size is 14

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through nomination and Ministerial appointment
  - Board members are nominated by the health boards for appointment to the Board e.g. One officer of each health board designated by the CEO of the health board
  - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- The Board is required to produce annual statistics and a financial analysis of claims and payments in the preceding year, published in an annual report. However, the accountability arrangements between the Payments Board and individual health boards is not clear from the legislative base, for example where formal accountability for the levels of spending under the GMS Payments Scheme lies

Note: The structure and governance arrangements of the GMS Payments Board are currently the focus of an independent review, running in parallel with this Audit

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Health Boards Executive (HeBE) **(Office for Health Gain has been subsumed)**	11	11 CEOs of the health boards, area health boards and the Eastern Regional Health Authority	Term of Office continues as long as they hold the office of the CEO of their respective Boards	Not specified	Minister for Health and Children C&AG Houses of the Oireachtas	*Accounts:* The annual financial statements of the Executive for each year shall be prepared in accordance with accounting standards specified by the Minister and shall be submitted to the Comptroller and Auditor General for audit within 3 months of the end of the year to which they relate and an audit shall be carried out by the Comptroller and Auditor General in accordance with section 5 of the Act of 1993 Upon completion of the audit under *subsection (8),* the Comptroller and Auditor General shall draw up a report in writing in relation to the accounts and shall submit a copy of the accounts together with his or her report thereon to the Minister, each health board and the Area Health Boards, and the Minister shall, as soon as may be, cause a copy of the report and a copy of the accounts to which the report relates to be laid before each House of the Oireachtas *Report:* The Executive shall, not later than the 31st day of March in each year, make a report on its activities during the preceding year and shall submit a copy of the report to the Minister, each health board and the Area Health Boards

Health Boards Executive (HeBE)

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size of between 9 and 17. The Board size is 11, e.g. the CEOs of the health boards

Board Membership, Appointment, Independence and Capability:

- Board members are appointed by direct Ministerial appointment
    - Board members are the chief executives of the health boards and area health boards, e.g. *The members of the Executive shall be the chief executive officers of the health boards and the area chief executives*
    - No explicit public representation on the Board (e.g. members of the public, public representatives)

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
    - The Board reviewing the performance of the CEO/ management team
    - The Board reviewing its own performance

Reporting arrangements:

- Clear criteria for the nature of reporting on an annual basis to the Minister for Health and Children
    - Accounts
    - Annual report

Health Boards

Provisions relating to all Health Boards	
Legislation:	HEALTH ACTs 1947 -1968 HEALTH ACT,1970 HEALTH (AMENDMENT) ACT, 1996 HEALTH (AMENDMENT) (NO. 2) ACT, 1996 HEALTH (AMENDMENT) (NO. 3) ACT, 1996
Size, composition and source of appointment to the Board	**4.**—(1) For the administration of the health services in the State, the Minister shall after consultation with the Minister for Local Government by regulations establish such number of boards (to be known and in this Act referred to as health boards) as may appear to him to be appropriate, and by such regulations shall specify the title and define the functional area of each health board (2)(*a*) Membership of a health board shall consist of— (i) persons appointed by the relevant local authorities (ii) persons appointed by election by registered medical practitioners and by election by members of such ancillary professions as are specified in the appropriate regulations under subsection (1) (iii) persons appointed by the Minister (*b*) In a specification of membership of a health board by regulations under this section, the number of persons fulfilling the condition in paragraph (*a*) (i) shall exceed the total number of other members of the health board (*c*) Paragraph (*a*) (ii) shall not apply in the case of the first appointments of members of a health board, but the first appointments to a health board under paragraph (*a*) (iii) shall include appointments made on nominations of bodies which, in the opinion of the Minister, are representative of the medical and ancillary professions or of particular branches thereof (3) For the purposes of subsection (2) and paragraphs 14 (1) and 16 (2) of the Second Schedule the relevant local authorities shall be each council of a county or corporation of a county borough the functional area of which (or part of the functional area of which) is included in the functional area of the relevant health board and, in the appropriate case, the Corporation of Dún Laoghaire shall be a relevant local authority (4) The Minister shall consult the council of a county, the corporation of a county borough or the Corporation of Dún Laoghaire before making regulations under this section which relate to the functional area of the council or corporation concerned
Frequency of meetings	The board shall hold at least twelve meetings in each year and such other meetings as may be necessary for the performance of its functions
Reporting to:	Minister for Health and Children
Accountability/reporting arrangements	*Accounts:* **11.**—(1) A health board shall keep all proper and usual accounts of all moneys received or expended by the board including an income and expenditure account and balance sheet and, in particular, shall keep all such special accounts as the Minister may from time to time direct (2) A health board shall prepare annual financial statements in accordance with accounting standards specified by the Minister (3) The annual financial statements shall be adopted by the health board on or before the 1st day of April in the year following the financial year to which they relate (4) The Minister may by order (made after consultation with the Minister for Finance) vary the date specified in *subsection (3)* (5) The adoption of annual financial statements shall be a reserved function

Provisions relating to all Health Boards	
Accountability/reporting arrangements	*Annual report:* **15.**—(1) A health board shall, not later than the 30th day of June in each year, prepare and adopt a report (which shall be known as and in this section is referred to as an 'annual report') in relation to the performance of its functions during the preceding year (2) An annual report shall include— (*a*) a statement of the services provided by the board in the preceding year, and (*b*) such other particulars (including financial statements) as the board considers appropriate or as the Minister may specify (3) The adoption by a health board of its annual report shall be a reserved function (4) As soon as may be after adopting an annual report, a health board shall submit a copy thereof to the Minister (5) Copies of the annual report of a health board shall be made available at the principal office of the board during normal office hours for inspection by members of the public or for purchase by them at such price as may be determined by the board, and a health board shall give public notice of the date on and from and the place at which the annual report will so be made available *Reserved/executive functions of a Health Board* *Reserved functions* **3.**—(1) A health board shall perform the following functions: (*a*) a function of a health board specified in a section mentioned in *column (3)* of the *First Schedule*, of the Act mentioned in *column (2)* of that Schedule opposite the mention aforesaid (*b*) a function (if any) as maybe declared to be a reserved function by order made by the Minister, and (*c*) a function which is specified as a reserved function in this Act (2) Every function of a health board that is required to be performed pursuant to *subsection (1)* shall be a reserved function and 'reserved function' shall be construed and have effect accordingly (3) The chief executive officer shall assist a health board in the performance of its reserved functions, in such manner as the health board may require (4) The Minister shall not make an order under *subsection (1) (b)* in relation to any function or class of functions that is or are specifically conferred on a chief executive officer under this Act or any other enactment (5) The Minister may by order amend or revoke an order under this section (6) A health board shall not take any decision or give any direction in relation to any function of a health board that is not a reserved function *Executive functions* **4.**—(1) A function of a health board that is not a reserved function shall be a function of the chief executive officer unless otherwise provided for, whether in this Act or in any other enactment, and a function that is required to be so carried out shall be an executive function and 'executive function' shall be construed and have effect accordingly (2) A chief executive officer shall furnish the health board with such information (including financial information) in relation to the performance of his or her executive functions as the board may from time to time require (3) A chief executive officer shall furnish the Minister with such information (including financial information) in relation to the performance of his or her executive functions as the Minister may from time to time require *Functions of Chief Executive Officer (3, 1996)* **9.** (1) The chief executive officer shall implement the service plan, or amended service plan, on behalf of the health board so that— a. the amount of net expenditure of the board for the financial year does not exceed the amount of net expenditure determined by the Minister, and b. the indebtedness of the board does not exceed the amount specified by the Minister under *section 8 (1)* (2) If the chief executive officer is of opinion that a decision of the health board will, or a proposed decision of the board would, if made— a. result in net expenditure by the board for a financial year in excess of the amount determined by the Minister, or b. result in the indebtedness of the board exceeding the amount specified by the Minister under *section 8 (1)*, he or she shall, as soon as may be, inform the Minister and the board of that opinion

Provisions relating to all Health Boards	
Accountability/reporting arrangements	*Adoption of a service plan by a health boards (3, 1996)* **6.**—(1) Subject to *section 7 (1) (a)*, a health board shall, within— (*a*) 42 days, or (*b*) such shorter period not being less than 21 days as the Minister may direct in any particular case of the receipt by the board of a determination, adopt and submit to the Minister a service plan (2) A service plan shall be prepared in such form and shall contain such information as may be specified by the Minister from time to time and, without prejudice to the generality of the foregoing, shall— (*a*) include a statement of the services to be provided by the health board and estimates of the income and expenditure of the board for the period to which the plan relates, and (*b*) be consistent with the financial limits determined by the Minister under *section 5* (3) If a service plan is not submitted by a health board in accordance with *subsection (1), the Minister may direct the board to submit a service plan to him or her within such period not exceeding 10 days from the receipt of the direction as may be specified therein* *(4) Where a health board fails to submit a service plan to the Minister in accordance with the provisions of subsection (1)*, or pursuant to a direction under *subsection (3)*, the Minister may direct the chief executive officer to prepare and submit a service plan to him or her within 10 days of the receipt of the direction and the chief executive officer shall comply with any such direction (5) A service plan submitted by the chief executive officer under *subsection (4)* shall be deemed to have been adopted and submitted by the relevant health board (6) Where in the opinion of the Minister the service plan of a health board— (*a*) does not contain such information as was specified under *subsection (2)* (*b*) proposes net expenditure which exceeds the net expenditure as determined by the Minister, or (*c*) is not in accordance with the policies and objectives of the Minister or of the Government in so far as they relate to the functions of the board, the Minister may, not later than 21 days after the receipt by him or her of the service plan, direct the health board or, in the case of a service plan submitted in accordance with subsection (4), the chief executive officer, to make modifications to the service plan and the board or the chief executive officer, as the case may be, shall comply with any such direction (7) Subject to *subsection (5)*, the adoption of a service plan under this section shall be a reserved function
Accountability/reporting arrangements	*Supervision and amendment of a service plan* **7.—**(1) The Minister may, after the amendment by him or her of a determination under *section 5 (3)*, either— (*a*) direct that the service plan of the health board concerned shall stand amended in such manner as the Minister may specify in the direction, or (*b*) direct the health board concerned to submit an amended service plan in accordance with the amended determination and the health board shall comply with such a direction (2) Where the Minister directs a health board to submit an amended service plan in accordance with *subsection (1)(b)*, the provisions of *section 6* shall apply to such plan with the necessary modifications (3) A health board shall supervise the implementation of its service plan in order to ensure that the net expenditure for the financial year concerned does not exceed the net expenditure determined by the Minister for that year (4) A health board may amend a service plan and, in so doing, it shall ensure that the net expenditure for the financial year concerned does not exceed the net expenditure determined by the Minister for that year (5) A copy of an amended service plan shall be furnished to the Minister by the health board as soon as may be and the provisions of *section 6* shall apply to such plan with the necessary modifications (6) Subject to the provisions of this section and *section 6*, the supervision of the implementation of and the amendment of a service plan shall be reserved functions

Name of Board	Size of the Board
Mid-Western Health Board	28 Board members
Southern Health Board	33 Board members
North Eastern Health Board	30 Board members
North Western Health Board	27 Board members
South Eastern Health Board	31 Board members
Midland Health Board	30 Board members
Western Health Board	31 Board members

Comments against best practice based on available evidence (for health boards)

Size:

- Best practice recommends a Board size of between 9 and 17.
    - Health board size ranges between 27 and 33

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through election and direct Ministerial appointment
    - There has only been a provision for selective professional representation on the Board e.g. nurses, doctors, pharmacists, dentists
    - Apart from the professional representation there are no competency based requirements for Board appointments
    - The legislation provides that persons appointed by the relevant local authorities will be in the majority
    - Public representation — No explicit user representation on the Board (e.g. members of the public, users of the service)

Scope of role:

The 1996 Act introduced provisions for annual service planning, within the budget determination provided by the Minister. It states that:

- The Board is responsible for submitting the service plan between 21 and 42 days after receipt of the budget determination. If the service plan is not submitted within that timeframe or it fails to adhere to the guidelines set out by the Minister, the Minister may direct the CEO to prepare and submit an alternative service plan
- There are no prescribed organisation structures for the health boards within the legislation
- Requirements in relation to monitoring and evaluation of services, measuring outputs and standards in assessing need and matching it to funding are also absent in the legislation
- There is no requirement for the Board to consult with the general public
- The 1996 Health Act and C&AG Act both require efficiency with regard to financial expenditure but there is no corresponding requirement for evidence in relation to effectiveness of service delivery and its measurement
- There is no requirement to measure quality of output

Monitoring Processes:

- The legislation does not provide for a 'monitoring process' with regard to:
    - The Board reviewing the performance of the CEO/ management team (currently a set of performance measures have been agreed between the Department and the CEOs of the health boards, but it is unclear where they are monitored)
    - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and Houses of the Oireachtas laid out in the legislation with regard to:
    - Accounts
    - Annual Report
- There are no obligations in the legislation for the Annual report to link back into the service plan
- No requirement for the annual plan to be in a specific or in a user-friendly format

Eastern Regional Health Authority/Area Health Boards

Provisions relating to the Eastern Regional Health Authority and Area Health Boards	
Legislation	HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT, 1999
Size, composition and Source of appointment	*Membership of Authority.* 11.—(1) The Authority shall consist of 55 members (2) Of the members of the Authority— (*a*) 30 shall be appointed by the local authorities whose functional areas are included in the functional area of the Authority, of whom— (i) 10 members of Dublin Corporation shall be appointed by Dublin Corporation, and (ii) 4 shall be appointed by each of the councils of the counties of Fingal, South Dublin, Dún Laoghaire-Rathdown, Kildare and Wicklow, and the members appointed by the council of a county shall be members of that council, and the persons so appointed shall, where so prescribed, include such numbers of persons from such local electoral areas as may be prescribed (*b*) 13 shall be members of registered professions appointed by election, of whom— (i) 9, including not less than 2 consultants in general hospitals, not less than one consultant psychiatrist, not less than 2 general medical practitioners and not less than one registered medical practitioner with special knowledge or experience in preventive medicine, shall be appointed by election by registered medical practitioners practising in the functional area of the Authority (ii) one shall be appointed by election by registered dentists practising in the functional area of the Authority (iii) one shall be appointed by election by registered nurses (other than registered psychiatric nurses) practising in the functional area of the Authority (iv) one shall be appointed by election by registered psychiatric nurses practising in the functional area of the Authority, and (v) one shall be appointed by election by registered pharmaceutical chemists and registered dispensing chemists and druggists practising in the functional area of the Authority (*c*) 9 shall be representative of voluntary service providers, appointed by the Minister, of whom— (i) 3 shall be nominated for appointment by such persons or organisations as the Minister considers to be representative of the voluntary hospitals in the functional area of the Authority (ii) 3 shall be nominated for appointment by such persons or organisations as the Minister considers to be representative of the voluntary intellectual disability service providers in the functional area of the Authority, and (iii) 3 shall be nominated for appointment by such persons or organisations as the Minister considers to be representative of other voluntary service providers in the functional area of the Authority (*d*) 3 shall be appointed by the Minister *Source of appointment to an Area Health Board* Membership of an Area Health Board shall include at least one member of the Authority who has been appointed by each of the following, namely— (*a*) the local authorities mentioned in *section 11(2) (a)* (*b*) the registered professions mentioned in *section 11(2)(b)* (*c*) the Minister, on the nomination of each of the voluntary service providers mentioned in subparagraphs *(i), (ii)* and *(iii)* of *section 11(2)(c)*, and (*d*) the Minister under *section 11(2) (d)* (6) With respect to each Area Health Board, persons appointed to the Authority under *section 11(2) (a)* and subsequently appointed by the Authority to an Area Health Board shall exceed the total number of other members of that Area Health Board and be from local electoral areas within the functional area of the Area Health Board
Frequency of meetings	**ERHA:** 6 meetings a year or as many as may be necessary to carry out their functions **Area Health Boards:** At least 9 meetings a year or as many may be necessary to carry out their functions
Reporting to:	**Minister for Health and Children**

Accountability/reporting arrangements	*Accounts:* **18** (2) An Area Health Board shall prepare annual financial statements in accordance with the accounting standards specified by the Minister for the purposes of section 11(2) of the No. 3 Act of 1996 and shall submit such financial statements to the Comptroller and Auditor General for audit on or before the 1st day of April in the year following the year to which they relate (4) The annual financial statements of an Area Health Board shall form part of the consolidated annual accounts of the Authority (7) The annual financial statements of the three Area Health Boards, together with the reports of the Comptroller and Auditor General thereon, shall be appended by the Minister to the annual financial statements of the Authority (as submitted to the Minister by the Comptroller and Auditor General in accordance with section 6 of the Act of 1993) and the consolidated annual financial statements of the Authority (as submitted to the Minister by the Comptroller and Auditor General in accordance with *subsection (6)* and section 6 of the Act of 1993) and laid before each House of the Oireachtas **Functions of Authority.** 8. (1) The Authority shall perform the functions conferred on it, under this Act and any other functions which are performable by a health board and such other functions as may be provided for by law (2) The Authority shall, having regard to the resources available and as it sees fit, plan, arrange for and oversee the provision of services in its functional area (3) In performing its functions under this section, the Authority shall— (*a*) make arrangements under *section 10* with persons for the provision of services (*b*) co-ordinate the provision of services (*c*) put in place systems, procedures and practices to enable it to monitor and evaluate services provided in accordance with arrangements made under *section 10* (*d*) provide in its annual report an account of measures taken to monitor and evaluate services and an account of the outcomes of such measures (*e*) have regard to the advice (if any) tendered to it by each of the three Area Health Boards, and (*f*) have regard to the right of voluntary bodies who provide services in accordance with arrangements made under *section 10* to manage their own affairs in accordance with their independent ethos and traditions (4) Nothing in this Act shall be construed as prejudicing the performance by the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital of its functions under its Charter *Accountability of Regional Chief Executive.* 13.—(1) The Regional chief executive shall, whenever required by the Committee of Dáil Éireann established under the Standing Orders of Dáil Éireann to examine and report to Dáil Éireann on the appropriation accounts and reports of the Comptroller and Auditor General, give evidence to that committee on— (*a*) the regularity and propriety of the transactions recorded or required to be recorded in any book or other record of account subject to audit by the Comptroller and Auditor General which the Authority or the Area Health Boards are required by or under statute to prepare (*b*) the economy and efficiency of the Authority and the Area Health Boards in the use of their resources (*c*) the systems, procedures and practices employed by the Authority and the Area Health Boards for the purpose of evaluating the effectiveness of their operations, and (*d*) any matter affecting the Authority or any Area Health Board referred to in a special report of the Comptroller and Auditor General under section 11(2) of the Comptroller and Auditor General (Amendment) Act, 1993, or in any other report of the Comptroller and Auditor General (in so far as it relates to a matter specified in *paragraph (a), (b)* or *(c))* that is laid before Dáil Éireann (2) In the performance of his or her duties under this section, the Regional chief executive shall not question or express an opinion on the merits of any policy of the Government or a Minister of the Government or on the merits of the objectives of such a policy

Accountability/reporting arrangements	*Arrangements by Authority for provision of services.* **10.** (1) Subject to *subsections (2)* and (4), the Authority shall, having regard to the resources available to it, make one or more arrangements with one or more persons for the provision of services within its functional area (2) (*a*) Subject to *section 9(2)* and *subsection (3),* the Authority shall, having regard to the resources available to it, make and carry out an arrangement with each Area Health Board for the provision within the Area Health Board's functional area of services which, immediately before the establishment day, were provided by the Eastern Health Board (*b*) The Authority may make arrangements with an Area Health Board for the provision of services other than those specified in *paragraph (a)* (*c*) *Paragraph (a)* shall not be construed as preventing the Authority or an Area Health Board from discontinuing or curtailing any service (3) The Authority may determine an arrangement or any part thereof made under *subsection (2) (a)* in relation to the provision of a service and make and carry out an arrangement in lieu thereof with a voluntary body for the provision of the service (4) An arrangement made under this section shall include the following: (a) a written agreement between the Authority and the person who proposes to provide the services, covering a period of not less than 3 years and not more than 5 years and specifying— (i) the principles by which both parties agree to abide for the duration of the agreement, and (ii) such standards relating to the efficiency, effectiveness and quality of the services to be provided as may be agreed between the parties and (*b*) a written agreement, to be renewed annually, between the Authority and the person who proposes to provide the services specifying— (i) the services to be provided, and (ii) the funds to be made available therefore (5) The Authority may delegate its power to make an arrangement under *subsection (1)* to an Area Health Board, other than where: (*a*) the arrangement is with any one of the persons specified in the *Second Schedule,* or (*b*) the arrangement is with another Area Health Board (6) A person (not being an Area Health Board) who provides services in accordance with an arrangement made under this section shall keep, in such form as may be approved by the Authority, all proper and usual accounts and records of all income received or expenditure incurred by it (7) Accounts kept in pursuance of *subsection (6)* shall be submitted annually for audit and a copy of the accounts and the auditor's certificate and report thereon shall be presented to the Authority within such period as may be specified by the Authority (8) The expense of an audit carried out under *subsection (7)* shall be paid for by the person keeping the accounts *Delegated functions to the Area Health Board CEOs* (6) The Regional chief executive shall delegate in writing to each area chief executive such of his or her functions in relation to the provision of services within the functional area of the relevant Area Health Board which, immediately before the establishment day, were performed by the chief executive officer of the Eastern Health Board (7) Notwithstanding *subsection (6)*, the Regional chief executive may, from time to time, and where he or she considers such action would secure the most beneficial, effective and efficient use of resources, provide in writing for such of his or her functions as he or she may determine to be exercisable in relation to the whole or part of the Authority's functional area by a specified area chief executive and where the Regional chief executive does so, any delegation made under subsection (6) in relation to those functions shall be revoked
Name of Board	**Size of the Board**
Eastern Regional Health Authority	55 Board members
East Coast Area Health Board	18 Board members
Northern Area Health Board	19 Board members + 2 observers
South Western Area Health Board	21 Board members + 2 observers

