Tallaght University Hospital
Ospidéal Ollscoile Thamhlachta
An Academic Partner of Trinity College Dublin

Tallaght University Hospital Board

Corporate Governance Manual

July 2024

Tallaght University Hospital
Ospidéal Ollscoile Thamhlachta
An Academic Partner of Trinity College Dublin

Table of Contents **Page No**

1. Introduction 3
2. Statement on corporate governance philosophy 5
3. Summary guidance for Board Members 7
4. Code of Governance 10
5. Standing Orders to regulate the procedures and business of the Board 24
6. Formal schedule of matters reserved for Board decision 28
7. Committees of the Board 32
   - 7.(a) Audit Committee 36
   - 7.(b) Quality, Safety & Risk Management Committee 41
   - 7.(c) Staff & Organisation Development committee 46
   - 7.(d) Finance Committee 50
   - 7.(e) Governance and Nominating Committee 54
   - 7.(f) Research & Innovation Board Committee 60
8. Code of Conduct 64
9. Procedures for avoiding/dealing with conflicts of interest 67
10. Procedure for recording concerns of Board Members that cannot be resolved through the normal processes at Board or committee level 70
11. Procedure for obtaining independent professional advice 71
12. Hospital Seal and signature of documents 73

Appendices

1. Hospital Charter
2. Hospital Bye-laws
3. Appendix 12 of HIQA Report of 8 May 2012
4. Charities Governance Code.
5. Future Skills and Competencies for Governance and Nominating Committee Members.
6. Governance Checklist for Tallaght University Hospital 2022.
7. TUH Risk Appetite Statement 2022.
8. TUH Board Statement on Fraud. 2022.

Section 1

Introduction

1. Tallaght University Hospital was established on 1 August 1996 under a Charter approved by the Minister for Health in accordance with section 76 of the Health Act 1970 following the enactment of the Health (Amendment) (No. 2) Act 1996. A copy of the Charter is attached at Appendix 1.

2. The new Hospital was an amalgamation of three Dublin city centre Hospitals namely the Adelaide Hospital (established in 1821), the Meath Hospital (established in 1753) and the National Children's Hospital (established in 1821). It accepted its first patients on 21 June 1998.

3. The Charter provides that all the powers of the Hospital are vested in and exercisable by the Hospital Board. It also provides that the general function of the Board is to manage the activities of the Hospital and the services provided by it.

4. The Charter also provides for the making of bye-laws for the government of the Hospital. Such bye-laws may be made by the Hospital Board with the consent of the Adelaide Health Foundation, the Meath Hospital and the National Children's Hospital.

5. As you are aware the Hospital Charter has gone through a number of iterations based on feedback from TUH Board of Directors CHG subgroup and the three Foundations. In addition, several meetings were held with Department of Health officials and the most up to date version reflects their position and that of the Minister for Health. The appointment process is as follows:

   (a) 1 (one) member shall be appointed by The Adelaide Hospital Society;

   1 (one) member shall be appointed by the Meath Foundation;

   4 (four) members shall be appointed by the Minister on the nomination of the President of the Hospital; 2 (two) members shall be appointed by the Minister, one of whom shall have been nominated by the Health Service Executive (or any successor to its functions in relation to hospitals) for such appointment and the other of whom shall have been nominated by the Board of Trinity College, Dublin for such appointment.

   At present and before the new Charter comes into place there are 11 members on the Hospital Board.

   When the new Charter comes into place the NCH member will no longer be, which brings the membership on the Board down to 10.

   Then under the new Charter, two members shall be appointed by the Board, one of whom shall have been nominated by the Meath Foundation and one of whom shall

have been nominated by the Adelaide Health Foundation. This will bring the Board membership up to 12 members in accordance with the revised Charter.

6. This corporate governance manual is intended to provide Members of the Tallaght University Hospital Board with the information they need about corporate governance to perform their duties to the highest standards of accountability, integrity and propriety. It sets out the systems and procedures by which the Hospital Board directs and controls its functions and manages its business.

7. The manual reflects and takes account of the Hospital Charter, relevant recommendations in the HIQA Report of 8 May 2012, the HSE Annual Compliance Statement, the general terms and conditions set out in the formal Service Level Agreement between the Hospital and the HSE including the HSEs Performance and Accountability Framework, the HSE's latest Framework for Corporate and Financial Governance, the 2006 Framework for Corporate & Financial Governance of Agencies Funded by the Department of Health, the 2016 Department of Public Expenditure and Reform Code of Practice for the Governance of State Bodies the Charities Act 2009 and the Code of Governance for Charities 2019. Copies of these documents are available from the Board Secretary and some of them are included, for ease of reference, in the appendices to this manual.