Comments against best practice based on available evidence (for the Eastern Regional Health Authority/area health boards)

Size:

- Best practice recommends a Board size of between 9 and 17.
  - The ERHA Board size is 55
  - The area health board size is between 18 and 21

Board Membership, Appointment, Independence and Capability:

- Board members are appointed through election and direct Ministerial appointment
  - There has only been a provision for selective professional representation on the Board, e.g. nurses, doctors, pharmacists, dentists
  - Apart from the professional representation there are no competency based requirements for Board appointments
  - There is unbalanced representation of voluntary groups representing certain sectors, e.g. *(ii) 3 shall be nominated for appointment by such persons or organisations as the Minister considers to be representative of the voluntary intellectual disability service providers in the functional area of the Authority,*
  - The legislation provides that persons appointed by the relevant local authorities will be in the majority
  - Public representation — No explicit user representation on the Board (e.g. members of the public, users of the service)

Scope of role:

There are particular difficulties in the ERHA/area health board model which require further examination. The legislative framework creates a complex web of relationships and accountabilities. For example:

- The Authority is required to delegate its reserved functions for service provision in the former Eastern Health Board areas to the appropriate Area Board, and the CEO must delegate the related executive function. This raises a question about where absolute legal responsibility for service planning and budgeting as set out in the 1996 Health Amendment (no.3) Act resides — with the chief executive of the ERHA or with the CEOs of the area health boards. While it may be possible to remedy this situation by direction under section 16 of the 1996 Act, which we understand has been done, it would be preferable to see a stronger legislative base with accountability clearly outlined
- The Authority has the duty to plan for the region. The area health boards have the duty to plan for their area, which would appear to result in unclear boundaries between local and regional planning. The Authority may not delegate the making of arrangements for service provision with certain service providers (the voluntary hospitals, the learning disability organisations and a small number of others). This presents particular challenges in relation to these Schedule II Agencies (who have a direct funding relationship with the Authority) and whose operations may not feature adequately in the area health board plans
- There is a requirement under the 1996 Health Act for the Authority to submit its service plan within 42 days. Given the timescale from the date of issue from the Letter of Determination, typically in December in the preceding year, the 42 day timescale which is followed by 21 days in which the Minister can accept or alter the Service Plan, appears to mean that technically, it can be mid to late February before the plan takes legal effect. This timescale difficulty is exacerbated by the subsequent need for the Authority to then finalise the 39 individual Provider Plans with each of the Agencies
- The 1999 legislation does not provide a clear obligation on the Schedule II providers to conclude annual service arrangements with the Authority. This in effect means that the Authority is responsible for the delivery of services but not in a position to require Service Providers to come to a conclusion on the Annual Provider Plan. In order to allow it, in turn, deliver on its formal commitment to the Department under the terns of its Annual Service Plan
- There appears to be no formal sanction open to the Authority in situations where they are 'out of agreement' with providers. Equally, the legislation is silent in terms of accountability obligations on parties with whom the Authority interacts
- Finally, there appear to be discrepancies in accountability arrangements with the statute-based hospitals (St James's; Beaumont Hospital, etc). While these hospitals are part of the normal contracting process for Schedule II Agencies, technically under their Statutory Instruments they are still open to report directly to the Minister on a number of matters

Monitoring Processes:

- The ERHA 1999 Act provides for the Eastern Regional Health Authority to put in place monitoring and evaluation arrangements and for area health boards to 'monitor and evaluate' services provided by arrangement within its area i.e. section 15 (4)
- The legislation does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/management team (currently a set of performance measures have been agreed between the Department and the CEOs of the health boards, but it is unclear where they are monitored)
  - The Board reviewing its own performance

Reporting arrangements:

- There are clear requirements for reporting on an annual basis to the Minister for Health and Children and Houses of the Oireachtas laid out in the legislation with regard to:
  - Accounts
  - Annual Report
- There are no obligations in the legislation for the Annual report to link back into the service plan
- No requirement for the annual plan to be in a specific or user-friendly format

Non-statutory organisations

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Board for the Employment of the Blind	7	1 Chairman 6 Ordinary members	Appointed on an honorary basis by the Minister for Health and Children	Not specified	Minister for Health and Children	Not specified

Board for the Employment of the Blind

Comments against best practice based on available evidence

Size:

- Best practice recommends a Board size of between 9 and 17. The Board size is 7

Board Membership, Appointment, Independence and Capability:

- Board members are appointed on an honorary basis by the Minister for Health and Children
  - It is noted that in December 1999 the Board made recommendations to the Minister for Health and Children regarding the future of the organisation. Having looked at various options in detail, the Board unanimously recommended that the operation be closed through a process that would be sensitive to the needs of the workforce. Following consultation the Minister decided against closure of Blindcraft. No new appointment of Chairman or Board members has taken place since 1997 due to uncertainties regarding the legal status of the organisation. To rectify this situation, we understand, from material received from the Department of Health and Children, that an Order is being prepared under the Health (Corporate Bodies) Act 1961, to put the existing Board for the Employment of the Blind on a proper legal footing

Scope of role:

- There are no clear statements of authority and accountability for the Board vis-à-vis the management team in the areas of strategy and planning, financial control and oversight, risk management and people management

Monitoring Processes:

- The literature received does not provide for a 'monitoring process' with regard to:
  - The Board reviewing the performance of the CEO/ management team
  - The Board reviewing its own performance

Reporting arrangements:

- Not specified
- Board is a Registered Charity but does not pursue any public fundraising activities

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
The Institute of Public Health	8 members on the management team	No governing Board The management committee is made up of representatives from the Department of Health and Children/Department of Health and Social Services (NI) and the Royal College of Physicians	Department of Health and Children/Department of Health and Social Services (NI) and the Royal College of Physicians	Not specified	North/South Ministerial Council	Annual production of work-plan under 4 headings: 1. Surveillance 2. Research 3. Education 4. Training

The Institute of Public Health

Comments against best practice based on available evidence

Size:
- No governing Board. The management team size is 8

Board Membership, Appointment, Independence and Capability:
- No governing Board

Scope of role:
- No governing Board

Monitoring Processes:
- The literature received does not indicate provision for a 'monitoring process' with regard to:
- The Institute reviewing the performance of the CEO/management team

Reporting arrangements:
- Not specified
- Annual development of a work-plan, unclear from the literature received if the Agency is benchmarked against performance of plan

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
The National Disease Surveillance Centre	7 members on the Management Board Scientific Advisory Committee 11 members	Not applicable	Management Board members nominated by the DoHC and health board CEOs	Not applicable	Department of Health and Children	Annual Report

The National Disease Surveillance Centre

Comments against best practice based on available evidence

Size:
- No governing Board. The Management Board size is 7
- The Scientific Advisory Committee size is 11

Board Membership, Appointment, Independence and Capability:
- No governing Board

Scope of role:
- No governing Board

Monitoring Processes:
- The literature received does not provide evidence of a 'monitoring process' with regard to:
- The Management Board reviewing the performance of the CEO/ management team

Reporting arrangements:
- Produces an Annual report detailing the activities of the preceding year

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Social Services Inspectorate CHILD CARE ACT, 1991 CHILDREN ACT, 2001	Not applicable	Not applicable	A Steering Group made up of representatives of the health boards and the Department of Health and Children has responsibility for overseeing the development of the Inspectorate and its establishment as an independent statutory body	Not specified	Department of Health and Children	Annual Report

Social Services Inspectorate

Comments against best practice based on available evidence

Size:
- No governing Board.

Board Membership, Appointment, Independence and Capability:
- No governing Board. A Steering Group has responsibility for overseeing the development of the Agency

Scope of role:
- No governing Board
- Currently gets administrative support from the Department of Health and Children. *Quality and Fairness* has stated that the SSI will be established on a statutory basis and that its remit will extend to the areas of disability and services for older people

Monitoring Processes:
- Not applicable

Reporting arrangements:
- Produces an Annual report detailing the activities of the preceding year

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
Office for Health Management	Not applicable	Not applicable	The OHM is an independent non-statutory organisation with specific consultative/steering group committees for each of its areas of work e.g. Steering Group on Study of Management Skills and Attributes e.g. Consultative Group	Each consultative/ steering group hold as many meetings as may be necessary	Minister for Health and Children	Not specified

Office for Health Management

Comments against best practice based on available evidence

Size:
- No governing Board

Board Membership, Appointment, Independence and Capability:
- No governing Board. The OHM is an independent non-statutory organisation with specific consultative/steering group committees for each of its areas of work e.g. Steering Group on Study of Management Skills and Attributes

Scope of role:
- The Office's mode of working has been based on extensive consultation with the client population. The staff compliment of the Office is small, therefore the Office calls on staff within the health service to participate in projects, steering committees and development programmes

Monitoring Processes:
- The consultative/steering groups meet on a regular basis to review the operation and future plans

Reporting arrangements:
- Agency produces an Annual Report detailing the activities of the preceding year

Name of Agency	Size of the Board	Composition of the Board	Source of appointment to the Board/replacement to the Board	Frequency of meetings	Reporting To	Accountability/reporting arrangements
National Children's Advisory Council	30	30 members drawn from the following sectors: • Statutory • Voluntary • Research/training • Children • Independent Nominees	Minister of State for Children	Meets every 2 months approximately	Minister of State for Children	Not specified
National Children's Office	5 members on the Cabinet Committee	Members from the Cabinet	Not applicable	Not specified	An Taoiseach chairs the meeting	Not specified

National Children's Advisory Council

Comments against best practice based on available evidence

Size:
- Best practice recommends a Board size of between 9 and 17. The Council size is 30

Board Membership, Appointment, Independence and Capability:
- Council members are appointed by direct Ministerial appointment
    - The Council is a representative one, e.g. members are drawn from statutory, voluntary etc

Scope of role:
- The NCAC has an independent advisory role in relation to the implementation of the National Children's Strategy, reporting to the Minister of State for Children. The Council maintains the partnership approach developed through the Strategy to influencing policy on children's issues

Monitoring Processes:
- The literature received does not provide for a 'monitoring process' with regard to:
    - The Council reviewing its own performance
    - The Council independently monitors the implementation of the National Children's Strategy

Reporting arrangements:
- The NCAC has no full time staff — staffing support is provided by the NCO

Appendix 8

Analysis of International Healthcare Structural Reform

Appendix 8

Analysis of International Healthcare Structural Reform

A brief review of international health care reforms was carried out as part of the Audit of Structures and Functions of the Health system. The review was lead by Watson Wyatt. It was intended to inform the audit with information on trends and leading practice in the reform of international health systems and structures. This appendix presents a summary of the key learnings from this review.

The appendix contains the following sections and attachments.

1. Introduction and Methodology

The objective of this review was to provide relevant insights into specific aspects of international healthcare structural and functional reform of particular interest to the Irish health system and the implementation of the National Health Strategy. We also wished to identify structural reforms and concepts that would warrant further consideration as the reform of the Irish health service continues into the future. The research was conducted over a four-week period in July 2002 and spanned eight jurisdictions.

This review has been compiled using the methodology detailed below.

Scope of the review

In practical terms, the main focus and scope of the review covered relevant reforms in member countries of the OECD and Central and Eastern Europe.

The key issues for exploration were:

- Accountability
- Quality
- Governance
- People-centredness.

The main focus of our analysis was structural reforms. In recognition of the fact that structural issues cannot be analysed in isolation, consideration was also given to the influence of supporting mechanisms as well as the host of other factors that impact on the performance of a health system, such as funding and the role of the state.

Data gathering

To ensure the maximum benefit of this analysis, two forms of research and several data sources were utilised. These were as follows:

- Desk research
- Interview of international colleagues with expertise in the healthcare field.

Desk research

- The data gathering stage is a critical stage of the analytical process. It involves gathering preliminary and contextual data in relation to structural and strategic initiatives within each of the national health systems in this review.

Input from international colleagues with expertise in the healthcare field

- The wider international team of Watson Wyatt consultants and associates provided validation of findings and further insights into the local healthcare system within their country of location.

Data sources

The principle sources of data utilised for this review were the key health authorities in each of the countries within this

review. Information was obtained from our contacts within these organisations, as well as through a review of the published information available. These included:

- Information available from the national health department in each of the countries within the scope of our analysis
- Regional health authorities and local sites (i.e. hospital, health centres) within each of the national healthcare system within the scope of the review
- Independent research and advisory reports conducted into healthcare organisations within each of these countries
- General review of all available literature, including media reviews, of organisations' strategies, policies and operations.

2. Summary of Key Learnings

During this review of international practice it soon emerged that, while some common trends and issues could be identified, the action taken by different countries was highly situational and that the effectiveness of many recent structural reforms still has to be fully evaluated. Some of the general international themes that did emerge were as follows:

- The move towards developing leaner, more responsive structures
- Adoption of structures and processes to improve implementation of national policy
- Centralisation (and independence) of quality assurance functions
- Recognition of the value of the purchaser provider split but with some shift away from full market orientation
- Improvement of organisational efficiency and economies of scale e.g. by adopting various shared services models

Below we have extracted 12 specific ''learnings'' from this review. They represent trends; principles or initiatives that have been adopted by at least one country and that are consistent with the overall strategy and direction as set out by *Quality and Fairness*. The reality is that there are no ''off- the- shelf'' solutions to the complex issues being dealt with. Examples cited are not meant to represent a recommendation that a particular agency or process be replicated in Ireland.

Key learnings

Learning 1: Improving accountability by strengthening governance arrangements through:

- devising a governance framework that is based on a whole-system approach, incorporating the relevant principles and recommendations of the OECD (2001), IFAC (2001) and Cadbury Reports (1992).
- review of current arrangements against the recommendations of Sendt (2001) and emerging trends in health systems internationally. This includes developments such as:
  - centralisation and standardisation of the Board appointment system
  - developing Board education and appraisal programmes
  - engaging the public.

Models and principles to consider:

- Sendt, B (2001); 'Best Practice Standards for Public Sector Corporate Governance'
- Cadbury Report (1992) 'Report of the Committee on the Financial Aspects of Corporate Governance'
- IFAC (2001); 'Corporate Governance Review by the Standing Committee on Company Law Reform'.

Learning 2: Efficient utilisation of resources while safeguarding equity and accountability through:

- introduction of frameworks and mechanisms designed to increase resource efficiency
- lengthening of the period covered by contracts to encourage collaboration and reduce short-termism.

Models and principles to consider:

- District Health Boards, New Zealand:
  - where local 'oversight' committees exist to manage potential conflicts of interest intrinsic to the dual role of DHBs
  - the option exists to contract with providers managed by other DHBs
  - the requirement exists to co-operate with other DHBs where necessary to deliver services. However, it is still unclear how this will be enforced in New Zealand.
- The New Zealand Public Health and Disability Act 2000 where:
  - providers must be given notice on the terms and conditions under which payments will be made
  - notice as much as is possible is nationally consistent to contain transaction costs and maintain a degree of national consistency and equity of access.

Learning 3: Effective implementation of national priorities through:

- involvement of stakeholders in strategy and policy development
- embedding organisational accountability in the legislative framework
- development of an explicit system for obtaining commitment and ownership for specified objectives for approval by central government
- clarification of roles and responsibilities among central Government and key players
- incentivisation of performance at both the individual and organisational level.

Models and principles to consider:

- accountability guidance; Sendt (2001)
- strategic planning and accountability documentation, New Zealand
- award-winning stakeholder consultation model at the Capital Health Authority, Canada
- National Service Frameworks, UK
- National Performance Assessment Frameworks, UK
- NHS Performance Fund, UK.

Learning 4: Development of patient-centred integrated services through:

- alignment and optimisation of health and social care planning and delivery
- development of organisation cultures, processes and ways of working that effectively link disciplines, taking into account factors such as funding streams
- introduction of organisational frameworks supported by clear lines of accountability and performance targets.

Models and principles to consider:

- National Service Frameworks, UK.

Learning 5: Promote ongoing development of healthcare quality and system performance through:

- centralisation of the development of performance criteria and technological infrastructure for performance monitoring within a single structure

Models and principles to consider:

- Health Information & Quality Authority (HIQA), Ontario Canada.

Learning 6: Supporting the practice of evidence-based medicine and good health/social care practice generally through:

- establishment of a central function or body responsible for the assessment of health technologies in support of evidence based medicine. Such an organisation could also have responsibility for the collation of research on other health and care related practice and the dissemination of information on good practice.
- establishment of a function or body responsible for the assessment of health technologies in support of evidence based medicine.

Models and principles to consider:

- The National Institute of Clinical Excellence (NICE), UK
- The National Institute of Clinical Studies, Australia.

Learning 7: Enhancing objectivity and accountability for health system appraisal through:

- separation of the monitoring and audit function through the establishment of an independent function/body to monitor health and care services provision across all sectors, public and private.

Models and principles to consider:

- proposed health and social service monitoring bodies, UK.

Learning 8: Enhancing quality by means of improved professional regulation through:

- establishment of an umbrella function to facilitate collaboration and change among the professional regulatory groups
- supporting and expediting the process of professional investigation and disciplinary procedures.
- the establishment of supports as required for healthcare organisations through the provision of advice as well as the strengthening of internal mechanisms

Models and principles to consider:

- The Council for Health Regulation, UK
- The Health Professions Council, UK
- Clinical Governance Framework, UK

- The National Clinical Assessment Authority (NCAA), UK.

Learning 9: Strengthen the capacity of local structures to manage resource allocation and planning by:

- facilitating prioritisation and planning according to local needs
- facilitating meaningful citizen participation in decision making.

Models and principles to consider:

- District Health Boards, New Zealand
- Primary Care Trusts, UK.

Learning 10: Improvement of people-centredness of services through:

- enshrining the requirement for public participation and accountability for reporting in legislation, making it a statutory requirement for the relevant health care organisations to involve local communities in decision-making
- establishment of a centralised body or commission with responsibility for facilitating public participation, through the provision of information and other support
- establishment of a single independent patients' representative body with the collective power to seek patient redress.

Models and principles to consider:

- 'Designed to Care' initiative, Scotland
- Capital Health Authority, Canada, — award winning stakeholder consultation model
- Strategic planning and accountability reporting consultations of DHBs, New Zealand
- Patients Forums, UK
- The proposed Commission for Patient and Public Involvement, UK
- Community Health Councils, UK.

Learning 11: Improvement of operational efficiency through the development of shared services potentially in the following areas:

- Finance, Human Resource Management and Information Technology
- clinical services, such as diagnostics
- other services such as procurement, estate management,
- Public Private Partnerships and other risk sharing activities.

Models and principles to consider:

- National Shared Services Initiative, UK
- NHS Purchasing and Supply Agency, UK.

Learning 12: Achieving successful implementation of proposed reforms through:

- implementation of a phased change programme
- establishment of an ongoing evaluation of the reforms

- development of 'enabling' legislation where appropriate
- creation of frameworks which are 'tight', yet allow scope for innovation
- establishment of a central capability to lead strategic change and develop leadership
- incentivise performance at the individual and organisational level.

Models and principles to consider:

- National Service Frameworks, UK
- The NHS Modernisation Agency, UK
- NHS Performance Fund and other incentives, UK.

3. Achieving Successful Implementation of Healthcare Reforms

As part of the review of international health system reforms, we also considered some of the influencing factors associated with successful implementation of these initiatives. The most common of these factors are highlighted below.

- The ability of governments to successfully implement health system reform is dependent on a variety of factors. Strong, stable majority governments are more likely to ensure adoption of health reform policies than minority and relatively unstable ones. In countries such as Finland and Sweden where coalition governments are often the norm, health system reform has tended to be more incremental.
- Flexibility around policy criteria is required if governments wish to secure buy-in from key stakeholders. One observation arising from the Swedish experience is that incremental change seems to result in more acceptable policies than rationally driven radical change (as in the UK and New Zealand in the early 1990s). Indeed, in the UK, political counter-pressures resulted in a slowing down of the reform process (Ashton 1995; Gladstone and Goldsmith 1995).
- An example of phased implementation of structural reform is the introduction of Primary Care Trusts in the UK in the late 1990s. PCTs were allowed to evolve through three stages from elementary Primary Care Groups to fully-fledged Trusts.
- It is also important to design and implement an evaluation programme to support reform, to provide the opportunity for evidence-based review and revision, and to distil lessons learned. This has been a major omission in most reform programmes (Bloom 2000). A project has commenced to evaluate aspects of the ongoing wave of reforms in New Zealand. The three year project is being conducted by the Health Service Research Centre and is sponsored by the Health Research Council, the Ministry of Health and the State Services Commission.
- Stakeholder interests are critically important in the policy implementation process. Establishing alliances with stakeholders and organisations that support the change is essential to ensure its successful implementation. The UK government undermined the opposition of the medical profession during the 1991 reforms through forming such an alliance with health sector managers who stood to gain financially and professionally from the proposed reforms (Gladstone and Goldsmith, 1995).
- In the case of New Zealand, the 1993 reforms were implemented 'wholesale' in the face of opposition from the health professions, but in the knowledge that it was generally favoured by the business community (Ashton 1995).
- Clinicians and other health professionals should be included in the policy development and reform process. Developing clinicians in management at all levels of the health system will foster the development of a cadre of managers that are distanced from professional 'silos' having the credibility of their peers.

A number of mechanisms and devices have been deployed to facilitate change and improve implementation of national (or regional) objectives.

'Enabling' legislation (New Zealand)

This entails framing proposed changes within a legislative framework that is sufficiently flexible to allow for experimentation as well as change. This approach can help to gain buy-in, and saves on time lost due to the need for amendments (Bloom 2000).

The development of frameworks (UK and New Zealand)

National Service Frameworks for facilitation of integrated services — UK

National Service Frameworks (NSFs) were developed to facilitate the implementation of central policy regarding the development of integrated health services. The frameworks:

- Set national standards and define service models for defined service or specific disease management
- Put in place strategies to support implementation
- Establish performance milestones against which progress within an agreed time-scale will be measured.

Local organisations, including Local Authorities (LA), co-ordinated by the Strategic Health Authority, are required to work together to produce Health Improvement Plans. They have the freedom to develop new methods of working together such as setting common targets, pooling budgets, creating shared appointments, new opportunities for staff secondments, and integrating information systems.

Accountability for NSFs

The lines of accountability for NHS and Local Authority services are outlined below.

- Each StHA agrees an annual performance agreement with the Department, covering each of the key objectives of the StHA for the year, and incorporating the plans set out into the Service and Financial Framework.
- Annual accountability agreements between each StHA and its PCTs contain key targets, objectives and standards for service delivery, consistent with national priorities and the local Health Improvement Programme, embodied in long-term service agreements.
- Local government overall is subject to the Best Value regime.
- It is anticipated the NSFs will effect improvements in the design and delivery of effective health services nationally. Critics have argued that the 'dual' lines of accountability built into the framework is inadequate and that the Minister for Health should have sole responsibility for cross-sector initiatives (Nuffield Trust 2001).

Creation of central 'steering' or 'enabling' bodies

Example: NHS Modernisation Agency

The NHS Modernisation Agency was recently established to support change management initiatives in the health service. One such initiative is the introduction of clinical governance. The agency also co-ordinates management and leadership development.

A Structural Reforms in International Healthcare

This section provides an analysis of recent structural reforms to health systems in seven jurisdictions. The countries were chosen as offering particular points of relevance or comparisons in the light of their recent experience of reform. The jurisdictions examined here are Canada, Australia, Finland, New Zealand, Scotland, Sweden and the United Kingdom.

Canada

Overview of national healthcare system

The Canadian national healthcare system is highly fragmented, and essentially consists of 10 separate provincial systems, each responsible for provincial healthcare management. The Provinces vary greatly in population and geographic size. For example, Ontario has some 10 million people and a health budget of approximately $24B dollars and in contrast Prince Edward Island has about 150,000 people and a proportionally smaller budget.

The federal government exerts a degree of control over the provincial governments through enabling national legislation, such as The Canada Health Act (1984). The Act sets out the broad framework of principles that steer the provincial health systems. Health services are jointly funded by the Federal Government in conjunction with each Province. In the 1970's, this funding was split 50/50. Today, the Federal funding share varies by Province and is less than 20%, which has significantly diminished the federal influence in setting priorities on the healthcare agenda.

Each Province has a Ministry of Health headed by a Minister, who is an elected member of the provincial government. Each Ministry is responsible for areas such as resource allocation, standard setting, services and health data collection, governing board appointment and professional regulatory legislation within their particular Province. With the exception of Ontario, each provincial healthcare system has been undergoing a consolidation of different types of health service organisations (e.g. acute care hospitals, community care services, geriatric care and public health) into Regional Health Authorities (RHAs). British Columbia, for example has moved from about 600 health organisations 20 years ago to 6 regional health authorities today.

Generally, the RHAs in each Province are responsible for the co-ordination and operational delivery of health services within provincial guidelines and/or standards. The geographic and population sizes served by RHAs vary considerably within each Province. The boards of RHAs vary in their selection methods, number of members and performance expectations. While most Provinces have indicated a desire to have some or all members publicly elected, to date most board members are appointed by the provincial governments.

Public participation in decision-making is facilitated by Community Health Councils. Every Canadian jurisdiction has recently sought public input into health policies and priorities through public commissions but to date there has not been substantive public dialogue about health.

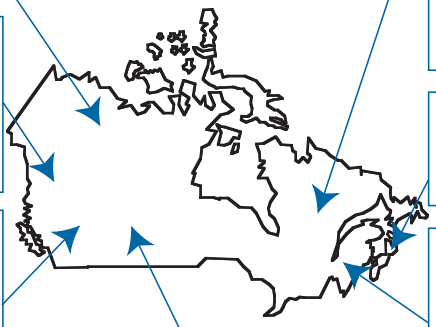
There is significant variation across Provinces with regard to the range of services available and access to these services. "Equity" is generally discussed within each Province rather than at a Federal level.

Historically, approximately 70% of health services have been publicly funded and publicly delivered. Policy on engagement with the private sector varies among the Provinces and has been hotly debated. Private service providers have significantly increased their share of the Canadian market in recent years, providing increased capacity and supporting the reduction of waiting lists. This, and the commercial market's requirement for viability and profitability in its undertakings, has contributed to a situation where there are significant variation in access to healthcare services across Provinces.

Recent reforms

The past two years have witnessed a wave of consolidation and integration in a number of Provinces aimed at containing costs and improving the co-ordination of service delivery. Changes in British Columbia are described below. Given the relative infancy of these changes, the impact of these have not yet been assessed.

Figure 1: A selection of recent structural reforms in the Canadian health system



Northwest Territories
January 2002
'Action Plan 2002-2005'

- Eliminating two health and social services regions and introducing one new one
- Standardising the nomination appointment, orientation and training process for new board members
- Introducing two system wide management structures - the Joint Leadership Council and the Joint Senior Management Committee
- Changing their goverance structure from 'Boards' to 'Authorities'

Quebec
June 2001

- Moved from elected to appointed boards
- Modified board composition. New boards consist of 16 or 17 members appointed by the Government, including the Executive Director, who is also President of the regional board.
- Provincial organisation of regional health authorities dissolved

British Columbia
December 2001
The province replaced its previous structure with:

- 5 regional Health Authorities
- 1 Provincial Health Services Authority
- 16 Health Service Delivery Areas

Nova Scotia
January 2001

- Replaced its 4 Regional Health Boards with 9 District Health Authorities

Alberta
October 2001
The government passed legislation that will:

- replace its Regional Hospital Corporations with regional Health Authorities
- Replace (in 2004) its system of fully appointed boards with a mixed system, with 8 elected and 7 appointed board members

New Brunswick
December 2001
The government passed legislation that will:

- replace its Regional Hospital Corporations with regional Health Authorities
- Replace (in 2004) its system of fully appointed boards with a mixed system, with 8 elected and 7 appointed board members

Saskatchewan
December 2001
'Action Plan for Saskatchewan Health Care', 2001

- Changes included:
- Replacing 32 District Health Boards with 12 Regional Health Authorities
- Moving away from elected boards to appointed boards

Restructuring in British Columbia

In 2001, British Columbia implemented a programme of structural reform to address the following issues:

- Distribution of, and access to, basic medical and specialist services
- Fragmented, poorly co-ordinated care of inconsistent quality.

The 52 existing health boards were collapsed into 5 Health Authorities responsible for the planning and co-ordination of services and 1 Provincial Health Services Authority responsible for specialist services such as transplants. This structure is supported by 15 Health Service Delivery Areas with responsibility for the delivery of co-ordinated hospital and community-based health services.

Evaluation

Cost containment remains an issue for the Canadian health system. In response to continuing concerns regarding the consistency of healthcare provisions nation-wide, the Commission on the Future of Health Care in Canada chaired by Roy Romanow (the Romanow Commission) was finalised in November 2002. The commission's mandate was to recommend policies and measures required to ensure the long-term sustainability of a universally accessible and publicly

funded health system that will continue to provide Canadian people with quality services. The report includes 47 recommendations that are intended to provide a roadmap for the reform and renewal of the public healthcare system and include the following:

- Creation of a health council to facilitate cooperation between levels of Government and provide national leadership on healthcare issues.
- Establishing a Canadian Health Covenant to ensure commitment to a universally accessible and publicly funded healthcare system.
- Provision of stable and long-term healthcare funding which enhances accountability.
- Development of comprehensive strategies for injury prevention and health promotion.
- Expansion of the definition of ''medically necessary'' to include access to diagnostic services, limited home care, etc.
- Prevention of potential international challenges to the healthcare system by existing and future trade agreements.

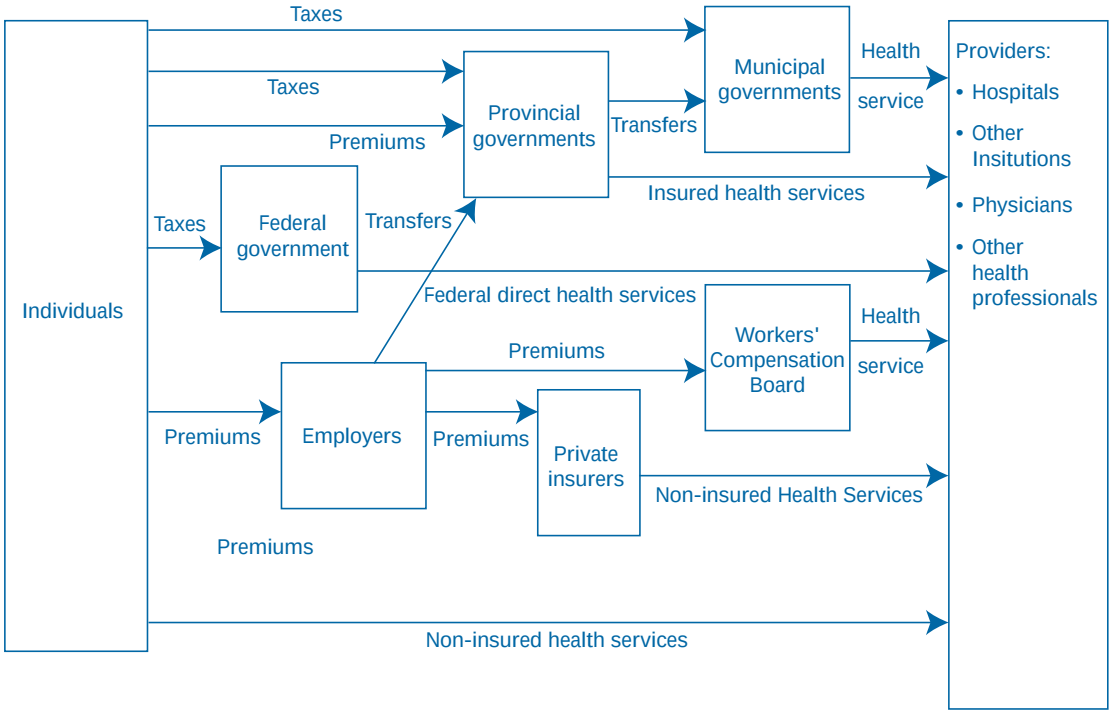
Australia

Overview of national healthcare system

The Australian health care system can be characterised as pluralistic and in a state of continuous change. Australia has three tiers of government: the national government of the Commonwealth, the six States and two Territory governments, and local governments. Within this structure, the Commonwealth government funds health and social care, while the States are responsible for planning and service delivery.

A high level overview of the Australian system is outlined overleaf.

Figure 2: The 'Pluralist' Australian system



This system has allowed a number of different health system models and regulatory mechanisms to develop at the sub-national level. A model of particular interest at sub-national level can be found in Victoria and is described below.

The Department of Human Services, Victoria

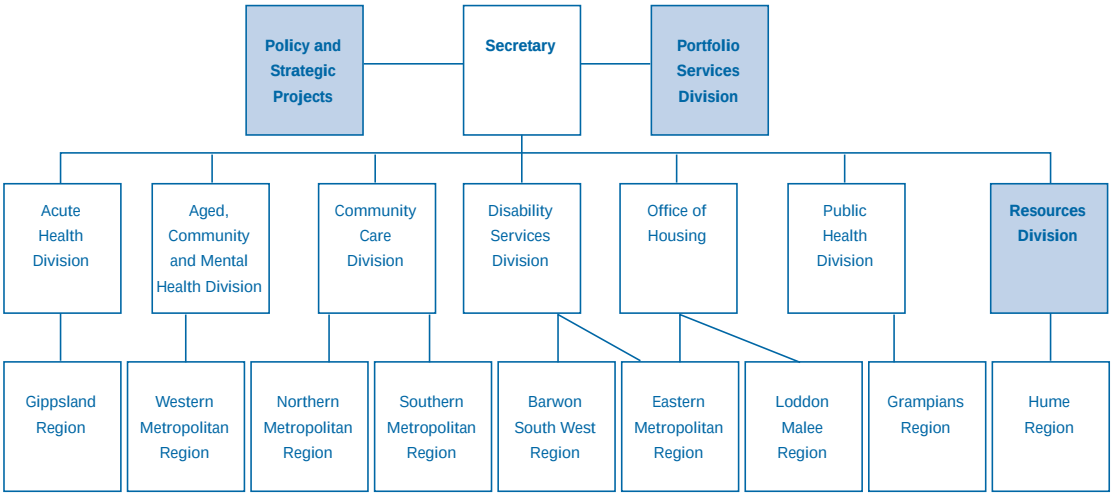
The Department of Human Services was formed in 1996 as a result of a merger of the health and welfare services. It serves as the key purchaser of health care services within each of the three regions.

It operates within four portfolio areas which are in turn accountable to three Ministers i.e. the Minister for Health, Minister for Community Services and Housing and the Minister for Senior Victorians.

The Department is divisionalised along the following service lines: Development and Planning, Resources, Acute Health, Public Health, Aged, Community and Mental Health, Community Care, Disability Services, Rural Health, Youth and Family and Office of Housing.

The diagram below provides an overview of the department.

Figure 3: Structure of the Department of Human Services, Victoria



Evaluation

This model is consistent with an emerging trend in some countries, and has the potential to facilitate the development of integrated care services.

However, the divisionalised structure of the Department has presented difficulties in developing a seamless service delivery. In recognition of this, the Department recently introduced initiatives to improve 'cross programme responses' in problem areas including the development of primary care partnerships and health promotion.

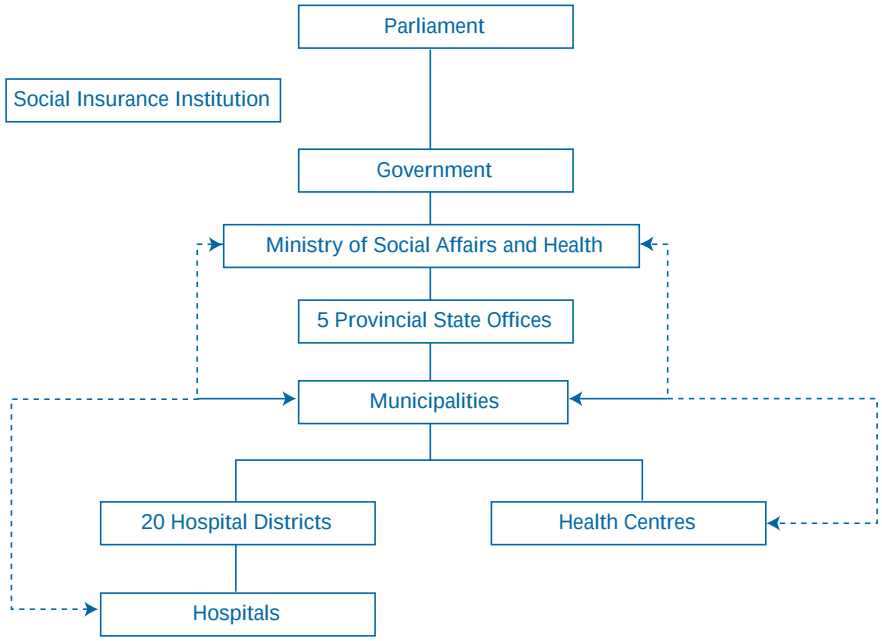
This initiative involved assigning lead responsibility for delivery of the program to one division and clear specification of the roles and accountability of the supporting divisions. The effectiveness of these initiatives in addressing the problems have not yet been assessed.

Finland

Overview of national healthcare system

The predominant feature of the Finnish health care system is its highly decentralised nature. There are currently five provincial states plus the autonomous Áland Islands, which are individually charged with the responsibility for promoting the national and regional objectives of the central government.

Figure 4: The Finnish health system



Each Province has a Ministry of Health and a Ministry of Social Affairs, which are responsible for planning and monitoring health and welfare services, as well as the approval of capital development plans. Each Province is in turn divided into municipalities responsible for the delivery of health care within a relatively loose regulatory environment. There are 448 municipalities, often covering very small populations. 75% of municipalities have fewer than 10,000 inhabitants and 20% have fewer than 2,000.

Finland is also divided into 20 hospital districts, each responsible for providing and co-ordinating specialised medical care. Each municipality is a member of a hospital district of its choice. A municipality has the freedom to provide services through another district of a private provider. The provision of services is negotiated annually between the municipality and its hospital district.

Evaluation

Managerial capacity and capability are key for the effective operation of a decentralised health system (Saltman et al 1998). The small size of municipalities creates problems with resourcing the right managerial capability to plan and deliver health services.

Historically, most municipalities have not had a strong negotiating position with the hospital districts, which set prices.

There is also an economic risk: one costly treatment could potentially break the economy of a small or medium-sized municipality. This hazard has been mitigated by the introduction of an equalisation mechanism among hospital districts that helps to manage this problem through risk pooling.

It was reported in 1993 that the numbers of in-patient cases and surgical procedures per capita varied markedly from region to region and different levels of morbidity or age and sex structure could not explain the differences. There are also wide differences in per capita expenditure on health care among municipalities.

A further review in 2000 showed that significant variations still exist. Despite significant variations in clinical practice and the delivery of health services, there has been little opposition to decentralisation in Finland where the population is dispersed and local democracy highly valued.

New Zealand

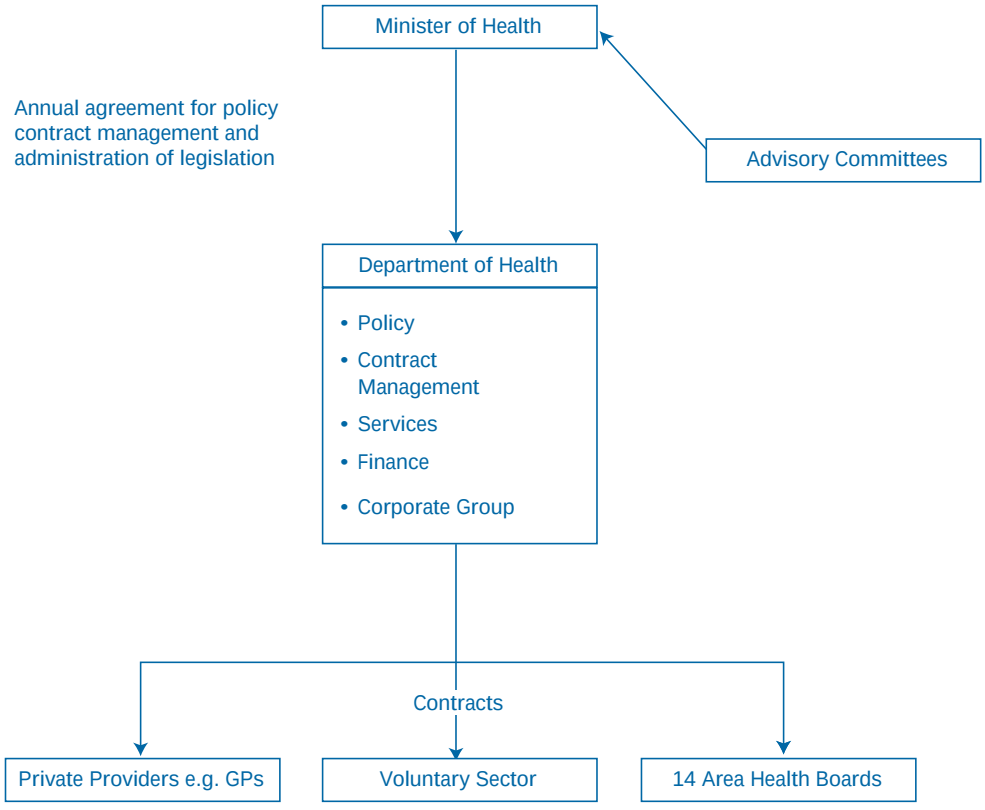
Overview of national healthcare system

The health system in New Zealand covers all residents and is funded predominantly from general taxation. The health system in New Zealand has seen unprecedented reforms over the last decade. The key changes are outlined below.

1993 reforms

Prior to the reforms in 1993, New Zealand's health system was highly centralised (see Figure 5).