8. This manual was formally adopted by the Board. It will be used as a dynamic document of reference. The Board will endeavour to integrate current best practice and new legislation for public interest bodies as it develops.

Section 2

Statement of Corporate Governance Philosophy

1. The Hospital's Corporate Governance Manual sets out the Board's commitment, cognisant of its public interest role, to the establishment of best practice structures, processes, cultures and systems that will engender the successful operation of the Hospital enshrining principles of accountability, transparency and best ethical practice.

2. Although the Manual, set out herein, delineates the codes, guidelines and policies adopted by the Board to achieve best practice, it is clear to the Board that such procedures are dynamic in nature and are not fixed in stone. Therefore, they are based on the fundamental governance philosophy given below and will be subject to regular monitoring to ensure the incorporation of developing best practice and to tri-annual formal review of the document.

3. The Hospital's governance ethic is not based on compliance with a codified listing of rules that have been derived from previous poor societal behaviour. Rather our underpinning governance philosophy is based on the belief in and acceptance of a commitment by the Board to the following principles.

4. We undertake to declare our objectives and use our very best endeavours to build a team comprising the Board, the executive managers, employees and expert advisors who will apply high technical standards in achieving those objectives. We undertake to embrace the principles of integrity, transparency, accountability, risk management, value for money and high standards of medical and business ethics in serving our patients and society in a fair and just manner. We will remain vigilant in assessing our compliance with these principles. We will set strategic plans for the Hospital and monitor the implementation and flexing of those plans by the management team.

5. In order to achieve our objectives and to meet our social responsibilities, the corporate culture will be one of fair dealing, integrity, respect and honour such that, as far as practicable, no individual will be hurt by our actions. Members of the Board and employees will uphold the highest standards of ethical behaviour including:

   Respect and Dignity of the Person: The health (physical and mental) and safety of individual stakeholders will be protected at all times.

   Medical Ethics: The highest standards of compliance with the extant body of medical ethics will be expected of all medical, nursing and allied health practitioners who are employed by the Hospital under all forms of contract.

   Research Ethics: All research conducted under the aegis of the Hospital or its associates will conform to the highest international standards.

   Utmost Good Faith: The highest standards of loyalty and trust will be applied to dealings with employees and to the management of the Hospital.

Integrity: The highest standards of integrity are to be expected in all business interactions. We prohibit any and all forms of corruption, extortion and embezzlement. Enforcement procedures shall be implemented to ensure conformance. The Board's statement on Fraud and corruption is published on the Hospital's website. The Board undertakes to review same on a yearly basis. A copy is included in the appendices.

Corporate Governance: The Board will operate to the highest standard of appropriate corporate governance guidance and regulation. The TUH Risk Appetite Statement was published in 2022 and is published on the Hospital's website. A copy is included in the appendices.

No Improper Advantage: Bribes or other means of obtaining undue or improper advantage are not to be offered or accepted.

Disclosure of Information: Information regarding hospital activities, structure, financial situation and performance is to be disclosed in an open transparent way, always complying with applicable regulations and legislation.

Intellectual Property: Intellectual property rights are to be respected; copyright must be dealt with at all times in accordance with the law and best industry practice.

Privacy: Appropriate means of safeguarding patient confidentiality will be applied in all circumstances.

Protection of Identity: Policies that ensure the confidentiality of and fair dealing with supplier and employee whistle-blowers are to be maintained.

Protection of the Environment: The Hospital will, in all its decision making, apply the highest standards of resource utilisation and protection of the environment.

Section 3

Summary Guidance For Board Members

What is corporate governance?

1. Corporate governance is defined as the system, principles and process by which an organisation is directed and controlled. The principles underlying corporate governance are based on providing the service and conducting the business with integrity and fairness, being transparent with regard to all transactions, making all the necessary disclosures and decisions, and complying with all the laws of the land. It is broadly concerned with the relationships between a board and its stakeholders, accountability, risk management and achieving value for money. In the case of Tallaght University Hospital, good governance should facilitate efficient, effective and entrepreneurial management that can deliver the best possible service to patients and to society over the longer term, given the unavoidable constraints that exist.

How is the Hospital structured?