Figure 5: The New Zealand health system before 1993 reforms



The key aims of the 1993 reforms were to:

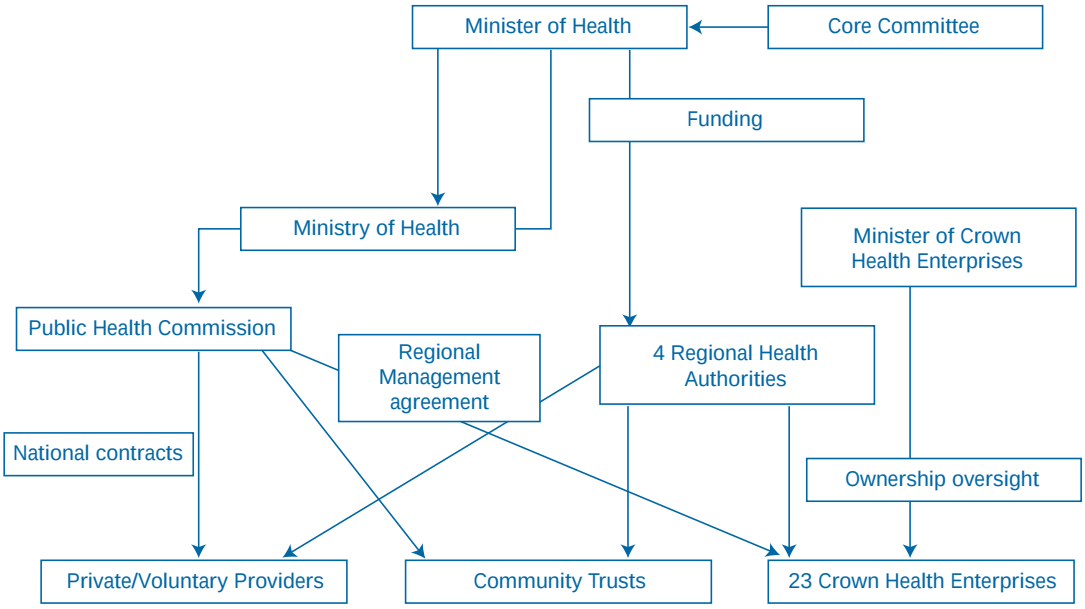
- promote greater flexibility and innovation in the delivery of health care
- support public health
- improve access to effective and affordable health care (Ashton 1997).

The central components of the reforms were dissaggregation of the functions of financing, purchasing and the provision of health services coupled with the introduction of an internal market.

Four Regional Health Authorities (purchasers) were created covering populations ranging from 75,000 to 1 million. State-owned Crown Health Enterprises (CHEs) were also established to manage the provision of health services.

The role of public health was given greater visibility through the establishment of a Public Health Commission — a Crown agency independent of the Ministry of Health, which was responsible for the development of public health policy and purchasing of public health services.

Figure 6: New Zealand health system after the 1993 reforms



Impact of 1993 reforms

Overall, corporatisation and commercialisation failed to provide an adequate package for addressing the problems faced by the sector, and have tended to deflect long-term planning (Bloom, 2001). The model did have some success in constraining health care costs. However access remained an issue, with the lengthening of waiting times for elective surgery and the exacerbation of geographical access problems.

1996 reforms

The election of a new coalition government in 1996 initially resulted in an adjustment of the existing structure. Public Health funding was ring-fenced and both the Public Health Commission and the Public Health Agency were abolished.

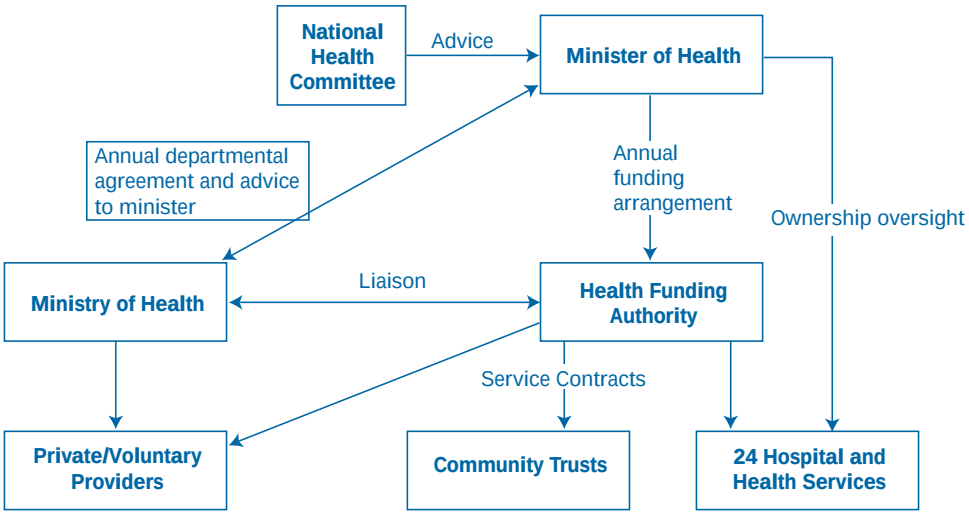
1999 reforms

Under the 1999 wave of reforms, the four RHAs were merged into a single national purchaser called the Health Funding Authority (Figure 7), which was designed to lower administration costs and eliminate unjustifiable geographic variations in service access.

Provider organisations were renamed Hospitals and Health Services (HHS) and the internal market abolished. These were made directly accountable to the Ministers of Health and Finance. An additional HHS was also established to manage blood services nationally. HHSs are now directly accountable to the Ministers of Health and Finance. The position of Minister for Crown Health Enterprises was eliminated.

Public health funding was ring-fenced and both the Public Health Commission and the Public Health Agency were abolished.

Figure 7: 1999 Reforms within New Zealand health system

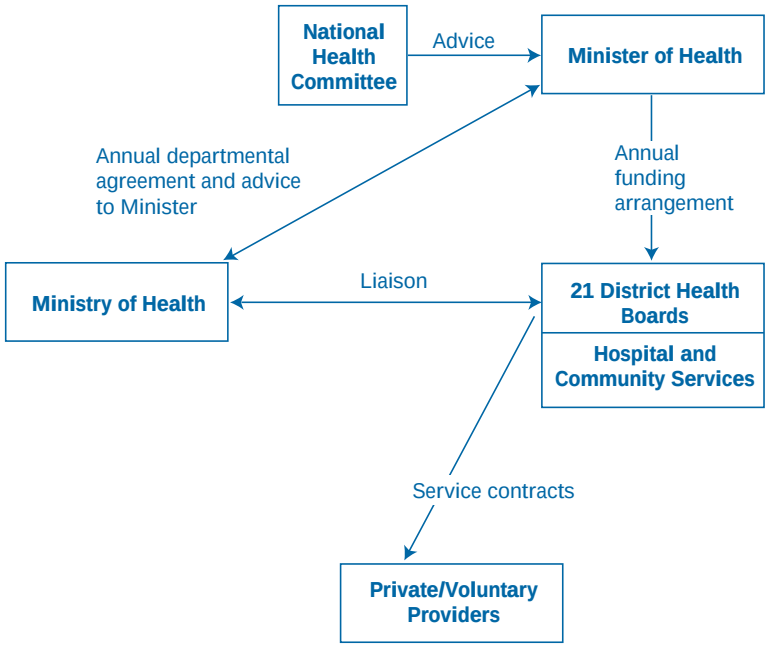


Impact of 1999 reforms

The establishment of a single purchasing organisation is a unique departure from the trends towards devolved decision making observed in the majority of OECD countries. This structure was only in place for a relatively short period before it was replaced by the current organisation.

The latest reforms to the New Zealand health system are being phased in under 'The Health and Disability Act, 2000'. They have resulted in the structure depicted below.

Figure 8: Latest reform: Post The New Zealand Public Health and Disability Act, 2000



The Health Funding Authority (HFA) and Hospital & Health Services (HHS) were abolished in 2001. In January 2001, the HFA was replaced by 21 District Health Boards (DHBs), largely consistent with current HHS boundaries and based on local government boundaries. Funding for DHBs will be based on the size of the population, adjusted to reflect the characteristics of the area, i.e. rurality, age of the population and levels of deprivation.

District Health Boards (DHBs)

The 21 DHBs are responsible for providing or buying Government funded health care services for the population of a specific geographical area. The statutory objectives of DHBs are to:

- improve, promote and protect the health of communities
- promote the integration of health services, especially primary and secondary care services (similar to UHBs of Scotland)
- promote effective care or support of those in need of personal health services or disability support
- promote the inclusion and participation in society and independence of people with disabilities
- reduce health disparities by improving health outcomes for Maori and other population groups
- foster community participation in health improvement, and in planning for the provision of health services.

Each DHB board has up to eleven members which is regarded as a good balance, and should allow for good community representation, but not be too unwieldy. Every three years, the community elects seven residents of each DHB district to each board at the same time as local government elections. The Minister for Health, in consultation with his/her colleagues, also appoints up to four members to each DHB board. Each board must have at least two Mäori members, or a greater number if Mäori make up a higher proportion of the DHB's population.

The Minister's appointment process will aim to ensure that each board has the best mix of skills and knowledge, and is representative of its population. For example, in those areas where Pacific people form a large part of the population, the DHB board will need the appropriate skills to consider their needs.

Citizen participation & consultation

Elected representatives to the DHB

The elected community representatives to the DHB are responsible for the governance of the DHB. They must manage the financial resources in a manner which best serves the interests of the health of the population and which best meet the requirements of the Minister for Health.

The DHB board is responsible for the management of the entity to ensure it delivers on its fundamental objective of working within allocated resources to improve, promote and protect the health of a defined population, and to promote the independence of people with disabilities within a defined population.

Board members are not responsible for the management of the DHB. Instead that is the responsibility of the Chief Executive appointed by the Board and the staff who report to the Chief Executive.

Other mechanisms

The elected membership of DHBs helps to ensure democratic participation in the decision-making process of the healthcare system. However, this is not a substitute for community, consumer and provider involvement and participation in decision-making through other mechanisms. DHBs are to establish consultation processes whereby providers and users of services, and the community, will be able to have input into major decisions taken by the Boards.

Although formal consultation is usually only carried out for a small range of issues, there is also a need for the DHBs to be open to responses from individuals and groups who are concerned about issues that might affect them. In the future, DHBs will develop methods of ensuring that this more informal consulation takes place freely. Some suggestions for necessary structures include the:

- establishment of a system to ensure the availability of useful and timely information on the Board's processes and decisions
- establishment of a system to ensure that Board members and ''liaison'' staff are available to respond to issues
- encouragement of community health groups that will in turn have an established feedback loop with the Board.

A component of each DHBs' accountability is to ensure that communities are involved in the deliberations of DHB boards where possible. DHB board meetings are, therefore, also open to the public and the community are involved in the DHBs' planning processes. DHB performance information is also publicly available.

Managing potential tensions in the integrated purchaser provider structure

To manage any tension which DHBs may experience in their dual roles as funders and providers of services, DHBs must establish three core advisory committees:

Health Improvement Advisory Committee which will provide advice on the mix and range of services that will best meet local health improvement and independence objectives recognising both resource constraints and the requirements of the New Zealand Health and Disability Strategies

Hospital Governance Advisory Committee which will provide advice to the Board on the performance of its hospital(s) and related DHB-owned services, and strategic issues associated with the provision of hospital and related services
Disability Support Advisory Committee which will advise the board on issues facing people with disabilities and how these can best be managed by the DHB.

Evaluation

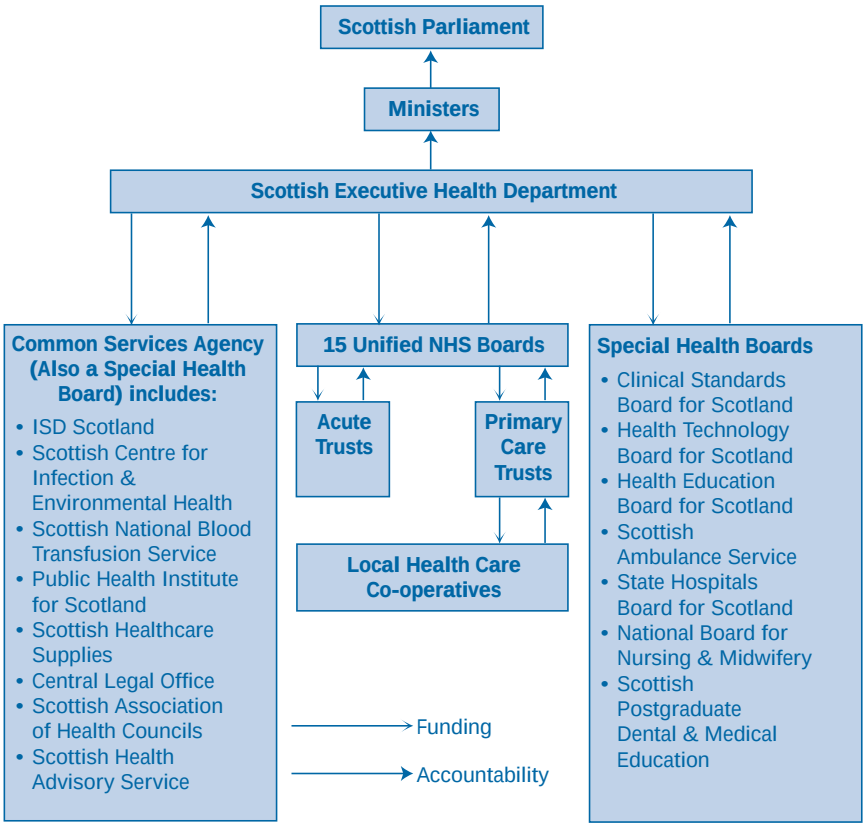
It is too early to assess the impact of these reforms. A major evaluatory project by the Health and Social Research Unit commenced in 2001.

Scotland

Overview of national healthcare system

The NHS in Scotland is the responsibility of the Minister for Health & Community Care, working through the Scottish Executive Health Department and accountable to the Scottish Parliament. The NHS in Scotland shares the same policy drivers identified in England, but they have been implemented differently — this has resulted in different policies and different institutions.

Figure 9: Structure of the Scottish health system, 2001



The Scottish Executive Health Department (SEHD)

The Scottish Executive Health Department (SEHD) was formed in September 2000. It is an amalgamation of the former NHS Management Executive and the Public Health Policy Unit. The Chief Executive of the SEHD is accountable to ministers for the efficiency and performance of the service. It consists of the following directorates:

- Directorate of Health Policy (including all aspects of public health and community care)
- Directorate of Planning & Performance Management
- Nursing Directorate
- Finance Directorate
- Directorate of Corporate Development
- Directorate of Human Resources.
- The Chief Executive heads the Management Executive which oversees the work of the 15 NHS Boards.

NHS Boards

Scottish NHS Boards were established in 2001, replacing the original Health Boards whose responsibilities included health needs assessment, resource allocation, and administering the provision of healthcare services. The core function of NHS boards is strategic. They are responsible for:

- strategy development — development of a single local health plan
- resource allocation — in accordance with strategic objectives laid out in the health plan
- implementation — of the health plan
- performance management — of the local NHS system.

Each NHS Board has a Public Health Department, the director of which holds a place on the board.

Unified NHS Boards

Unique to Scotland, is the concept of Unified NHS Boards. There are 15 'unified' NHS boards, which have membership from the Health Board, NHS Trusts, Primary Care Trusts and local authorities. The actual structures of the constituent organisations are not unified.

The aim of unification is to provide a single focus of accountability for the performance of the local health system. The main objectives of the concept are improved decision-making within the Scottish health system and the development of integrated, customer-focussed health services to improve the health of the Scottish population.

As stated by a Minister in Scottish Parliament on the occasion of the introduction of the UHBs: *"we hope that people will sit around the same table with one common purpose in mind: how to make their area as healthy as it can be. The unified health boards will also produce local health plans and examine the range of services and the different strands of service delivery in order to provide better health services for the people of their areas".*

Structure of the Board *(Example — Grampian NHS Board)*

Grampian NHS Board has 16 board members. This includes:

- Chairs and Chief Executives of the Primary and Acute Trusts (including the University Teaching hospital)

- elected representatives of its three local council partners.
- Chairpersons of the local clinical forums (consisting of clinicians and other health professionals) attend Board meetings to provide professional input as required
- two lay members.

Accountability

Unified Boards are required to produce a single local health plan for the area as opposed to each Area Health Board producing a Health Improvement Programme for implementation by Trusts via a Trust Implementation Plan.

As in the UK, Performance Assessment Frameworks (PAFs) were introduced in 2001 to monitor performance and health improvement within each NHS Board area. The PAF aims to place equal weight on the quality of clinical and service delivery, financial management, and public involvement.

Primary Care Trusts

Primary Care Trusts were established in Scotland in 1999 and are responsible for all primary and community services. Unlike the English NHS, this includes mental health and learning disability services. Primary Care Trusts also oversee Local Health Care Cooperatives (described below).

Local Health Care Cooperatives (LHCCs)

Primary care professionals are engaged in 82 Local Health Care Cooperatives (LHCCs). The objective of these LHCCs is to involve GPs (and other primary care professionals) in the development of primary care services. GP participation in co-operatives is voluntary and, whilst they do hold some budgets, they do not directly secure service delivery from Acute Trusts through a commissioning mechanism. This is the responsibility of the 15 Unified NHS Boards. Acute Trusts and Primary Care Trusts are given joint investment funds to encourage service integration.

Special Health Boards

There are 8 Special Health Boards that plan and provide services on a national level. These are:

- Health Education Board for Scotland (HEBS) — responsible for health education and health promotion on a national level
- Clinical Standards Board for Scotland (CSBS) — responsible for a national system of quality assurance and accreditation of clinical services
- Health Technology Board for Scotland (HTBS) — assesses the clinical and cost-effectiveness of new technologies (Scottish equivalent to the National Institute for Clinical Excellence (NICE) in England)
- Scottish Council for Post-Graduate Medical and Dental Education (SCPMDE) responsible for funding, managing and supporting post-graduate training in Scotland
- Scottish Ambulance Service (SAS) — provides ambulance service for accidents, emergencies and non-emergencies
- State Hospitals Board for Scotland — provides high security forensic and psychiatric care
- National Board for Nursing Midwifery and Health Visiting in Scotland — ensures standards of education and training for Scotland's nurses, midwives and health visitors

- Common Services Agency — provides essential services for health boards that could be organised more efficiently at a national level. It includes a number of bodies such as the Scottish National Blood Transfusion Service, the Information and Statistics, Division (ISD) and the Scottish Centre for Infection and Environmental Health (SCIEH). The agency was established in 1974. A review of the agency was commissioned in 2002.

Citizen participation & consultation

Patients Charter and Designed to Care (Scotland)

With regard to patient consultation in Scotland, the Patients Charter and the 'Designed to Care' initiatives were introduced to address this objective. 'Designed to Care' is an initiative which was specifically aimed at creating a partnership between patients and the health professionals who care for them by giving both parties a bigger say in the design and management of the NHS in Scotland.

A Code of Practice on Openness in NHS Scotland (1995) predates the 'Designed to Care' Programme. This was produced by the Management Executive in May 1995 and sets out the basic principles underlying public access to NHS information in Scotland. In terms of consultation, this provides that Health Boards must consult the Local Health Council and other interested parties on any plans to change the service which they purchase or plan for their residents. Local Health Councils are in turn responsible for 'representing the interests of the public in the health services in the districts for which it has been established.

The same regulation provides that each health board should consult with each council in its area when preparing its strategic plans, when it plans any substantial developments or variations in any aspect of its services or any other matter it deems appropriate. Health councils may also be requested by health board or Scottish Ministers to consider any other health issue and submit report in relation to this.

Sweden

Overview of national healthcare system

The Swedish national health system provides coverage for all residents irrespective of nationality. Health and social care are funded largely through local taxation at the county, municipal and parish level. Priority setting is guided by three principles — human rights, need or solidarity and cost-effectiveness.

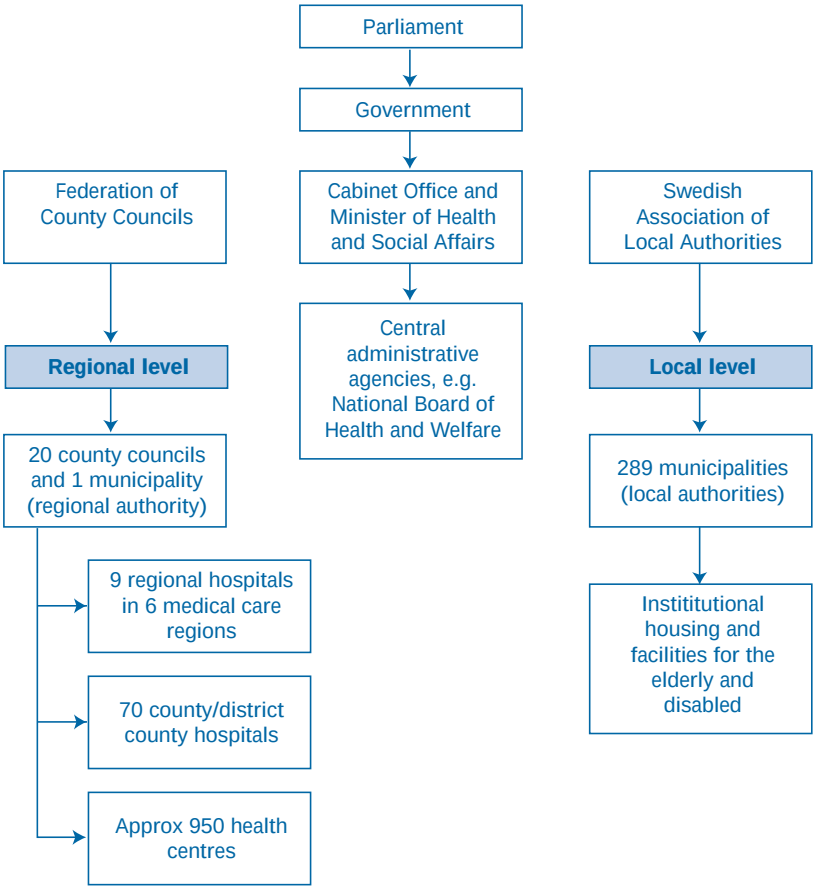
Sweden has a highly decentralised system, with responsibility for healthcare devolved to 21 regional county councils. These are independent, regional bodies that have the character of independent local government. Below this level there are 289 municipalities. Longterm care is devolved further to the municipalities.