2. The Hospital is a body corporate (i.e. it has its own legal identity) set up under a 1996 Charter. All the powers of the Hospital are exercised by the Board. The Board is made up of eleven members and its function is to manage the activities of the Hospital and the services provided by it. Although it is a body corporate, the Hospital is not an incorporated body under the terms of the Companies Acts. However, for corporate governance purposes, it can be seen as a public interest body and is expected to comply with the same standards of corporate governance as a public limited company. The Hospital considers the Companies Act and implements best practice where relevant. It is a voluntary Hospital which receives funding, not via share capital, but largely by way of funding from the Government through the HSE. Its financial statements are prepared in accordance with the Department of Health Accounting Standards for Voluntary Hospitals making necessary disclosures to provide additional information as required under the Service Level Agreement with the HSE and the adoption of the Charities SORP (FRS102) format for a Board Report. The audit of the financial statements is prepared for the Members of the Board only.

What is a Board Member?

3. A Member of the Hospital's Board is similar to a non-executive director in a business corporation set up under the Companies Acts (also called an external director, independent director and outside director). A non-executive director typically does not engage in the day-to-day management of the organisation, but is involved in policy making and planning exercises. In addition, non-executive directors' responsibilities include the monitoring of the executive managers, and a requirement to act in the interest of the stakeholders. In business corporations, there is no legal distinction between an executive and a non-executive director. Yet there is a sense that the non-executive director's role can be seen to balance that of the executive director. Executive directors have an intimate knowledge of the company and generally provide an entrepreneurial spur, whereas the non-executive director is generally expected to have a wider perspective of the community at large and often has more to say about prudent control.
   Tallaght University Hospital is committed to a diverse, inclusive and equitable environment where all Board members feel respected and valued regardless of gender,

civil status, family status, sexual orientation, religious belief, age, disability, race, national origin or member of the travelling community.

4. In the case of Tallaght University Hospital, the Board does not include any employees, or "executive members". However, as a matter of practice and save in exceptional circumstances, the Chief Executive and appropriate members of the Executive Management Team (EMT) attend and participate fully in all Board meetings. This is designed to ensure, on the one hand, that the Board Members are fully aware of the practical impact on the Hospital of their decisions and, on the other hand, that the EMT is fully aware of the governance and other requirements of the Board. The aim is to achieve a corporate approach by all concerned. Decisions are taken by consensus involving both the Board Members and the members of the EMT but, should a vote be required, voting is confined to Board Members.

What can I expect to be paid as a Board Member?

5. Although there is no mention of remuneration in the Charter or in subsequent Bye Laws, no remuneration is paid to Board Members. They may be reimbursed with reasonable expenses.

How long can I serve as a Member on the Hospital Board?

6. The Charter and bye-laws provide for a term of three years, although you may be eligible for reappointment for a further period.

What would be expected of me as Chairman of the Board?

7. The Chairman's primary role is to ensure that the Board is effective in its tasks of setting and implementing the Hospital's direction and strategy. You would also be expected to uphold integrity and probity, promote effective relationships and open communication, initiate change and planning succession, promote the highest standards of corporate governance, ensure clear structure and implementation of Board decisions and most importantly, provide coherent leadership. The Chairman also chairs the Board meetings. The Chairman is appointed by the Board from amongst its members. There is also provision for a Vice-Chairman to be appointed by the Board from amongst its members.

What are the duties of the Board Secretary?

8. The Charter makes no provision for a Board Secretary, other than the requirement for the Board to keep a record of minutes of all its proceedings. However, in accordance with good corporate governance, there is a Board Secretary who reports separately to the CEO and the Chairman. The duties of the Board Secretary are set out in Section 4 of this Manual.

As a Board Member, do I have any responsibility for the financial statements?

9. Yes. It is the Board Members' responsibility to prepare audited financial statements for each financial year, in accordance with the Guidelines of the Department of Health for Voluntary Hospitals. A statement acknowledging the Board Members' responsibility for keeping proper accounting records and preparing financial statements is usually included in the annual report. If you are unsure of any item/s included or not included in these financial statements, you should ask questions of the finance team, audit committee and other Board Members. If you remain uncertain, you may request independent financial or legal advice, which will be provided at the Hospital's

expense. You cannot rely on your lack of technical knowledge for failing to satisfy yourself that you understand the implications of all matters covered by the financial statements.

What are the specific duties of the Board of the Hospital?

10. They are specifically mentioned in the Charter and you will see them in Sections 4 and 6 of this Manual. In summary, they include the treatment of patients (securing their health, happiness and welfare); the management of the Hospital; provision of a teaching/training/research function; the maintenance of a religious, multi-denominational and pluralist ethos; cooperation with the HSE and the promotion of preventative medicine.

10. The Board is specifically responsible for strategic planning and for setting the three to five Strategic plan and monitoring the KPIs and their implementation. It is the role of the Executive Management Team to implement that plan and to conduct the business of day to day management of the Hospital.

Section 4

Code of Governance

Introduction

1. Corporate governance is the system by which organisations direct and control their functions and relate to their stakeholders in order to manage their business, achieve their mission and objectives and meet the necessary standards of accountability, integrity and propriety.

2. The Board organises itself into the main Board and committees with specific roles, reporting to the main Board. At its core, governance focuses on the sets of relationships between board members, committee members, management, staff, patients and other stakeholders in determining the direction and performance of the organisation. It is a key element in improving efficiency and accountability as well as enhancing openness and transparency.

3. Good governance leads to good management, good performance, good stewardship of public funds, good public engagement and ultimately good outcomes.

4. This Code of Governance sets out a corporate governance framework within which the Hospital wishes to operate. Members of the Board, employees of the Hospital or anybody contracted by the Hospital must subscribe to the Hospital's Code of Governance and Code of Conduct. The Hospital will include such an undertaking to subscribe to the Codes in all contracts of employment and of service provision.

5. The Board has a key role in promoting and ensuring standards of good governance within the Hospital. The Board as a collective, and each member, have an important and challenging task to lead, direct and control the Hospital and to ensure that the governance objectives are appropriately fulfilled. Board and committee members are expected to observe the highest ethical and professional standards and to work constructively with the Chief Executive and the Executive Management Team[1](EMT).

6. In undertaking its role the Board will respect the principle that the executive is responsible for the operational management of the Hospital.

Composition of Hospital Board

7. In accordance with bye-laws made in November 2014 (Appendix 2), the Board comprises eleven Members who are appointed as follows:

   - one appointed by the Adelaide Health Foundation;
   - one appointed by the Meath Foundation;
   - one appointed by the National Children's Hospital;
   - four appointed by the Minister for Health on the nomination of the Church of Ireland Archbishop of Dublin/President of the Hospital;
   - one appointed by the Minister for Health on the nomination of Trinity College Dublin; and

[1] The Executive Management Team means the direct reports of the Chief Executive.

- one appointed by the Minister for Health on the nomination of the HSE.
- two appointed by the Minister for Health on the nomination of the Board.

8. Appendix 3 contains a board competency framework developed by HIQA and included in its Report of 8 May 2012.

9. The Chairperson is elected by the Board from among those members appointed by the Minister. The Vice-Chairperson is appointed by the Board from among its members.

10. The term of office of the Board Members is three years. An outgoing Member may be re-appointed to the Board. However, a person may not serve for more than three consecutive terms or nine consecutive years, whichever is the longer.

11. In accordance with the HIQA Report of 8 May 2012, no employee of the Hospital can be a member of the Board. However, as a matter of practice and save in exceptional circumstances, the Chief Executive and appropriate members of the EMT attend and participate fully in all Board meetings. This is designed to ensure, on the one hand, that the Board Members are fully aware of the practical impact on the Hospital of their decisions and, on the other hand, that the EMT is fully aware of the governance and other requirements of the Board. The aim is to achieve a corporate approach by all concerned. Decisions are taken by consensus involving both the Board Members and the members of the EMT but, should a vote be required, voting is confined to Board Members.

Remuneration and expenses

12. No remuneration is paid in respect of Board membership.

13. Board Members may recoup reasonable expenses incurred by them in the performance of their functions in accordance with standard public service travel and subsistence rules and rates. Details of any such payments to Board Members, which must be approved by the Chief Executive, are provided in the Hospital's annual financial accounts.

Function of Hospital Board

14. In accordance with the Charter the function of the Board is to manage the activities of the Hospital and exercise the powers of the Hospital which are vested in the Board. In summary, the Board shall:

    - carry out the objects of the Hospital in accordance with the Charter;

    - ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the Hospital;

    - develop and review on a regular basis the mission, vision, values, and strategic direction of the Hospital within the overall policies and priorities of the Government and the HSE, define its annual and longer term objectives and agree plans to achieve them;

    - oversee a quality performance management system for the regular assessment and review of patient care, ensuring corrective action is taken when necessary;

- ensure effective financial stewardship through value for money, financial control, internal control, financial planning and strategy;

- work with Trinity College Dublin, other educational institutions and bodies responsible for the regulation of health care professionals to fulfil the patient care, education and research mission of the Hospital;

- oversee appropriate systems for managing risks that arise from the Hospital's operations with a view to improving the quality of care provided by the Hospital;

- develop an effective dialogue with the local community and ensure the Hospital's plans and performance are responsive to the community's needs;

- develop the voluntary character of and support for the Hospital;

- appoint, remunerate and appraise a Chief Executive in accordance with health sector pay policy and other relevant national guidelines;

- delegate agreed responsibilities to the Chief Executive; and

- establish and review committees of the Board to assist in its functions.