The county councils are responsible for the delivery of services across the continuum of healthcare, including public health and preventive care, and also have overall authority over publicly owned hospitals. The population covered by county councils ranges from approximately 133,000 to 1.8 million.

Within each county council, there are usually several health care districts, each with the overall responsibility for the health of the population in its area. The county councils are grouped into six medical care regions, which were established to facilitate co-operation in tertiary care. Each region serves a population averaging more than one million.

Municipalities in turn are responsible for the delivery of education, social welfare, long term care and other local services. Municipalities also operate public nursing homes and home care facilities.

Figure 10: Structure of the Swedish health system



Sweden was one of the pioneers of internal market reforms in 1989 and the separation of the purchaser provider roles. By 1999, most county councils had adopted the model. This has given rise to a wide variety of purchasing organisations of various sizes.

Recent reforms

The past six years have seen a tempering of the purchaser provider model due to a number of factors including public discontent; rising costs and activity; and a change in political leadership.

District purchasing agencies were integrated into unified county agencies, and in several counties the management of county hospitals was transferred to a single managerial team between 1997 and 1998.

Stockholm model

The Stockholm county council model has a highly market driven nature. Underpinning this model is the introduction of private providers into the healthcare sector and at present, there are 150 private contractors, contracted by or operating on, public funding.

Hospitals are managed by private providers on a contractual basis on behalf on the council and are in the process of becoming publicly owned limited companies. The council now compensates hospitals for the services which they actually

deliver. Co-operation between publicly funded and private providers has also been fostered. Patients under the remit of this council are free to choose between care providers, so as to reduce waiting times and improve the quality of care provided.

Impact: Reimbursing providers in Stockholm for services that they actually deliver, in the first year alone, resulted in a 19% increase in productivity. It is widely reported that this model has served as a key inspiration for aspects of the 2001 NHS Plan in the UK.

Evaluation

County councils vary in income and healthcare need, two factors that tend to be inversely related. To ensure equity of access in this decentralised system, the Swedish government has introduced two schemes:

- Compensation of poorer councils to equalise total revenue per head
- In 1999, a funding formula to account for differential needs.

Devolution has not dealt with the underlying problems in Swedish health care. In principle, Sweden's decentralised system allows local government to tailor reforms that handle the delicate balance between efficiency, equity and political accountability, and it has shown that equity of access across counties can be guaranteed by the use of formulas that adjust for variations in local tax income.

However, strict cost containment has resulted in decreasing access to care. County councils have responded to this pressure in different ways. Some have sought to increase technical and allocative efficiency by separating the purchaser and provider role. Others have taken a step further by expanding private participation in the system.

Increasing numbers of medical staff are opting for employment in the private sector, and in 1999, over 20% of hospital beds were privately funded (Diderichsen 1999). There is concern that the increasing expansion of the private sector will threaten the equity and sustainability of a universal system that depends on loyalty from broad constituencies.

United Kingdom

The UK National Health Service provides coverage for all legal residents. The system is largely funded by central government through a mixture of direct taxation and National Insurance contributions.

The NHS is in transition following a wave of reform introduced by the Labour government. A key component of the 1997 reforms was the abolition of the internal market and GP fundholding.

Figure 11: The NHS before 1997

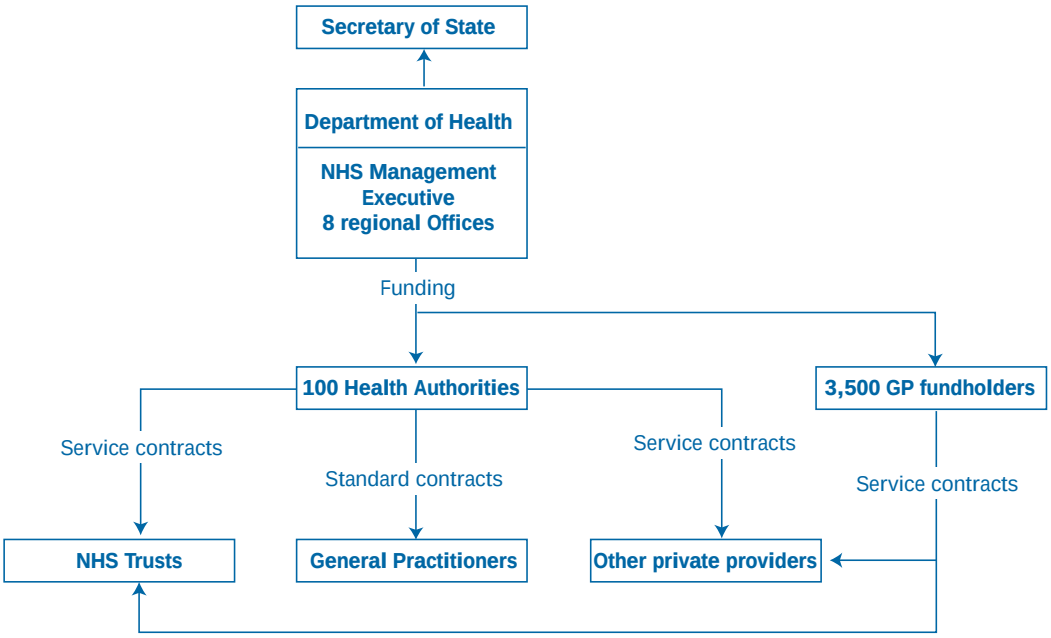
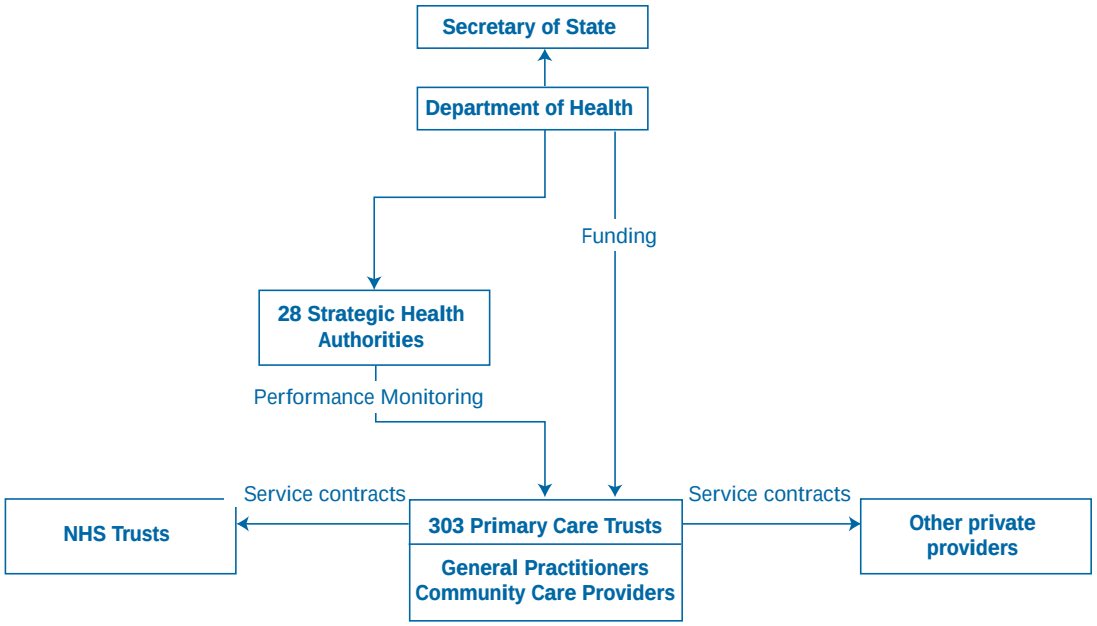


Figure 12: Current structure of the NHS, England



Primary Care Trusts (PCTs) are responsible for the commissioning and delivery of all primary and community health services excluding mental health and learning disability services. By 2004, PCTs will be the main purchasing bodies within the healthcare system, with responsibility for 75% of the NHS budget. PCTs are geographically specific, covering populations of between 50,000 and 250,000. They are legally established statutory bodies directly accountable to their Strategic Health Authority. Boards include local authority membership.

The Strategic Health Authorities (SHAs) came into effect in late in 2002 and have responsibility for managing the performance of the local health system and are essentially the headquarters of the NHS locally. There will be 28 SHAs, each serving an average population of 1.5 million. They have been formulated based on the catchment area of the Primary Care Trusts and Trusts within the area.

Evaluation

An objective evaluation of the recent reforms in the UK is difficult due to the fact that it is still very much in its infancy. For example, Strategic Health Authorities were only created in 2002.

The overall aim of the new structure is to create an efficient, responsive organisation that supports the wide-ranging objectives outlined in the 2001 NHS Plan.

Anticipated benefits of PCTs include improved resource allocation guided by local priorities and improved support for the development of integrated services. Earlier pilots of similarly configured 'Total Purchasing Projects' introduced under the previous Conservative regime were largely well received, but were not uniformly successful.

With regard to PCTs, concerns have been raised about the actual extent to which they will be able to exercise their budgetary freedoms due to the increasing weight of national targets and objectives.

B Purchasing and Provision: Integration or Separation?

The purchaser provider separation was introduced as a means of improving technical and allocative efficiency within health systems (Enthoven 1985). Throughout the 1990s, health system reforms in a number of OECD countries incorporated a shift from highly integrated forms of service delivery and finance towards models based on separation of the purchaser from the provider.

Fundamental to the traditional purchaser/provider separation is the process of competitive tendering, or contracting, designed to encourage competition among providers.

Arguments for contracting include:

- improved priority setting
- enhanced contestability
- minimised conflicts of interest
- improved operational efficiency
- focus shift from the providers to the consumers.

Experience from the UK and NZ suggests that although it may valuable to have separate purchasing authorities to promote discussion of the issues in a local community, the questions of resource allocation cannot be avoided under a purchaser/provider separation any more than under other forms of health system organisation.

It has been argued that the anticipated advantages of competitive tendering may not be as significant as advocates of the model maintain. The contracting process entails high transaction costs. Moreover, when there are large sunk costs associated with providing a service, the bidding process may be inefficient (Harris & Wood 1993).

Competitive tendering introduced an unproductive adversarial element into the UK health system. It was not uncommon to find purchasers and providers locked in disputes resulting in some contracts remaining unsigned until well into the financial year (Audit Commission 1993).

Quality could potentially be a casualty of competitive tendering (Shiell 1992). Indeed, as managed care has gained the upper hand in the US and costs were being squeezed, the concern has turned increasingly to the perceived threat to the quality of care.

Even if contracts included some quality specifications, providers may be able to skimp on non-verifiable aspects of care, especially if purchasers have a limited ability to scrutinise providers to ensure that contracts are fulfilled. Quantitative details such as price and volume are easier to measure than qualitative issues.

Another potential problem with the competitive contracting process is that it is likely to jeopardise access to particular health care providers. This was ultimately the case in the UK. Although hospitals were obliged to admit all accident and emergency patients, there was no requirement for them to accept, for other forms of treatment, patients who reside in health authorities with which the hospital has no contract.

Although provision could be made for the hospital to bill the Health Authority retrospectively on a one-off basis, cases arose where the HA had not agreed that emergency treatment was necessary and had been reluctant to pay. In turn, hospitals have been unwilling to accept further patients from the defaulting HA. Caught in the middle of the billing argument it is not clear who is responsible for the patient.

Clear criteria are required to adjudicate between providers and purchasing authorities when no contract exists between them. But even with such criteria in place, the basic problem remains. With contracts being the mechanism by which resources are allocated, referral patterns and patient choice are likely to be limited in the internal market. Those who wish to use providers, institutions or services which their DHA has not contracted for will find their access to them compromised.

Furthermore, the efficiency of the contracting process depends upon the presence of effective competition to drive providers to continually strive for improvements in their service delivery, so that they do not lose business to other agencies. It has been shown that hospital prices are lower in more competitive markets (Melnick, Zwanziger, Bamezai et al. 1992).

However, this competitive edge may be blunt for a number of reasons. Competition may not be realised in sparsely populated areas where existing providers enjoy a natural monopoly (Kronick, Goodman, Wennberg et al. 1993). Particularly, in rural areas where it may not be possible for the purchasing authority to transport patients further afield. Rather than reflecting the cost of production, prices offered by rural hospitals may be set slightly below the amount that the purchaser would be willing to pay to transfer patients elsewhere, with hospitals reaping monopoly profits.

Even where more than one provider exists, the advantages of competition may be short lived if one of the local competitors is forced out of business. The threat of potential entrants may not be enough to ensure that monopoly practice does not occur. In an industry with high barriers to entry, including large capital costs and problems in doctor recruitment, the threat of competition may not be a significant deterrent to monopoly behaviour. Competition may be lacking even without the existence of monopoly.

Retrospective analysis of the national efficiency index in the UK suggests that there was an acceleration in the rate of improvement of (measured) hospital productivity following these reforms. The rate of increase was about 2% per annum in the first half of the 1990s.

By 1995, the gain in measured hospital productivity had caught up with the gain in measured productivity in the UK economy as a whole — arguably a notable achievement for a service industry. Most of the explanation for the improvements in hospital productivity lay in sharp increases in rates of day case surgery and reductions in the average length of stay.

Again, it can be argued that the further rises in the index were due in part to the combination of targeting performance and the introduction of new, contractual incentives. There was also considerable success in changing the distribution of waiting times — eliminating the longest waits and bringing down the average wait for those patients on the waiting list. Hospitals seemed to be particularly responsive to GP fundholders, raising charges of there being a 'two-tier' system.

By the mid 1990s doubts had begun to set in about the sustainability of repeated annual rises, in excess of the rate of growth of real hospital expenditure, in the volume of hospital activity. There was growing concern at hospital level that the volume of care was being driven up at the expense of the quality of care. At the centre, there were increasing worries about gaming in the system. For example, endoscopies which had been labelled as outpatient visits might be re-labelled as day surgery cases, attracting a higher cost weight, thereby boosting the activity index. Overall, the introduction of the internal market had little measurable impact on performance, whether defined in terms of volume, quality, or unit costs.

The Current Labour government's reforms retained the internal market structure but placed much more emphasis on conscious performance management of the health care system, rather than relying on the market to improve performance. In the UK, powers are merely devolved, with no tax raising authority, giving purchasers limited freedom to deviate from patterns laid down by central government.

Dissatisfaction with traditional command and control patterns have fuelled interest in contracting. However, the actual implementation of the contractual process has often not matched theoretical expectations. Obstacles to successful contracting include:

- lack of information to support the process and measure performance
- need for increased managerial capability and capacity
- high transaction costs.

Two of the pioneers of the purchaser provider split (UK and New Zealand) and associated market reforms have abolished or modified their models. The focus is shifting from competitive to more 'cooperative' engagements between the two parties.

In the UK, where the market mechanism has been dismantled, NHS contracts are no longer legal documents and may be described as service agreements. In the UK, contracting between public health sector entities is effectively a process of negotiations that results in a mutual agreement involving specified rights and obligations. There has also been a shift towards longer contracting cycles.

There is a distinction to be made between 'hard' and 'soft' contracting. Under hard contracting, the contracting parties are relatively autonomous and press their interests actively. Under soft contracting, parties have a closer identity of interests and the relationship depends more strongly on co-operation, mutual support, trust and continuity in relations, as opposed to competition and opportunism (Saltman and van Otter 1992).

A successful contracting process will need to be supported by measurable quality performance indicators, building on traditional activity and cost measures.

The re-emergence of integrated models of health organisation as seen in New Zealand is driven by the desire to reduce the transaction and administrative costs of the previously described models and apply 'whole-systems' thinking to the planning and delivery of health services.

C Accountability: Quality and Performance Monitoring

USA

The US has been at the forefront in the introduction of mechanisms to provide external review of health services and systems. There is a requirement for federal and state governments to provide reports on their health policies to the legislature.

Prior to the late 1980s, information about quality collected by US health care organisations had largely been for internal use and rarely made available to the general public. Since then, several schemes have evolved, covering specific types of medical interventions as well as health care organisations. There are several independent organisations (profit and non-profit) involved in the delivery of these schemes.

One of the oldest accreditation organisations is the Joint Commission on Accreditation of Healthcare Organisation (JCAHO), which was founded in 1952 to establish standards for hospitals. JCAHO is currently involved with accreditation standards for a substantially broader array of providers, such as long term and ambulatory care facilities, home care organisations and clinical laboratories. The scheme has the authority to terminate hospitals' participation in the Medicare programme if the quality of care is found to be deficient.

Another such organisation is the National Committee for Quality Assurance (NCQA) which ranks the quality of health care delivery. This non-profit organisation was established in 1990 by a consortium of private businesses and non-profit organisations. NCQA is recognised by 23 states in the US and plays a key role in the accreditation of managed care and other health care organisations. Accreditation by the NCQA is voluntary.

The NCQA manages the Health Plan Employer Data and Information Set (HEDIS) — a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. It has a board of 16 members, drawn from the business (including healthcare) and medical community.

Moreover, HEDIS indicators have not escaped criticism due to:

- the cost and administrative burden to health plans
- voluntary participation — which potentially leads to only the better performing plans being willing to participate
- potential conflict of interest due to the nature of the organisation contributing to indicator development
- emphasis on process over outcome measures of quality.

In 1998, the President's Commission created two organisations who would work together representing private and public sectors respectively. The two organisations are the Forum for Health Care Quality Measurement and Reporting (Quality Forum) and the Advisory Council on Health Care Quality. The President called on Congress to create a Quality Council through legislation to establish national goals to improve health care quality and develop strategies to achieve them.

In March 1999, the Quality Forum released its policy document outlining the following goals:

- creation of an intellectual framework for quality measurement
- standardisation of quality measurement by endorsing common sets of measures for national use
- public access to valid, comparative data
- use of the data to facilitate improvement by health care providers and plans, inform consumer and purchaser choice and stimulate market demand for quality improvement.

The Quality Forum planned to include stakeholders from key organisations such as JCAHO and NCQA. In addition, the President's Advisory Commission set up the Quality Interagency Co-ordination Task Force (QuIC) to ensure that all federal agencies involved in performance and quality measurement work to common goals.

One of the workgroups — led by the AHRQ and HCFA has produced an inventory of all system-wide performance measures (clinical, population, and health system) developed, in use, or under development by Agencies and Departments within the Federal Government to be used by the Measures Workgroup. Additionally, legislation was pending at the time of preparing this report to make these processes formal and official, but it had not yet been passed.

The US has a national quality report on healthcare delivery that has been mandated by Congress to report annually commencing in 2003. This review, a National Quality Report on Health Care Delivery, has been commissioned to ensure that the required information be gathered on a national basis to allow Congress examine health status and thus determine which aspects of the service are underperforming, and assess whether the quality of care is improving over time. The report format has been developed with a view to allowing both policy-makers and the general public to make year-to-year comparisons and determine where the quality of care diverges from desired levels. The report will cover the complete spectrum of healthcare settings, not just in-patient care. In the future, it is proposed to allow for state or regional level measures, as well as measures that compare the quality of care received by minority populations.

Evaluation

The US quality measurement system is fragmented and uncoordinated across levels of care and across public and private sectors. As is characteristic of the wider health system, current arrangements are driven by market forces and based on temporary compromises between powerful vested interests, as opposed to any agreed national policy.

Canada

There are currently several players in Canada's health information and quality system. Statistic Canada, the central census organisation, has played a significant role in reporting on the nation's health status and its determinants. There is also a number of provincial initiatives e.g. 'Report Cards' published by Ontario on the quality of services delivered in its health facilities.

One organisation, the Canadian Institute for Health Information, has been actively involved in the development of an integrated system with a national focus.

Canadian Institute for Health Information

The Canadian Institute for Health Information (CIHI) is an independent, national, not-for-profit organisation that aims to improve the quality of health services through the dissemination of health information. The organisation receives funding from both the federal and provincial governments.

CIHI's mandate is:

- to co-ordinate the development and maintenance of a comprehensive and integrated approach to health information for Canada
- to provide and co-ordinate the provision of accurate and timely data and information required for:
  - establishing sound health policy
  - effectively managing the Canadian health system
  - generating public awareness about factors affecting good health.