15. The Board is collectively responsible for promoting the success of the Hospital by leading and directing its activities. It should provide strategic guidance to the Hospital, and monitor the effectiveness of management. Board members should act on a fully informed basis, in good faith, with due diligence and care, and in the best interest of the Hospital and those who need its services, within whatever policy and financial framework is set by the Minister for Health on behalf of the Government.

16. The Board is responsible for compliance with all statutory obligations applicable to the Hospital. It should satisfy itself that all such obligations are identified and made known to it.

17. The collective responsibility and authority of the Board should be safeguarded. All Board Members, regardless of how they are nominated or appointed, have a collective responsibility for the discharge of the Board's functions.

18. New Board Members undergo orientation through a planned induction programme to ensure that they understand their responsibilities and duties, and the Hospital's functions and services, including their obligations in relation to confidentiality and to act in good faith and in the best interests of the Hospital. The Board Secretary shall supply new Board Members with appropriate induction material. All new Board Members shall formally acknowledge in writing that they understand, and will comply with their responsibilities as Board Members.

Formal Resignation Process for TUH Board Members.

19. Board Members who wish to resign from their position as TUH Board Members are required to submit a formal letter of resignation to the Chair of the Board, outlining their intention to resign and the date in which the resignation takes place. The Board member should provide a notice period of 3 months (where possible) along with the reason for the resignation.
20. The Board member will be required to return all Hospital property and documents to the Board Secretary.

21. The Board member is required to sign a formal letter to confirm they have destroyed all documents pertaining to the Hospital as outlined within the formal assurances and confidentiality agreement.

Specific duties and responsibilities of the Chairperson
Role and Responsibilities of the Chairman

Role

22. The Chairman is responsible for providing leadership to, and overseeing the functioning of the Board to ensure that it acts in the best interests of (TUH) and that Board meetings are planned and conducted in an effective manner

- Ensures the Board of TUH stays true to its Charter and mission

- Sets and maintains the highest standards of integrity and probity, set clear expectations concerning TUH's ethos, values and behaviours and the style and tone of board discussions

- Oversees the orderly operations of the Board

- Ensure appropriate interactions between the Board, Executive management and its stakeholders

Responsibilities

Key duties and responsibilities of the Chair are:

- Plan the Board's annual schedule of meetings and agendas, in consultation with the Committee Chairs and the Board Secretary and other members as appropriate

- Coordinate with the CEO and Board Secretary to ensure that the Board receives the appropriate accurate and timely information to enable it to perform its role and to make informed decisions

- Chair all meetings of the Board and ensure that meetings are conducted efficiently and effectively
- Call and Chair special meetings as required under the Charter
- Ensure that TUH has the appropriate polices to guide the executives in the Hospital
- Ensure that TUH has a strategic plan supported by an annual business plan and budget
- Ensure that the Board determines TUH's risk appetite that it is willing to undertake to achieve it strategic objectives
- Ensure that TUH has a risk management plan that is reported upon on a regular basis to the Board
- Foster a good relationship of mutual trust with the CEO together with a strong working relationship with the rest of the executive team
- Ensure that decisions are made in the best interests of TUH and in doing so ensure that the Board undertakes a thorough analysis of all issues and concerns
- Exploit board members knowledge and experience for the benefit of the Board and encourage all members to actively contribute during meetings
- Ensure that all board committees are properly constituted, have appropriate terms of reference which are reviewed annually
- Take a lead role in determining and reviewing the composition, ongoing renewal, structure and performance of the Board and its Committees in liaison with the Governance and Nominating Committee
- Ensure that the performance of the Board and its members are evaluated annually
- Ensure that the performance of the CEO is evaluated annually
- Ensure that the board is kept up to date on all relevant corporate governance issues.
- Create an appropriate boardroom environment to foster constructive debate and effective decision making by the Board
- Facilitate full and candid Board discussions, ensure all members express their views on key Board matters and assist the Board in achieving a consensus

- Develop a cohesive Board culture and facilitate formal and informal communication with and among the members

- Establish the appropriate committees to facilitate the Board in carrying out its work, and appoint competent committee chairs who are also Board members

- Work with Committee Chairs to ensure that each committee functions effectively and keeps the Board apprised of actions taken

- Be authorised to attend all committee meetings, as an ex officio member

- Collaborate with the Governance and Nominating Committee on the performance and structure of the Board of Directors and its committees, including the performance of individual directors and the CEO

- Ensure that Matters Reserved for the Board are updated as and when required

- The Chairperson also has a particular role to play in promoting the mission and work of the Hospital and managing key relationships/communications with:

    a. the Board, reflecting a tone of respect, trust and candour that allows for challenging questions and inputs;

    b. the Chief Executive and the Executive Management Team;

    c. the President of the Hospital, the Adelaide Health Foundation, the Meath Foundation and the National Children's Hospital;

    d. the Minister for Health, the Department of Health and the HSE; and

    e. other key external parties.