The CIHI currently publishes an annual survey that compares the quality of services by geographic zone. The Partnership for Information Standards is a CIHI initiative that began in 1996 to develop and build consensus on national standards for health information. The goal of the Partnership is to leverage current provincial, national and international activities to contribute to the adoption and tailoring of existing standards for the Canadian health system.

Accountability

The CIHI board consists of 15 members drawn from the various health sectors and regions of Canada. It links federal, provincial and territorial governments with non-government health-related groups. The Board provides strategic guidance to CIHI and the Health Statistics Division of Statistics Canada, as well as advice to the Conference of Deputy Ministers of Health and the Chief Statistician of Canada on health information matters.

The Canadian Council on Health Services Accreditation

The CCHSA promotes excellence in the provision of quality health care and encourages the efficient use of resources in health organisations for the benefit of Canadians. Participation in the scheme is voluntary.

Evaluation

Leadership by a single organisation supported by the federal and regional governments is a positive step towards the development of an integrated quality system. The board composition and independence of the CIHI could, amongst other things, enable the organisation to make objective decisions about the development of the system.

Sweden

Quality registers

Quality registers were created by medical professionals to support local quality improvement activities in Swedish hospitals. Today there are 40 registers, which serve as internal benchmarks for clinical services. The registers are managed by a network of managers in county councils and clinical departments throughout Sweden. Generally, the registers have undergone a gradual transition from serving local interests to becoming national in scope.

The registers have advanced from focusing mainly on interventions related to hospital services to focusing on several of the major public health diseases, e.g. stroke and diabetes. These registers now include data from hospital services and other types of health care services, e.g. primary care.

Since 1990, funds have been allocated annually under the Dagmar Agreement between the Swedish government and county councils. New statutes and rules regarding the establishment of quality registers were introduced in 1997.

Accountability

Since 1997, quality registers have been overseen by the National Board of Health and Welfare. It collaborates with the Federation of County Councils and the Swedish Society of Medicine to enhance the development of registers and support the establishment of a national database. Activities at the national level are co-ordinated by a Steering Committee of representatives from the three bodies.

Other initiatives from the National Board of Health and Welfare:

In 1996, the National Board of Health and Welfare began developing national guidelines to enhance patients' opportunities for receiving equitable, evidence-based care throughout the country. A medical information database is also under development.

Swedish Health Services Quality Award

At national level, the Federation of County Councils has introduced the Swedish Health Services Quality Award, which is presented to an organisation considered exemplary within the Swedish health care system.

Evaluation

Low compliance has been reported by some registers e.g. Vascular Surgery (Karlstrom, 2001). This particular situation was attributed to the sheer number of forms and registries that clinicians are required to complete and duplicate. A computer-based system designed for vascular surgery is currently being constructed to address these issues. The proposed model will serve as both a medical record and a vascular registry, avoiding duplication.

While registers are required to produce annual reports, there is some resistance for increased openness about performance of specific healthcare organisations. *"Professional societies must be given the opportunity to develop methods to interpret, discuss, and present the data from quality registers in appropriate ways. It is from this platform that the national quality registers (at a pace adapted for each particular register) can take necessary steps toward greater openness" (Lagersten and Andersson 2001)*

There have been clear attempts by the central government to create a national focus for the development of this quality initiative in Sweden. The collaborative approach towards developing a national system incorporating changes in health care delivery systems is a positive step in the right direction. However, the issues highlighted above reveal that there are structural and procedural barriers in the current arrangements, which will have to be overcome if the quality needs of a modern health system are to be achieved.

United Kingdom

Over the past five years, the NHS has introduced a new centralised regime for quality and performance improvement. It has taken a three-pronged approach by introducing:

- performance frameworks and guidelines
- incentives
- methods of supporting behavioural change.

Performance frameworks and guidelines

Performance assessment framework

This is the key tool for monitoring performance in the NHS. Targets for strategy outcomes are expressed in terms of the elements defined within the framework. These targets are also reflected in a Delivery Contract with the Prime Minister's office and in a Public Service Agreement with the Treasury. Clinical targets are based on National Service Frameworks (see below).

Clinical governance

This is a framework for the quality assurance of clinical performance. Clinical governance is a 'whole-system' process and includes all disciplines involved in patient care (medical, nursing, clinical support, professional and management). It has a number of features:

- Patient centred care — this means that patients are kept well informed and are given the opportunity to participate in their care.
- Good information about the quality of services is available to those providing the services as well as to the patients and the public.
- Variations in the process, outcomes and access to health care are greatly reduced.
- Risks and hazards to patients are reduced to as low a level as possible, creating a safety culture throughout the health service.

The NHS in the UK has developed a range of structural and policy provisions specifically to underpin the clinical governance agenda. A 'duty of quality' for all NHS organisations was put in place under the 1999 NHS Act. This introduced corporate accountability for clinical quality on the same basis as more traditional measures of performance.

National Institute for Clinical Excellence (NICE)

NICE is a special health authority that provides current best practice guidance on the:

- use of new and existing health technologies, such as medicines, medical devices and procedures (this type of guidance is referred to as a technology appraisal)
- management and care of specific conditions
- use of new surgical procedures.

New independent inspection organisations

A proposed new Commission for Social Care Inspection will merge the Social Services Inspectorate with the care home regulation functions of the recently established National Care Standards Commission (NCSC).

A parallel Commission for Health Care Audit and Inspection will merge the private and voluntary healthcare regulatory functions of the NCSC with the Commission for Health Improvement and the Audit Commission's work on value for money in the NHS. The body is expected to resemble Ofsted, the education watchdog, in that its chief executive officer will be able to comment critically on government policy if it is deemed not to be working to the benefit of service users.

Incentives

A variety of incentives have been developed to reward high performing NHS organisations. These include:

- The NHS Performance Fund — provides resource to fund locally developed and designed incentive schemes aimed at supporting implementation of the NHS Plan
- Performance ratings
- Potential to earn autonomy from Whitehall control
- Contracts aligned to the achievement of national objectives and encouraging greater commitment to the NHS.

Supporting behavioural change

The NHS Modernisation Agency was established to disseminate best practice and develop leadership in the NHS. The agency has a dual role a) to co-ordinate work to modernise services to meet the needs and convenience of patients and b) to co-ordinate management and leadership development to foster leadership talent at all levels within the health service

Evaluation

These new arrangements represent not only a broadening of the measurement of performance but also the introduction of new institutions and new incentives for influencing performance. It remains to be seen to what extent these new arrangements — which will be accompanied by an increase of about one-third in real spending on the NHS over the next five years — will affect measured performance in the NHS.

Australia

Performance measurement activity at the national level

The Commonwealth and state governments, professional boards and associations share responsibility for regulation and quality assurance in the Australian health system. Measurement and assessment of performance has been conducted in Australia through the work of several governmental bodies and projects, and include:

- Australian Institute of Health and Welfare (AIHW) and its work on the National Health Priority Areas
- National Health Ministers' Benchmarking Working Group (NHMBWG) in collaboration with the Steering Committee for the Review of Commonwealth/State Service and the recently established National Health Performance Committee
- Australian Health Care Agreements and the Public Health Outcome Funding Agreements and the work to develop performance indicators for monitoring the major funding agreements between the Commonwealth and States and Territories.

Australian Council of Health Care Standards

Accreditation and quality control of hospitals and other health facilities is provided by the Australian Council on Health Care Standards. The AHCH initially focussed on standards of physical facilities and some administrative processes. It has recently started to focus on clinical outcomes as well as structure and process for the assessment of quality. As in many other jurisdictions, accreditation is not mandatory.

The Australian Council of Health Care Standards in conjunction with Medical Colleges and special societies has undertaken the joint development of clinical indicators (18 sets of indicators have been developed to date) designed for reporting through the accreditation process. There are also a number of privately owned accreditation organisations in Australia.

Performance measurement activity at the sub-national level

The National Institute of Clinical Studies

The National Institute of Clinical Studies was established in 2000 to act as a national focus for the collection and dissemination of strategies which achieve best practice clinical care by:

- Initiating and supporting activities which provide a better understanding of successful approaches to translate evidence into clinical practice
- Integrating the routine uptake of evidence into systems established to improve quality and accountability
- Facilitating cultural and attitudinal change in clinical practices.

The Institute works in partnership with a variety of groups including national health priority bodies, clinicians, consumers, universities and the private health sector to develop and disseminate best practice. The Institute is a Commonwealth owned company limited by guarantee and governed by a Board of Directors. The Board is accountable to the Commonwealth of Australia.

State level activity

Several States and Territories have been exploring the development of their own performance measurement systems to meet management and program reporting requirements. They are often developed in response to reporting needs in the budget process at federal level.

Victoria

The Department of Human Services in Victoria is developing an annual Hospital Comparative Data report to incorporate the concept of quality in the following areas: access to care, acceptability of care, appropriateness of care, effectiveness and safety of care provided, continuity of care, and organisational effectiveness of care.

The Department has aligned some of the indicators developed in relation to access to care and continuity of care with bonuses for high performing hospitals.

Evaluation

The major deficiency is the lack of a national focus for quality measurement remain despite a number of good initiatives.

Conclusion

The institutions of ‘external’ performance management differ widely among countries. The optimal role for external scrutiny is not yet well defined. Initiatives to steer the development of a national approach are at various stages of development across the spectrum, each with unique structural and professional challenges to overcome.

D Quality and Professional Regulation

Professional Regulation

As part of the drive for quality, a number of countries are reviewing their arrangements for the regulation of medical, nursing and other healthcare professionals. Systems of regulation across the globe involve the licensing of healthcare professionals either by government departments or agencies, independent authorities or professional bodies. These systems generally require close relationships between education standards, their attainment and professional behaviour.

The medical profession

A central component of the welfare state is the triangular relationship that has historically existed among medical profession, the general public and the State. The continued decline in public trust in the profession and increasingly assertive demands for quality health care have introduced new tensions in this relationship which the state is under pressure to address.

Within the E.U., national systems of regulation and recognition of professional qualifications must give due weight to qualifications obtained in other member states. Whilst regulatory bodies (i.e. the licensing body) sets standards, they are not generally providers of education and training. This is provided by universities and other professional bodies.

Salter (2000) has proposed an 'ideal', politically sustainable model of medical regulation.

Externally, it would:

- establish a common discourse
- fulfil the basic requirements of public accountability
- be credible to the public.

Internally, the model would

- have a statutory basis
- exhibit the system characteristic of logic, coherence and non-duplication
- encompass the full range of functions and activities
- demonstrate a single line of accountability through the governance functions of standard setting, evaluation and intervention for each activity area
- ensure mutuality between twin regulatory powers of certification and registration
- arrange the competing power interests into an explicit hierarchy with the capacity to manage change
- involve the public.

Drivers for unification, or at least the 'umbrella-ing', of health professionals under a single or much reduced number of regulatory bodies include:

- move towards closer multi-disciplinary-based delivery of health services
- perceptions of double standards — for instance, where a health professional in one grouping may be removed from a register for a breach of standards, whereas a professional belonging to another body may only be cautioned for a similar behaviour

- cost.
- The focus of the measures highlighted below is to increase quality assurance mechanisms within the health sector and to ensure the highest possible standards of professional conduct within the medical and healthcare professions.

There follows an outline of approaches to the regulation of professional groups in selected countries, with emphasis on recent proposals and developments in the UK.

Canada

Ontario is the most advanced Province in Canada with regard to the regulation of medical and healthcare professionals. Under the Regulated Health Professions Act, all 23 healthcare professions were brought under one umbrella body, the Office of Health Regulation. Reviews to date have illustrated the success of this structure in achieving high standards of quality assurance and professional conduct within the health services.

United Kingdom

The Department of Health has set out some key characteristics which should be inherent in any regulatory body. At a minimum, they must:

- be smaller, with much greater patient and public representation
- have faster, more transparent procedures
- develop meaningful accountability to the public and the health service

The Department is currently consulting on changes that include increased powers of the state to regulate medical and other health professionals.

The National Clinical Assessment Authority

Following a series of medical malpractice scandals, the government established the National Clinical Assessment Authority to support PCTs, trusts and other bodies to address concerns about individual doctors. It has the power to make rapid assessments and recommendations for future action, ranging from the complete discharge of a charged practitioner to referral to the GMC with a view to having the individual immediately struck off.

Council of Health Regulators

The Kennedy Report (2001) into the Bristol scandal called for the creation of an overarching regulatory body for health professionals although it was first mooted in the NHS plan.
The NHS Plan recognised the need for more formal co-operation among health regulatory bodies and announced the government's intention to establish a UK Council of Health Regulators. Initially, this body will act as a cross-profession forum, to develop strategies for dealing with issues such as complaints against practitioners.

The Department of Health says the new council will work with the regulatory bodies to build and manage a system of self regulation that:

- explicitly puts patients' interests first
- is open and transparent and allows for robust public scrutiny
- ensures that the existing regulatory bodies act in a more consistent manner

- provides for greater integration and co-ordination between the regulatory bodies and the sharing of good practice and information
- requires the regulatory bodies to conform to principles of good regulation
- promotes continuous improvement through the setting of new performance targets and monitoring.

These proposals have been welcomed by patient and consumer groups. *"The Consumers' Association has been lobbying long and loud for major reform of the regulation system for health professionals. . . . We are pleased this body will be working to ensure greater cohesion and accountability for the current eight professional bodies, and that the new council will hold these bodies accountable for their performance"*, Clara Mackay, principal policy adviser, Consumers' Association.

Health Professions Council

The new Health Professions Council (HPC) has replaced the Council for Professions Supplementary to Medicine and its 12 boards, which currently regulates 120,000 practitioners, including physiotherapists and Medical Laboratory Scientific Officers.

The organisation is presently conducting a consultation on its central aims. These are:

- To reform ways of working, by requiring the Council to: treat the health and welfare of patients as paramount, collaborate with and consult key stakeholders, be open and pro-active in accounting to the public and the professions for its work; and
- to reform structure and functions, by: giving wider powers to deal effectively with individuals who pose unacceptable risks to patients; creating a smaller Council, comprising directly elected practitioners and a strong lay input, charged with strategic responsibility for setting and monitoring standards of professional training, performance and conduct; linking registration with evidence of continuing professional development; providing stronger protection of professional titles; enabling the extension of regulation to new groups.

The extension of regulation to new groups is important. Groups awaiting new statutory regulation include support workers, operating department practitioners, clinical perfusionists, practitioners of complementary and alternative medicines and psychotherapists.

Clinical governance

A system of clinical governance has been introduced and largely embraced by medical professionals.

Conclusion

The structural and procedural proposals and reforms in the UK are grounded in the need to underscore the quality of care to patients. The recent wave of reforms were introduced after continued dissatisfaction with the General Medical Council, and in response to serious medical malpractice such as the Kennedy Report and the Shipman enquiry.

Strengthening the self-regulation of health professionals through the establishment of a overarching regulatory body that ensures collaboration and consistency across the professional groupings in terms of standards and continued development is a step forward.

Amid concerns from some parties about increasing control from the centre, there will be structural and professional barriers to strike a balance that is in the best interest of patient and acceptable to all stakeholders.

E Governance and Best Practice in the Public Sector

This section provides a review of best practice governance principles that are applicable to the public sector. It also provides an overview of compliance-based governance and Board arrangements that exist in health organisations in a selection of countries.

Principles of effective governance

Effective governance is essential for building stakeholder confidence in both private and public sector organisations. It is particularly critical for public sector organisations — who cannot meet their objectives without the confidence of their stakeholders.

It is widely accepted, and our research has confirmed, that there is no single model of good governance that can be applied across organisations. There are, however, a collection of core principles on which public sector governance frameworks can be based. These core principles are listed below:

- openness, integrity, accountability
- integrated whole-of-government framework
- clarity in roles and responsibility — Boards, Ministers.

These principles are described in the sections that follow. A description of the current governance structures in the NHS is also provided, as well as an example of award winning innovative practice in Governance in the Canadian public sector.

Openness, integrity, accountability

One of the simplest and yet most compelling descriptions of the quintessential qualities of governance was made 10 years ago in the UK Report of the Committee on the Financial Aspects of Corporate Governance (Cadbury Report, 1992). It identified three key principles of corporate governance:

- openness
- integrity
- accountability.

These three principles can provide a basis for testing governance processes. They clearly identify that a culture of openness and integrity must exist at all levels in a public sector organisation if effective governance and accountability is to be achieved. With regard to the accountability principle, it is the thinking, not just the systems, which need to be emphasised if accountability is to be achieved.

The OECD (2001) has identified the key principles of accountability in the public sector:

"The principles of accountability in public sector organisations should serve the general principles of good governance. In particular organisations should:

- Have a clear and credible set of objectives laid down in their founding instruments
- Have clear published annual objectives for their financial and non-financial performance, contribution to the government's priorities, and standards of management

- Be required to account to the government and the general public for their use of public resources against the normal public criteria of economy, efficiency, effectiveness and due process
- Disclose all information necessary to assure the government and the general public of due propriety in their operations such as the remuneration of board members and senior executives and codes of practice and other processes in place to ensure proper behaviour by management and staff
- Disclose any circumstance or event which is material to an assessment of the risk that they will not achieve their objectives or will affect the government's overall performance adversely
- Ensure that they make information about their operations available to all stakeholders, have clearly understood processes for communication with stakeholders and to enable stakeholders to enforce their rights with respect to the organisation.''

Integrated whole of government framework

True effective governance cannot be achieved without recognition of the integrated nature of public sector organisations. An integrated whole-of-government framework is required that recognises the interdependent nature of government agencies in delivering services to the community. Performance reporting must also address the issue of so-called ''integrated governance'' if it is to reinforce good governance practices.

Clarity of roles and responsibilities

Effective governance requires clarity in the roles and responsibilities of governing bodies and positions. While the need for this clarity is widely recognised and accepted as critical for effective governance, it can be very difficult to create or maintain, particularly in public sector organisations.

In the private sector, corporate governance is largely seen as being about the proper functioning of boards — in a very general sense it describes the process of determining which of the key players involved in a company is responsible for what and to whom.

However in the public sector, corporate governance takes on much wider dimensions. *'Organisational governance in the public sector refers to the control of public organisations so that they achieve the purposes for which they have been established and that their activities conform to the general principles of good governance.'* (OECD 2001). It is about how Parliament, the Government, boards, and management relate to one another in stewardship matters.

The Board: role, responsibilities, appointment, remuneration and liability

Observations cited by Sendt (2001) on public sector governance in New South Wales, Australia will be used to illustrate the importance of clarity in defining the role and responsibilities of a board.

Public sector organisations in New South Wales (NSW) are managed using a variety of arrangements often including boards and committees, some of which can be created by statute. In adopting this governing structure, the NSW Parliament distinguishes these bodies from Government departments — with the presumed intention that, in exercising their duties and powers, these statutory bodies should not be subject to day-to-day oversight by Government.

However the Audit office, in NSW, Australia has concluded that most of the public sector corporate governance models, to a greater or lesser extent, create confusion and tensions in the roles, responsibilities and decision-making powers of the board, the Minister and the CEO. These tensions were also noted in a recent RSA report on corporate governance in the public and voluntary sectors in the UK (Fitzgerald 2001).

Often these tensions reflect the fact that most governance models do not provide boards with sufficient powers to match their responsibilities. The effect is that many boards have become high level, advisory management committees rather than true governing boards.

In NSW, the Audit office noted a number of unsatisfactory situations emerging, such as:

- Boards and the Minister becoming embroiled in power struggles
- The CEO reporting to, and being given directions by, both the Board and the Minster. In these circumstances, directions were often in conflict
- Ministers seeking to give directions to Boards when they did not have the legal authority to do so
- Ministers tending not to put directions in writing, when there was a legal requirement to do so
- Boards failing to establish an effective value-adding role.
- In many cases, the boards may not have been established with intent to be a ''governing'' board. The status of many boards, and hence their role and powers, are quite unclear, bringing with it many problems.

Good governance is then supported by unambiguous relationships based on clear articulation of and division of responsibilities. It also requires that those charged with responsibilities have the powers necessary to carry them out.

Sendt (2001) proposed four principles that should be employed to achieve more effective governance where boards are used in the public sector:

- there should be a consistency of approach for governing boards, in terms of the functions of the board, the role of the Government, regardless of the nature, size, assets or income of the organisation being governed
- roles of Ministers and boards should be clear and separate
- roles, powers, responsibilities and accountabilities of the Government and its Ministers and boards should be defined in legislation. Legislation should provide boards with sufficient authority to carry out their governance responsibilities
- an objective mechanism should be used to oversee/manage all board appointments according to agreed selection criteria.

The IFAC (2001) has also published a study that recommended governance principles that are gradually assuming the status of a standard. The IFAC study accepts the three basic Cadbury Report principles but redefines them to reflect contemporary views. It also examines these from a number of contexts: standards of behaviour; organisational structures and processes; control; and external reporting.

Current governance initiatives in the UK NHS

The Audit Commission in the UK has defined corporate governance in healthcare as 'the systems and processes by which health bodies lead, direct and control their functions to achieve organisational objectives, and by which they relate to their partners and to the wider community'.

The governance arrangements for the NHS have recently been reviewed and an overarching framework developed to incorporate the requirements of the emerging organisations such as Primary Care Trusts and the Strategic Health Authorities.

From 2003, HM Treasury will require all government departments to meet the following principle of good corporate governance outlined in the Combined Code of the Committee on Corporate Governance and the Turnbull guidance on internal control:

''the directors should, at least annually, conduct a review of the [organisation's] system of internal control and should report to [stakeholders] that they have done so. The review should cover all controls, including financial, operational and compliance controls and risk management.''