Role and Responsibilities for the Vice Chair

23. Background

- Assumes the role and duties of the Chair of the Board if the Chair is no longer able to continue.

- Performs the responsibilities of the Chair of the Board during his / her temporary absence or temporary disability as Chair of the board.

- Like all officers, the first Vice Chair has no authority to speak or act on behalf of the Board other than by the authority specifically granted in the TUH Charter / Bye Laws, Board policy or by majority vote of the members of the Board

Role description

The Vice-Chair will amongst other things:-

- Play a full and active role in the governance of the TUH Board, both corporate and clinical
- Take an active part in discussions, providing his / her opinion and challenge and support to the Board on key issues
- Contribute to the work of the Board based upon his / her independence, past experience and knowledge, and ability to stand back from the day-to-day operations
- Contribute and accept corporate decisions to ensure a joined up, robust and transparent decision making process by the Board

Responsibilities

- Acts as the preferred contact for Board members.

  Whenever necessary, the Vice Chair can organise a meeting reserved exclusively for Board members to allow them to discuss certain issues outside full Board meetings without the Chair or Executives being present. He or she establishes the agenda for these meetings and leads them. Each Board member has the right to raise any issues not included on the agenda.

  Following these meetings, the Vice Chair can take the initiative to meet with the Chair and Chief Executive Officer in order to inform him or her of all or some of the comments, ideas or preferences voiced by the Board members.

- A point of contact for stakeholders not represented on the board. Vice Chair ensures that requests from stakeholders who are not represented on the Board are addressed and makes him or herself available to hear their comments and suggestions and, where possible, answers their questions after consulting the Chairman.
- Responsible for ensuring that the performance of all Board members is evaluated [annually] and that a report summarising the performance of the Members of the Board is submitted to the Chair.
- Assist the Chair of the Board as appropriate in the performance of his/her duties whenever requested to do so.
- Represent the organisation and carry out special assignments at the request of the Chairman.
- Take charge of handling any conflicts of interest that may arise within the Board or between the Chair, the Board and the CEO

Note: the Vice Chair could also be given a particular responsibility such:

- Ensuring the Board adheres to the goals and objectives of the strategic and business plans
- Monitoring implementation
- Working closely with the CEO in achieving TUH's goals and strategic objectives
-

Process for appointing Chair and Vice Chair

24. Introduction

Board Chairs are almost always selected from among board members who are already serving (or have recently served) as experienced Committee Chairs.

An exception is when an individual is specifically recruited for the role of Board Chair from outside the Board. Board Chairs are usually chosen from among board members who are not currently or recently been on staff, or too closely tied to narrow interests that could conflict with TUH's interests.

Options.

1. **Governance and Nominating Committee (GNC) vets candidates and recommends best choice for Chair / Vice Chair which is then ratified by the Board**

A typical approach to choosing the Board Chair is when the Governance and Nominating Committee (GNC) recommends candidates for election and appointment by the Board for Board Chair, Vice Chair and Committee Chairs, after both informal discussions and more formal consultations.

Research shows that about half of Boards that use this approach, the formal director assessment is the most important input into these choices. In the other half, the corporate needs and director skills profiles are the most important – although in all cases, both inputs are factored in, including informal assessments of qualities among the board members themselves.

The Board is free to accept the GNC's candidates for election and appointment or to choose their own, but in practice virtually always elects and appoints the GNC recommendations.

This is sometimes seen as a disadvantage to this chair selection method; that for practical purposes, the choice is left to a sub-set of the board, which may risk "cronyism". However the recruitment of two independent external candidates on the GNC should address this potential bias.

2. Open vote for Chair

Another, less formal approach but more open system, has been adopted by other boards. The meeting floor is opened for board members to nominate fellow board members for the position of chair. The person who has been nominated must accept the nomination in order for their name to stand for the position of chair. The floor remains open for nominations until no more nominations are made.