The Statement on Internal Control (SIC) recommended by the Turnbull Committee report (1999) has been adapted to the public sector and is a statutory requirement for the Department of Health. For the Department of Health Accounting officer to sign such a statement, all NHS bodies must provide assurances that they have effective systems of internal control.

Of key importance is the planned 'convergence' of the controls assurance and clinical governance streams. Guidance for directors, issued in November 1999, introduced the concept of 'convergence' between the controls assurance and clinical governance agendas. Controls assurance has historically been concerned with financial and organisational control matters. Clinical governance is concerned with improving quality — a key objective for NHS organisations. Both agendas are complementary. Taken together, and properly considered, they will enable boards to say with some degree of confidence whether effective systems of internal control, including risk management, are in place.

The following are key indicators of 'convergence':

- the organisation adopts a holistic approach to internal control through a common system that accords with the framework model issued by the Department of Health and is underpinned with credible, enabling, workable and, where appropriate, clinically owned standards
- all staff know the objectives of the organisation, and of the relevant department, directorate or function.

The Turnbull Report (1999) states that a sound system of internal control ''depends on a thorough and regular evaluation of the nature and extent of the risks to which the company is exposed''. It further states that the purpose of internal control ''is to help manage and control risk rather than to eliminate it''.

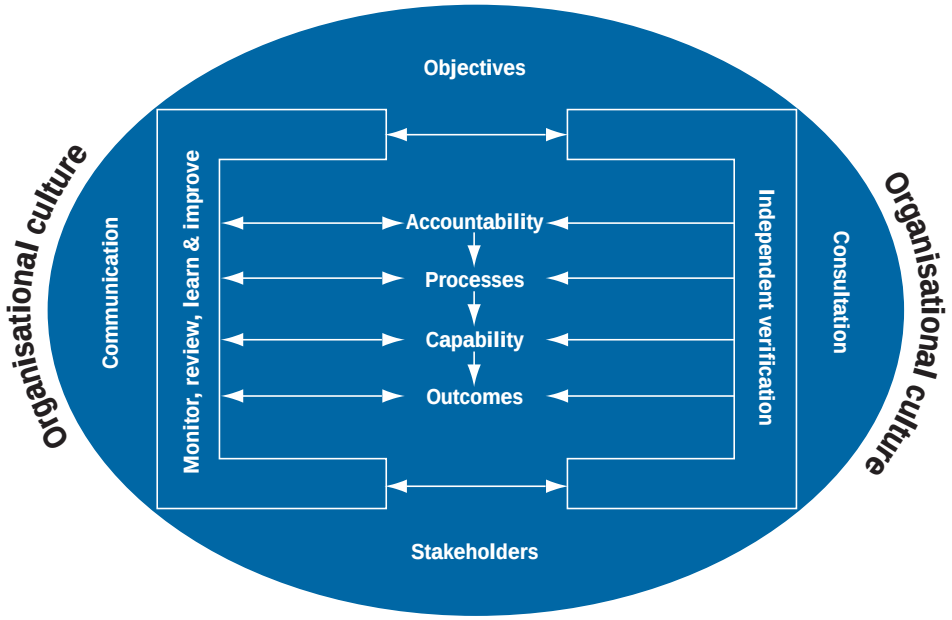
The SIC should therefore be the end result of a process of management that is embedded in the planning, operational, monitoring and review activities of the body, these activities being the critical elements of the statement. Production of the SIC should not be conducted as an ''add-on'' end of year activity.

Three crucial aspects of good governance in NHS were identified and are listed below:

- frameworks of accountability
- introduction of Audit Committees
- the controls assurance project — the practicality of rationalising and completing the control framework, integrating functions and involving people widely in the process.
- The NHS has defined key criteria and guidance (introductory at the time of writing) to assist boards of NHS organisations to determine the integrity of their systems of governance and internal control. The framework for developing controls assurance is outlined below:

The NHS has defined key criteria and guidance (introductory at the time of writing) to assist boards of NHS organisations to determine the integrity of their systems of governance and internal control. The framework for developing controls assurance is outlined below:

Figure 13: Framework for development of internal controls assurance



A Governance standard has been prepared which provides guidance on implementing a holistic board-level approach to good governance and internal control, including risk management. The Governance Standard is a high level overarching core controls assurance standard and is supported by two additional core standards covering financial management and risk management. The risk management criteria match the requirements of the individual NHS Litigation Authority Risk Management standards.

Table 1: The NHS Governance Standard

The 7 key criteria of the Governance Standard are outlined below:

Criteria	Requirement	The desired outcomes or results for any area of activity can be obtained by:
1. Accountability	There are clear accountability arrangements in place throughout the organisation	Establishing an appropriate accountability framework within which the internal control system operates and which encompasses management structures and practices (leadership, committees, reporting arrangements, policies and strategies etc)
2 and 3. Processes	The Board identifies the needs of its stakeholders on an ongoing basis and determines: • a set of key objectives and outcomes for meeting these needs, including how it meets its duty of quality • The Board ensures that there are proper processes in place to meet the organisation's objectives and secure delivery of outcomes	Ensuring that the core and supporting processes required to produce the desired outcomes are in place — this includes a risk management process which is required to ensure that all risks which could potentially threaten the ability of the organisation to meet any or all of its objectives are systematically identified, assessed and treated
4. Capability	The organisation is capable of meeting its objectives and delivering appropriate outcomes	Having the necessary capability (leadership, knowledgeable and skilled staff, and adequate financial and physical resources) to ensure the processes and internal controls work effectively
5. Monitor, Review, Learn	The organisation learns and improves its performance through continuous monitoring and review of the systems and processes in place for meeting its objectives and delivering appropriate outcomes	Management and the board continuously monitor and review the system of internal control to ensure that it is working properly and to learn and, where necessary, improve the accountability arrangements, processes or capability in order to deliver better outcomes
6. Independent Assurance	The Board ensures that there are proper and independent assurances given on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes	Ensuring proper communication and consultation at all levels within the organisation and with external stakeholders; the board obtaining sufficient independent and objective assurance as to the robustness of its processes in key areas
7. Outcomes	The Board can demonstrate that it has done its reasonable best to achieve its objectives and outcomes, including maintenance of a sound and effective system of internal control	

Board arrangements in health organisations of a selection of countries

Governance arrangements of a selection of health organisations are outlined in Table 5 of this document. It can be seen that practice varies significantly. In the new arrangements in New Zealand, community consultation is an integral part of the strategic planning process. Here, the board is required to elect 7 of the 11 board members from the local community. The UK, New Zealand and a number of Canadian Provinces (including British Columbia) has centralised, standardised appointment systems in order to promote transparency and accountability.

Current governance initiatives in the Canadian public sector

The Conference Board of Canada is an independent, not-for-profit, applied research organisation that aims to support leadership development. It presents an annual award to organisations in the private, public and voluntary sectors for innovative governance practice. Governance practices of one recipient in the public sector are highlighted below.

The Canada Pension Plan Investment Board

The Canada Pension Plan Investment Board was created by the federal and provincial governments in 1997 to invest surplus pension funds in capital markets. By last September, the board had invested some $12 billion. Its assets are expected to exceed $130 billion within 10 years.

The governance model adopted by the federal and provincial finance ministers requires the board's directors to have sufficient financial experience and expertise to ensure that management has effective strategies and policies in place to maximise returns on investments without undue risk of loss. Selection criteria for board candidates are set out in writing. A nominating committee, with members drawn from the public and private sectors from across Canada, prepares a list of suitable candidates. The federal finance minister, in consultation with the Provinces, appoints board members from this list.

Federal legislation assigns to the board's directors the authority to hire and fire the organisation's president and CEO. Procedures are in place to evaluate the president and the board of directors, as well as the board's chair and committees.

In 2001, the World Bank showcased the board's governance structure and procedures as a global best practice in public pension fund management. The Conference Board of Canada lauded the board's nomination process and selection criteria, citing them as examples for other public sector organisations to follow.

''These awards allow us to recognise boards who have broken the mould and developed bold, innovative solutions to governance challenges,'' says awards program co-chair Andrew MacDougall, President of Spencer Stuart Canada. ''By drawing attention to these approaches, it is our hope these awards will help contribute to excellence among other Canadian boards of directors.''

This approach is innovative in the Canadian public sector, where board members are typically selected based on political, geographic, cultural and gender considerations — with little meaningful consultation with the board or corporation.

Conclusion

Many different frameworks and models have been devised. None are perfect. What is important in the design of models and processes for governance are the underlying principles.

These principles have been articulated by a number of voices including the OECD, Cadbury Report and more recently the IFAC. Clearly defined roles, responsibilities and powers, supported by appropriate legislation are the foundations of effective board performance. The establishment of a centralised organisation for managing the appointment of boards is a growing trend in the public health sector. The UK NHS and some Canadian Provinces have adopted this approach.

An integrated whole-of-government framework recognising the inter-relationships with other government bodies is an ideal to strive for. Indeed, with the increasing involvement of the private sector in service provision, it is necessary to extend this consideration to external partners.

F Involvement of citizens in the development of patient-centred health services

This section provides an insight into the various models of citizen participation in the governance of health services.

United Kingdom

The NHS Plan is proposing significant changes to the current arrangements, with the introduction of new models of advocacy and patients' forums. The key organisations within this model are described below.

Commission for Patient and Public Involvement in Health

The Commission for Patient and Public Involvement in Health is due to be established in 2003. This organisation will provide advice and training material to patients' forums as well as setting standards. It will also ensure that local people will have a say in decisions concerning their health service.
It is also responsible for reporting to the Government on how the system of patient and public involvement in the NHS is working.

National co-ordination

There is a lack of provision in the NHS Plan for a national overview of patient representation and involvement. No single body will be responsible for identifying national patient concerns, and representing these concerns to both the Department of Health and other national bodies.

There is a clear requirement for a national body to take on a range of functions including: training of staff and volunteers, exchange of best practice, establishing performance standards, the provision of expert advice, legal services, human resources, and research and publications.

"There is a strong case for a national network of organisations to promote the public interest in health care . . . ACHCEW [Association of Community Health Councils] has been effective in raising important points of concerns about the standard of care provided by the NHS. Other national organisations may not have the same independence of central government, or, therefore, contribute in the same way to the accountability of the NHS."

Sir Donald Irvine CBE — President, General Medical Council

Patient Advocacy and Liaison Service (PALS)

Under the 2000 NHS Plan from April 2002 all hospital trusts, GP practices or frontline community health services established a Patient Advocacy and Liaison Service (PALS). The objective is to provide a forum to patients, their families and carers for the resolution of problems or to express dissatisfaction with treatment, care or support they are receiving. They have the authority to assist by providing patients with access to the Trust's chief executive and the power to negotiate an immediate solution. PALS will also feed patients' complaints back into the system to ensure that the right lessons are learnt and steps taken to ensure problems are tackled. It arose from the number of complaints being made about all aspects of health care. In particular it was felt that a large proportion of what became "formal" complaints could and should have been more easily resolved. It is important to emphasise that it does not replace formal complaints mechanisms, but rather work within the existing structures. A number of Patient Liaison Services were launched in 2002 on a trial basis to do the following:

- Build on existing customer service arrangements and information sources by a visible and accessible support service to patients/relatives/carers who have any issues or concerns about current health service provisions. This may include hospitals clinics, health clinics or services provided by a GP, dentist, optometrist or pharmacist.

- Help resolve patient/relative/carers concerns quickly and efficiently and improve the outcome of the care process — linked into clinical governance systems.
- Identify service gaps within an area and represent client views at Local Health Groups and NHS Trust Levels to develop appropriate local services.
- Act as a gateway to enable patients and public to become involved in opportunities for public involvement in the NHS.

Patients' Forum

To provide patients with a further voice, there are also plans for patients' forums to be set up in every NHS trust and Primary Care Trusts. These will be made up of local people, their main role being to provide input from patients on how local NHS services are run and could be improved. Each patients' forum will have a representative on the Trust Board.

Patients Charter and Designed to Care (Scotland)

As regards patient consultation in Scotland, the Patients Charter and the Designed to Care initiatives were introduced to address this objective. Designed to Care is an initiative which was specifically aimed at creating a partnership between patients and the health professionals who care for them by giving a bigger say in both the design and management of the NHS in Scotland.

A Code of Practice on Openness in NHS Scotland (1995) predates the Designed to Care Programme. This was produced by the Management Executive in May 1995 and sets out the basic principles underlying public access to NHS information in Scotland. In terms of consultation, this provides that Health Boards must consult the Local Health Council and other interested parties on any plans to change the service which they purchase or plan for their residents.

Local Health Councils are in turn responsible for representing the interests of the public in the health services in the districts for which it has been established. Each Health Council may keep under review the operation of the health service in its district and make recommendations for the improvement of such service or otherwise advise the relevant Health Board.

1990 role of health council regulation

Each health board must also consult with each council in its area when preparing its strategic plans, when planning any substantial developments or variations in any aspect of its services or any other matter it deems appropriate. Health councils may also be requested by health boards or Scottish Ministers to consider any other health issue and submit reports in relation to this.

Canada

Capital Health Authority 2001

The Capital Health Authority engaged with stakeholder groups as a part of the development of its strategic objectives. To achieve this, Capital Health formed seven geographically based community health councils, each with a membership of 80 volunteers.

A consultation session was held with the seven Councils, where participants were asked for feedback on the newly developed Core Business Framework and strategic goals, and specific outcomes that they would expect.

Following consultation, each CHC was asked to focus on a single core business. Councils were asked to report back on the three most important areas of information required by communities, to identify how they would see obtaining access to this information, and to identify resources within their communities that could help Capital Health in providing health information to the public.

The next stage brought together 100 stakeholders, including representatives from the medical community, other regional health authorities, unions, business and industry were brought together to discuss the plans. This was followed by focus groups with a broad cross section of staff. These councils continue to provide a valuable and direct link between the Capital Health Board and the communities it serves.

G Improving operational efficiency: shared services and centralised procurement

This section provides an analysis of the existing trends in the development of Shared Service initiatives across industry sectors, including the healthcare sector. The analysis focuses on the overall business model for Shared Service Centres and examines in particular the recently introduced National Shared Services Initiative within the UK health sector. Centralised procurement is another means of improving efficiency. This section also provides information on the NHS Purchasing and Supply Agency.

Shared services in the UK

The UK National Shared Services Initiative is intended to foster standardised, non-clinical national systems and processes, to improve service efficiency and quality. Similar shared service initiatives are underway in Victoria, Australia and a number of Canadian provincial healthcare systems.

More generally, the establishment of Shared Service centres for back office operations is quite commonplace with 2002 research by Bywater and the Shared Services Network revealing that as many as 93% of Fortune and European 500 companies are either developing or implementing a Shared service strategy.

Table 2: Top ten services

The top ten services generally provided from Shared service centres are:	
Accounts payable	Fixed assets
Accounts receivable	Cash management and treasury
Travel expenses	Compensation and benefits
General ledger and consolidation	Credit and collection
Payroll	Financial analysis and reporting

Source: AnderseN/Akris.com Shared services report 2001

Within the UK, the National Shared Services initiative forms part of the modernisation agenda and involves three main project streams. These are as follows:

- The Shared Services Development Project which is to manage the financial system across all NHS Agencies from between eight and 28 regional StHA service centres. Personnel within the financial shared services will remain

under NHS contracts of employment and will work in highly customer-focused environments. Each centre being tied into providing a high service quality through Service Level Agreements.

- The second stream of the national initiative is an Electronic Staff Record Project which will integrate and centralise HR and payroll for all NHS staff in a single system. This has been contracted out to a consortium led by McKesson Information Solutions who will provide the system for the next 10 years at a cost of £325 million. It is expected that this integrated system will save around £400 million over the same period.
- The third stream is an integrated NHS procurement and financing system to realise savings through the streamlining of purchasing and supplies. This will be operated through a PFI agreement.

Generally, the business case for Shared service centres includes:

- eliminating duplicate activities across different departments and sites
- creating economies of scale and the achievement of subsequent reductions in headcount, with estimated cost reductions in the region of 30-40% if implemented effectively
- ensuring the greater leverage of technology, management and specialist resources
- standardising processes and practices
- co-ordinating processes and apply best practice to improve the quality and overall consistency of services provided.

Within the UK model, initial estimates reveal that the NHS aims to achieve cost savings of £180 million per year through the Financial Shared Services Initiative alone. As stated above, the estimated net cost savings from the Electronic Staff Record Project is £75 million over the next ten years. It is the third stream of the UK National Shared Services Initiative which is expected to yield the greatest cost savings of £300 million per year.

Table 3: Risks involved in the model

Greatest risks involved in setting up a shared services centre include:
• Poor service quality
• Low support by employees, particularly during implementation phase due to perceived threat to their existing role
• Business disruption during implementation
• IT problems, and such centres are highly reliant on a good IT infrastructure
• High implementation costs

Governance of shared service initiatives in the UK

Guidance on good practice in the development of Shared Service Organisations has been issued by the NHS. Some of the issues around governance and accountability are outlined below:

Issues to be considered include:

Identity and accountability: The SSO is a service organisation, which if it is to function effectively, will require its own identity. Staff working within the SSO should identify themselves as part of an organisation providing a professional customer focused service. This shouldn't diminish the partner's accountability for the services provided by the SSO.

Corporacy and representation: Partner organisations have two roles. They have their own interests and accountabilities that they must consider from a self-interested perspective. They also must contribute to the health of the SSO as a corporate member. Separation of these roles may help manage that tension.

Accountability and partnership: The host organisation is statutorily accountable, but if this is exercised at an operational level it may prejudice trust in equity by the other partners. A balance between the role of the 'accountable' host is needed with the host's role as just one of the partners receiving services.

Boundaries and responsibilities: Clear and explicit definition of whom is responsible for what function is necessary. Losses or lack of control, arising from duplication or omission, may result if relative responsibilities are not well understood. Service Level Agreements (SLA) or underpinning procedures must define these in detail.

Commitment: A clear commitment to new arrangements is necessary if staff and partners are to make it succeed. The context of change suggests that in order to secure confidence and focus on performance, express commitment to these interim arrangements to carry them through until the national agenda is resolved should be given.

Multi-disciplinary approach: It is worth considering, particularly in single service organisations, engaging other disciplines in the governance structure to ensure broad perspective is maintained. This might be the involvement of other functional professionals or non-executive participation.

Expectations: Shared and reasonable expectations. Evidence is showing that expectations of absolute cost savings in the first year, without a major step change in technology and significant investment, are unrealistic. Most communities are sharing services to avoid the incremental cost of supporting new organisational configurations. This opportunity saving is possibly significant on its own. An expectation that immediate performance improvement can be achieved while managing services and people through change on this scale is probably optimistic.

NHS Purchasing and Supply Agency in the UK

The NHS Purchasing and Supply Agency is as a centre of expertise, knowledge and excellence in purchasing and supply matters for the health service. The agency contracts on a national basis for products and services which are strategically critical to the NHS. It also acts in cases where aggregated purchasing power will yield greater economic savings than those achieved by contracting on a local or regional basis.

Following an Audit Commission Review, it is currently undergoing a fundamental re-organisation of purchasing and supply throughout the NHS. This centres on the creation of a 'middle tier' of purchasing to bridge the gap between national (NHS PASA) and local (individual trust) level purchasing. It is recommended that the mechanism for achieving this will be inter-trust collaborative groups known as Supply Management Confederations. They will be formed on a geographical basis within (but not necessarily coterminous with) the Strategic Health Authority boundary.

Whilst there is no prescribed model as yet, Confederations will be expected to operate in accordance with agreed principles and to cover a number of functions.

Expected benefits include:

- purchasing savings and reduced costs through economies of scale and increased leverage
- development of centres of procurement excellence
- improved career prospects for supply professionals
- collective support and raised standards for poorer performing trusts.

H Key Data

Table 4: Population-based health decision-making organisations

	Organisational role & accountability	Size of population served
Canada Regional Health Authorities	• Whilst the specific role varies by RHA, overall they are responsible for the organisation, management and delivery of health services to the region under their remit • RHAs are accountable to the Minister for Health • Key deliverable is the Regional Health Plan	• Alberta: 17 RHAs serving a population of between 20,000 and 900,000 • Manitoba: 12 RHAs serving a population of between 7,000 and 650,000, with most serving populations of 30,000 to 50,000 • Prince Edward Island: 5 RHAs serving a population of between 15,000 and 40,000
New Zealand District Health Boards	• Responsible for the management and delivery of healthcare within allocated budget • Responsible for promoting the independence of people with disabilities • DHBs are accountable to the Minister for Health with a high degree of public accountability. E.g. public are entitled to attend DHB board meetings and District Strategic Plan is developed in consultation with public • Key deliverable is the District Strategic Plan which should have at least a five year and no more than 10 year focus	Size of population group varies by district — 21 districts, categorised into small, medium and large **7 large** • Auckland DHB serving a population of 369,700 • Canterbury serving a population of 434,000 **9 medium** • MidCentral DHB serving a population of 160,800 • Northland DHB serving a population of 144,400 **5 small** • Whanganui DHB serving a population of 67,500 • West Coast DHB serving a population of 32,500
Sweden County Council	• Responsible for managing the delivery of health and medical care and for promoting good health in the region — health management accounts for 80-85% of the Councils' total activities • More specifically, county councils are responsible for determining the allocation of resources to health services and for the overall planning of services offered i.e. the purchasers and providers of healthcare • County councils own and run the hospitals, health centres and other institutions • Where institutions are supplemented by private sector, county councils also manages the contract	• 20 county councils and one local authority (Gotland) also with responsibility for health care, serving populations of between 133,000 and 1.8 million • e.g. Stockholm county council covers the largest population group at 1.8 million
UK Strategic Health Authority	• Responsible for strategically developing the local health service and managing the performance of the PCTs, NHS Trusts and private providers • To come into effect in October 2002 and will essentially become the headquarters of NHS locally	• 28 SHAs formulated on a regional basis, based principally on the catchment area of the PCTs and Trust, each serving an average population of 1.5 million • E.g. Hampshire and Isle of Wight StHA serves a population of 1.8 million (covers 10 PCTs & 7 NHS Trusts)
UK Primary Care Trust	• Responsible for managing and planning healthcare services and improving health within locality and by 2004 will control 75% of NHS budget • Developing primary care services (including GPs and dentists)	• PCTs serve a population of approximately 100,000+ • E.g. Craven, Harrogate and Rural District PCT — 206,000 • East Yorkshire PCT — 145,000 • Eastern Hull PCT — 125,000

Table 5: Board arrangements in a selection of health organisations

	Appointment System	Composition	Time Commitment	Number	Remuneration per annum
Canada Regional Health Authority	Appointment system differs by region, in some regions the Board members are entirely appointed by the Minister, whereas in others two thirds are elected and one third is appointed	**Saskatchewan:** RHAs recently moved away from two thirds elected and one third appointed to full appointment **Alberta:** Moved to reverse: moved away from fully appointed to two thirds elected one third appointed		Board numbers vary by region **Saskatchewan** RHAs have 12 appointed board members **Alberta** RHAs have between nine and 15 board members	Board level remuneration and expenses authorised by the Minister for Health
New Zealand District Health Boards	Every three years, seven members are elected by the community Up to four additional members may be appointed by Minister for Health to each DHB Board: Purpose being to ensure each Board has appropriate mix of skills & knowledge and is representative of population Chair and Deputy Chair of each DHB Board is appointed by the Minister for Health	Each Board must have at least two Maori members, and preferably more if large proportion of Maori population within the DHB district	Board members are appointed for a term of a maximum three years, they may serve two three year terms and the Minister has the ability to extend a member's appointment to a third term Appointed members may serve concurrently on more than one DHB board Elected members may serve on one board at a time	Maximum of 11 members 7 elected by the DHB community and up to 4 appointed by Minister	Remuneration and terms and conditions of Board members are determined by the Minister for Health Examples: Small DHB 1999/2000 Whanganui DHB chair: $45,000 Board members $19-24,000 Large DHB 2000 Auckland Chair — $60,000 Board members $13,345 — $37,000

	Appointment System	Composition	Time Commitment	Number	Remuneration per annum
Sweden County Council	Varying aspects of healthcare are managed by a number of boards within County Councils: • County Council Assembly • Executive Committee • Health Care District Boards (to which county councillors are appointed) and; • Hospital Boards As regards Assembly and Health Care District Boards: Politicians are elected every four years in local elections Hospital Boards are appointed by the full county council	Composition of each county council varies and is made up of elected officials Political composition of Executive Committee is reflective of that of the overall County Council Hospital Boards are composed of combination of elected public officials and civil servants	County Council Assembly holds sessions twice every six months (may last few days) Executive committee members meet once a month	Number varies according to population within the council E.g. Varmland has a population of 275,000 and 81 Councillors 5 serve on its Sub Committee for Public Health (directs day to day responsibility for health care 17 serve on the Committee for Health and Public Care 11 councillors serve on the 5 District Health and Medical Committees	
UK Primary Care Trust	Appointment of Chair and Non Executive Directors is the responsibility of NHS Appointments Committee, in accordance with National Legislation Committee Since 1 April 2002 no longer a requirement to seek Ministerial approval to changes to the Board	To operate with a lay majority Statutory requirement for a Director of Public Health to be on each PCT Board Patients Forum to be established for every PCT and will elect one of their members to serve on PCT Board (1 June 2003 start taking up appointment) Recommended, but not statutory, that lead nurse is appointed to the Board	Chair to work 3 days a week Board Members to work 5 days per month	Maximum of 14 (allowing for increase to 16 during transitional periods until April 2004)	Chair remuneration levels for 2002 as below, going forward will be based on annual turnover of PCT 2002 Board Chair Level 1 — £20,420 Level 2 — £18,154 Level 3 — £16,017 Non Executive Directors £5,294
UK Strategic Health Authority	Chair is appointed for a four year period and is by open advertisement and subject to selection by the NHS Appointment Commission		StHA Chairs to work three days a week	Chair of Board is a Non Executive appointment	Chairs eligible to receive £20,420 Non Executive Directors to NHS Boards to receive a maximum of £5,140

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Appendix 9

Overview of the major system initiatives under way

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Overview of the major system initiatives under way

1. Development of a new model for Primary Care

The provision for significant development of primary care is outlined in the Primary Care Strategy which accompanied *Quality and Fairness*. A small, full-time National Primary Care Task Force has been established to support the implementation of the model of primary care outlined in the Strategy, which is constituted on Primary Care Networks and Primary Care Teams. The terms of reference of the National Primary Care Task Force (which is inter-disciplinary and will report to a wider representative Steering Group which will be chaired by the Department of Health and Children. This includes representation from health boards, primary care professional groups, unions and other relevant stakeholders) include:

- Driving the implementation of the primary care model as outlined in the Strategy
- Identifying representative locations for the implementation projects
- Planning human resources, information and communications technology and capital requirements for primary care on a national basis
- Putting in place a framework for the extension of GP co-operatives on a national basis with specific reference to payment methods and operational processes

The Task Force has already identified ten pilot implementation projects, which were announced by the Minister for Health and Children in October 2002.

The development of this ambitious primary care model will undoubtedly present challenges in terms of the interface between the primary care structures and existing statutory services as provided by the Health Boards at a local level. The strategy is not explicit about possible evaluation of the primary care teams/networks to a budget. holding or purchasing role. Nor does it contain detail on the managerial infrastructure needed to support the new model.

2. The review of medical manpower by the National Task Force on Medical Staffing

The National Task Force on Medical Staffing is currently considering the Report of the Forum on Medical Staffing and the Report of the National Joint Steering Group on the Working Hours of Non-Consultant Hospital Doctors. Its terms of reference are to:

- Oversee the implementation of detailed strategies for reducing the working hours of NCHDs, so that a 48-hour working is achieved by 2009
- Address the associated medical staffing needs of the Irish hospital system

- Analyse the practicalities and estimate the costs that would arise if a consultant-provided (rather than consultant-led) system was in place
- Consider the medical education and training requirements arising from any changes to the current model of delivering services

In January 2001, the Chair of the Task Force, Mr. David Hanly, highlighted the opportunities for wider system-change arising from changes to the medical manpower model:

> *'The legal requirement to reduce NCHD working hours forces us to look at how the service is structured, managed, operated and delivered to the patient. It gives us the opportunity to make fundamental and far reaching changes with vision, courage and professionalism to deliver the health service that we aspire to.'*

It is expected therefore, that this review will propose extensive reforms in manpower training, work methods, and supporting structural and organisational changes in the acute sector.

3. The Commission on Financial Management and Control

The Commission on Financial Management and Control in the Health Services (established in April 2002 and chaired by Professor Niamh Brennan) has as its objective 'to consider the various financial management systems and control procedures currently operated in the Department of Health and Children and by the main spending and service areas of the health sector'. The Commission's terms of reference are as follows:

- Examine the various financial management systems and control procedures currently operated in the Department of Health and Children, and by the key budget holders in the Health Boards and the main spending and service areas of the health sector
- Assess the various reporting procedures in these services
- Assess the capacity of the systems and procedures to provide relevant, timely and reliable information, in relation to current and capital expenditure, with particular reference to:
    - The measurement of resource use against outcomes
    - Management of resources within budgets
- Evaluate the capacity of these systems to develop cost consciousness among resource managers and to provide incentives to manage cost effectively
- Examine international best practice in regard to health service financial management systems, cost control and reporting arrangements
- Examine how the Estimates in the health area are compiled and allocations finalised and monitored
- Consider how the presentation of financial data can be enhanced so as to provide better information on how service delivery is proceeding
- Make recommendations in accordance with its findings, with a view to enhancing the timeliness and quality of financial management information throughout the health services and provided to Departments

It is clear from the above terms of reference that the Commission will be considering key aspects of current financial management and control processes which have a direct impact on the functioning of the health system. Better financial management and control has to go hand in hand with clearer structures and lines of accountability throughout the health services.

4. Review of Medical Practitioners Act

A review of the Medical Practitioners Act 1978 is currently underway. Action 105 of *Quality and Fairness* highlights the Government's commitment to strengthening existing legislation regarding certain professions such as doctors, nurses and pharmacists. The current body of legislation does not adequately meet the needs of today's society in relation to matters such as clinical governance, accountability, openness, concern with needs of the individual patient or public generally, fairness and efficiency of disciplinary procedures, and assurance of quality standards. The Strategy's Action Plan envisages a revision of existing legislation for doctors, nurses and the introduction of new legislation on other health professionals during 2003.

5. Action Plan for People Management

The Action Plan for People Management, which is a key Health Strategy objective, was published in October 2002 and sets out a detailed road map for the management of people in the health service over the lifetime of *Quality and Fairness*. The Action Plan builds upon the seven themes identified during the consultative phase of *Quality and Fairness*. These seven themes are:

- Manage People Effectively
- Improve the Quality of Working Life
- Devise and Implement Best Practice Employment Policies and Procedures
- Develop Partnership Further
- Invest in Training, Development and Education
- Improving Industrial and Employee Relations
- Develop Performance Management

Supporting actions are assigned to the Office for Health Management, the Health Services Employers Agency and senior management and HR and training units of individual health organisations. The action plan begins to provide a strategic HR platform which will be critical to delivery of *Quality and Fairness* objectives.

6. National Health Information Strategy

The National Health Information Strategy Committee established by the Department of Health and Children is in the final stages of developing a National Health Information Strategy in line with the commitment in *Quality and Fairness* to develop a strategic approach to the development and use of health information. In particular, the National Health Information Strategy Committee will:

- Review and assess present arrangements for the collection, reporting and use of health information, as broadly defined, in terms of requirements for both health service management and measurement of population health
- Examine approaches to integrated health information systems adopted elsewhere
- Address issues of data quality, standardisation of definitions, integration of data and timeliness
- Consider gaps in data and look at requirements for the development and use of performance indicators and outcome measures for monitoring and evaluating health and the effectiveness of health services
- Examine issues of access to data including protocols for confidentiality and release of data to third parties
- Investigate Information and Communications Technology (ICT) coordinated solutions for the improved storage,

updating, collection, analysis dissemination and standardisation of health and health related data in order to optimise data integration, management and delivery

- Recommend the required steps and estimated technical manpower and hardware resources required to develop and implement a national integrated health information model in a working environment where suitable IT and Statistical expertise is at a premium.

7. The restructuring of the Department of Health and Children

Quality and Fairness also identified the restructuring of the Department of Health and Children as a separate action under the Framework for Organisational Reform.

In relation to the Department of Health and Children specifically it became clear in the course of the project that significant restructuring of the Department was an intrinsic part of any significant reform and this has been factored into our analysis and recommendations.

Appendix 10

Details on wider public sector management reform

Appendix 10

Details on wider public sector management reform

The establishment of stand-alone central executive functions

- **National Treasury Management Agency**

The establishment of the National Treasury Management Agency in 1990 enabled the Government to delegate the borrowing and debt management functions of the Minister for Finance to the Agency. The Chief Executive Officer of this Agency is directly responsible to the Minister for Finance for the performance of the functions of the Agency. Prior to the establishment of the Agency the Irish national debt was managed principally by the Department of Finance. The Agency was established due to a number of factors which included:

- The substantial growth in the size and complexity of national debt during the 1980's
- The difficulty of recruitment and retention of experienced professional debt management staffing within the Department of Finance at that time

The National Treasury Management (Amendment) Act 2000 extends the role of the NTMA to cover the following functions:

- Management of personal injury and property claims against the State
- Central Treasury Services — the taking of deposits from and the making of advances to designated bodies such as local authorities and health boards
- Fund Management Services with respect to any fund managed or controlled by a Minister of the government

- **National Roads Authority (NRA)**

More recently, the National Roads Authority (NRA) was formally established as an independent statutory body under the Roads Act, 1993. The NRA's road development programme forms part of the Government's overall strategy for the improvement of national infrastructure, which is contained in the NDP, 2000-2006. The NRA's primary function is 'to secure the provision of a safe and efficient network of national roads'. It has overall responsibility for the planning and supervision of construction and maintenance of national roads. In addition, the NRA has a number of specific functions under the Act, including:

- Preparing, or arranging for the preparation of road designs, maintenance programmes and schemes for the provision of traffic signs on national roads

- Securing the carrying out of construction, improvement and maintenance works on national roads
- Allocating and paying grants for national roads
- Training, research or testing activities in relation to any of its functions.

Historically, the NRA has discharged these functions through the relevant local authority. However, it is empowered (where it considers it would be more convenient, expeditious, effective or economical to do so) to carry out such functions directly.

- **Courts Service**

The Courts Service was established as an independent body in late 1999 to manage and administer court services. The formation of this independent agency was recommended by the Working Group on a Courts Commission, which found a number of shortcomings in the previous arrangements for the delivery of the courts service within the Department of Justice, Equality and Law Reform. These shortcomings included;

- The fact that the Courts system had remained unaltered since 1924
- The increase in the volume of civil and criminal litigation
- A perception of unacceptable delays in the determination of cases
- Instances of overworked and poorly organised staff
- Lack of adequate back up and support structures
- The absence of adequate systems for communicating information and a lack of modern information systems

- **Irish Prisons Service**

The Irish Prison Service was established as an independent executive agency of the Department of Justice, Equality and Law Reform, pending the legislation to establish a statutory Prisons Board which will be responsible for the day-to-day management of the Irish Prisons Service. In advance of the statutory Board being established, the Minister appointed a Prisons Authority Interim Board in 2000. The possibility of the Prison Service becoming an independent executive agency was proposed by the Whitaker Report as far back as 1985. The rationale for the establishment of the agency was that significant change and development in the prison service was necessary and could be achieved more effectively through an independent agency. The establishment of the Agency relieved the Minister of the need to be involved in the day-to-day running of the Prisons Service, but specific powers were reserved for the Minister on matters of significant concern to the public or Oireachtas

Moving service delivery closer to the customer

The development of 'one-stop-shops' by a number of local authorities has supported the provision of customer services closer to the population served. This initiative, which has been funded by the Department of Environment and Local Government, has resulted in the development of a number of models whereby local offices are established in addition to the central offices. In some instances, other state agencies have become involved in providing services from these local offices (e.g. citizen's advice bureau, certain health board services). The use of technology has facilitated this development

greatly — Meath County Council for example support their one-stop-shops by providing access to on-line services such as review of planning applications. Another example of the one-stop-shop is in the North Western Health Board through the REACH project. The Health Board is jointly working with Donegal County Council, FÁS, Department of Social Community and Family Affairs and the National REACH project team in piloting the One Stop Philosophy Donegal.

Independent regulation and oversight

Recent years have seen the development of specialist agencies and legislation charged with independent oversight and regulation of a wide range of public and private services. Some of the most significant recent developments on the regulatory front include:

- **Freedom of Information Act (1997)**

The *Freedom of Information Act 1997* came into force on 21 April 1998. The Act established three new statutory rights:

- A legal right for each person to access information held by public bodies
- A legal right for each person to have official information relating to him/herself amended where it is incomplete, incorrect or misleading
- A legal right for each person to obtain reasons for decisions affecting him/herself

The Act asserts the right of members of the public to obtain access to official information to the greatest extent possible consistent with the public interest and the right to privacy of individuals.

- **The Office of the Ombudsman**

The Office of the Ombudsman was established under The Ombudsman Act 1980, which sets down the procedures and conditions governing the appointment of the Ombudsman and delineates the powers as regards examination and investigation of complaints made to him. The Ombudsman's role was increased (1985) to cover local authorities, health boards and An Post. He/she can investigate an action where a complaint has been made and having carried out a preliminary examination of the matter, is empowered to make recommendations to enable the complaint to be resolved with the minimum of formality, particularly in the case of the more straightforward complaints.

- **Competition Authority, 1991**

The Competition Authority is a statutory body with a specific role to enforce Irish competition law. Anti-competitive behaviour occurs when firms agree to fix prices, limit output, divide business between them or abuse their market power, with no benefits to consumers. In these situations the Competition Authority will use its enforcement powers to act promptly and rigorously to protect the interests of Irish consumers and overall economic welfare.

- **Ethics in Public Office Act, 1995**

The broad focus of the Ethics in Public Office Act, 1995 (the 1995 Act) and the Standards in Public Office Act, 2001 (the 2001 Act) is towards the disclosure of interests including any material factors which could influence a member of the Oireachtas, an office holder or a public servant in discharging their official duties. This embraces the adoption of position, persuasion, negotiation and decision-making and any other action which constitutes the performance of a function.

The 1995 Act was strengthened by the 2001 Act which provides additionally for tax clearance certification for all members of the Houses of the Oireachtas and for the Attorney General, the Judiciary and appointees to senior office in public bodies. Other provisions of the 2001 Act included codes of conduct, indicating standards of conduct and integrity for members of the Houses of the Oireachtas, office holders and the public service. The codes will be published by the Standards Commission.

- **The Employment Equality Act, 1998**

The Equality Authority 1999 was established under the above Act replaced the Employment Equality Agency, and has a greatly expanded role and functions. The Employment Equality Act, 1998 and the Equal Status Act, 2000 outlaw discrimination in employment, vocational training, advertising, collective agreements, the provision of goods and services and other opportunities to which the public generally have access on nine distinct grounds. These are: Gender; Marital status; Family status; Age; Disability; Race; Sexual orientation; Religious belief; and Membership of the Traveller Community.

- **The Office of the Director of Corporate Enforcement, 2001**

The Office of the Director of Corporate Enforcement (ODCE) was established under the Company Law Enforcement Act, 2001. Its mission is to improve the compliance environment for corporate activity in the Irish economy by:

  - Encouraging adherence to the requirements of the Companies Acts and
  - Bringing to account those who disregard the law.

Internationally, there has also been a growth in independent oversight and regulation within the health sector. This has been covered separately in Appendix 8.

Appendix 11

Incremental development of agencies audited

Appendix 11

Incremental development of agencies audited

Pre – 1970	1971 – 1993	1994 – 2000	2001 – 2002
• Hospitals Trust Board (1938) • Pharmaceutical Society (1951) • Adoption Board (1952) • Opticians Board (1956) • Poisons Council (1961) • Hospital Bodies Administrative Bureau (1961-Establishment Order 1972) • Dublin Dental Hospital Board (1963) • Irish Blood Transfusion Service (1965)	• Regional Health Boards (1970) • St. James's Hospital Board (1971) • Comhairle na nOspidéal (1972) • Board for the Employment of the Blind (1972)[1] • Beaumont Hospital Board (1977) • Medical Council (1978) • Post-graduate Medical and Dental Board (1978) • Leopardstown Park Hospital Board (1979) • An Bord Altranais (1985) • Dental Council (1985) • Health Research Board (1986) • Drug Treatment Centre (1988)[2] • St. Luke's and St. Ann's Hospital Board (1988) • National Cancer Registry Board (1991) • General Medical Services Payments Board (1972, 1994)	• Irish Medicines Board (1995) • Health Services Employers Agency (1996) • Board of the Adelaide, Meath Hospital (incorporating National Children's Hospital) (1996)[3] • National Council on Ageing and Older People (1997)[4] • National Social Work Qualifications Board (1997) • Office for Health Management (1997) • Women's Health Council (1997) • National Breast Screening Board (1998) • Food Safety Authority of Ireland (1998) • Eastern Regional Health Authority (1999) • Area Health Boards (1999) • Food Safety Promotion Board (1999) • Institute of Public Health (1999) • National Council for the Professional Development of Nursing and Midwifery (1999) • National Disease Surveillance Centre (1999) • Social Services Inspectorate (2000) • Pre-hospital Emergency Care Council (2000)	• Crisis Pregnancy Agency (2001) • National Children's Office (2001) • National Children's Advisory Council (2001) • Special Residential Services Board (2001) • Irish Health Services Accreditation Board (2002) • Office for Tobacco Control (2002) • Mental Health Commission (2002) • Health Boards Executive (2002) • Health Information Quality Authority (planned) • National Hospitals Agency (planned)

[1] The Board for the Employment of the Blind has existed for over 150 years. Responsibility for its functions were transferred to the Department in 1972

[2] The Drugs Treatment Centre was established in 1969

[3] The Adelaide and Meath Hospitals were statutorily established under the Health Act 1970 (Section 76)

[4] Succeeded from the National Council for the Elderly, which succeeded from the National Council for the Aged which began its work in 1981.

Appendix 12

The Prospectus/Watson Wyatt team members

Appendix 12

The Prospectus/Watson Wyatt team members

Prospectus Team

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