When nominations have been completed, the nomination process is declared closed and those individuals who have agreed to let their names stand are now candidates for chair. The election for chair is usually a closed ballot system. Board members write the name of the candidate they are voting for on a piece of paper. The ballots are collected and tallied by a third party (usually the senior staff such as the Corporate Secretary or Executive Director.) The candidate with the most votes becomes the chair. If only one person accepts the nomination for the chair position, they become chair.

If only one person accepts the nomination for the chair position, they become chair by acclamation and it is not necessary to formally vote on the matter.

In practical terms, the chair position is a very time consuming job and some would say onerous. As a result, acclamation occurs much more frequently than one might expect or hope, due to too few willing candidates for the position. This is one disadvantage to the "open contest" method of chair selection.

3. Designate Vice Chair as successor

A third Chair selection/succession method is to designate the Vice Chair as successor to the Chair. When a new Chair is chosen, another board member is elected as Vice Chair, and then groomed for the position over the term (may be one to three years or more.)

The advantages to this method are orderly chair succession, continuity of knowledge, process and relationships, since the Vice Chair has been "shadowing" the Chair and has access to all of these. The main disadvantage to this method is that you may have effectively "closed the door" on all the other board members or even new candidates becoming board chair for several years.

Once someone is designated as the successor, it is difficult to "change your mind" if that person turns out to be less than stellar as a team leader and spokesperson.

It is for these reasons, the practice of appointing Vice-Chair has dropped off significantly during the era of governance reform.

In some organisations the position of Senior Board Member is created by the Board to fulfil the duties of the Vice Chair, so as there is no expectation on the part of individual that they would be the next chair. As this is not provided for in the Charter, this is not currently possible at present.

4. Select Chair directly from outside the Board

And a fourth method is to select the Chair directly from outside the board, which could be specifically recruited if there are no potential candidates on the Board. This is quite popular in the private and even public sector, but less common in the not-for-profit sector. The advantage is that an outstanding chair may be recruited; however conversely, it may take time for the "outsider" to gain the trust of the rest of the board and the management team.

Recommendation

Governance and Nominating Committee identifies and evaluates potential candidates and makes recommendations for Chair or Vice Chair for potential ratification by the Board

Duties and responsibilities of Chief Executive

25. The Chief Executive manages the Hospital on behalf of the Board and exercises managerial responsibility on its behalf. The key functions of the Chief Executive are:
    - carrying on, managing and controlling generally, the administration and business of the Hospital;
    - creating and communicating the vision and leadership to ensure all staff are motivated to achieve the highest standards of individual and collective performance, and fostering and maintaining supportive working relationships between staff at all levels throughout the Hospital;
    - developing the Hospital's operational, financial and safety/quality management information systems and ensuring that such systems support and enhance the ability of the Board and management to plan, evaluate and manage the business of the Hospital in an effective, efficient and timely manner;
    - ensuring the Hospital develops and maintains effective channels of communication with its patients and staff; the Minister for Health, Department of Health and the HSE; other stakeholders including the Foundations[2], other health and social care providers; and other public organisations and officials;
    - ensuring the continuing development of the Hospital's reputation as a centre of excellence for medical, surgical, nursing and healthcare education and research;
    - acting in good faith and in the best interests of the Hospital and its patients;
    - putting in place procedures to enable the Board to meet its obligations including providing it with whatever information it requires;
    - implementing the Board's strategies, policies and decisions, and the annual Service Level Agreement with the HSE; accounting to the Board for his/her

[2] The term "Foundations" encompasses the Adelaide Health Foundation, the Meath Foundation the National Children's Hospital and the Tallaght University Hospital Foundation.

performance and the performance generally of the Hospital; and reporting on behalf of the Board to the HSE/Department of Health;

- establishing a unified management structure to manage the work of the Hospital; agreeing individual plans and performance targets with members of the EMT, monitoring their performance and holding them accountable;
- leading, through behaviour/actions, compliance with all aspects of this Code of Governance and providing the Board with appropriate assurances about the Hospital's systems of governance and internal controls;
- ensuring the business of the Hospital and the affairs of its patients and staff are at all times conducted with the required level of confidentiality;
- appearing before Oireachtas Committees when duly requested; and
- carrying out the full range of functions and fulfilling the range of responsibilities normally expected of a chief executive in an organisation of the Hospital's size, nature and economic and social significance and undertaking such other duties as the Board may require from time to time

Functions of the Board Secretary

26. The role of Board Secretary is important in providing effective support that enables the Board to achieve the required level of functionality and should reflect the nature of the governance relationship between the Board and the Chief Executive. The Board Secretary has two reporting lines, one to the Chairperson and one to the Chief Executive.

27. The Board Secretary shall facilitate the smooth operation of the Hospital's formal decision making and reporting machinery, in accordance with set procedures or protocols, by organising and attending Board and committee meetings; formulating meeting agendas with the Chairperson and/or the Chief Executive; collecting, organising and distributing in advance the information, documents or other papers required for such meetings; ensuring that all meetings are minuted; maintaining an "issues log"; and ensuring that appropriate action is taken in relation to issues discussed at Board and committee meetings.

28. The Board Secretary is responsible for ensuring that Board procedures are followed and applicable rules and regulations are complied with. The Board secretary shall:

(a) continually review developments in corporate governance in collaboration with the Chairman

(b) maintain and update the Corporate Governance Manual;

(c) complete and confirm to the Board an annual governance checklist;

(d) facilitate the proper induction of members of the Board into their role, advising and assisting the members of the Board in respect of their duties and responsibilities;

(e) act as a confidential sounding board to the Chairperson and Board Members;

(f) support the Chairperson in ensuring that any conflicts of interest are brought to light and dealt with; and

(g) ensure that Board Members are informed as to their legal responsibilities and that they are familiar with any statutory provisions which have relevance for them in the exercise of their functions as Board Members.

29. The Board Secretary shall ensure safe custody and maintain a register of the seal of the Hospital; maintain and ensure safe custody of the register of Board Member's interests; deal with and maintain records of correspondence to/from the Chairperson; and manage the Chairperson's diary.

30. The Board Secretary shall also coordinate the preparation, publication and distribution of the Hospital's annual report.

Internal Controls

31. It is the responsibility of the Board to ensure that systems of internal controls are established by the Chief Executive and continue to operate in practice. Internal control procedures are in place in relation to:

- financial expenditure and reporting;
- internal audit;
- risk management;
- public procurement;
- purchase to pay (procedures are in accordance with the *'Statement of Financial Controls'* of the Hospital);
- recruitment/appointments;
- public service pay and superannuation policy, including the one person one salary policy and policy on travel, subsistence and other expenses;
- taxation; and governance.

32. These controls are monitored and reviewed by the Board's Audit Committee. The Quality, Safety & Risk Management Committee, the Staff and Organisation Development Committee, Finance Committee, Research & Innovation Committee and the Governance and Nominating Committee also review the areas under their remit.

Internal audit

33. The Internal Audit function operates within the standards of the Institute of Internal Auditors and the Code of Practice for the Governance of State Bodies 2016. The Internal Auditor reports functionally to the Board (through the Audit committee) and will be free from interference in determining the scope of the internal audit rogramme, in performing its work and in communicating its results, in accordance with IIA Guidance 1110. The Internal audit unit functions professionally, adhering to the Code of Ethics and International Standards of the Institute of Internal Auditors or equivalent professional standards.

Procurement

34. The procurement function operates policies and procedures to adhere to Public Procurement Law and rules for Supplies, Services and Works pertaining to Public Procurement Directives (European), associated Irish Procurement Regulations, above

EU thresholds and below thresholds, Government Department of Finance Circular 10/14 and application of its rules. This function operates internal compliance processes to ensure Hospital practices are in line with policies and procedures. Procurement policies include scope and objectives, roles and responsibilities of both procurement and non-procurement personnel, procurement compliance, procurement plans, procurement strategy and governance, procurement autonomy, conflicts of interests, probity, confidentiality, prohibited activities, procurement authority policy and authority levels, formal procurement competitive tendering rules and sourcing, risk management and capital expenditure policy and guidelines, code of ethics, procurement contract management, among others. Procurement policies are made available to all staff on the Hospital's intranet (QPulse electronic library system). The procurement function reports to the Director of Finance.

External auditors

35. The Board, through its Audit Committee, ensures that the Hospital has an objective and professional relationship with its external auditors at all times. The external auditors are required to report in the Hospital's accounts each year (copies of which are sent to the HSE and the Charities Regulator) that the Hospital complies with Department of Health Accounting Standards for Voluntary Hospitals.

Annual report

36. As soon as may be after the end of each year, the Hospital prepares and publishes a report on its activities. This report includes details of the attendance by individual Members at Board, as well as the quantum of expenses, if any, paid to Board Members.

    The Annual Report should include a statement of how the Board operates, including a high level statement of which types of decisions are to be taken by the Board and which are to be delegated to management.

Openness and transparency

37. The Hospital endeavours to be as open and transparent as possible in respect of its activities. In addition to complying with Freedom of Information legislation, and publishing its annual financial statements and annual report, the agenda for and minutes of Board meetings are published on the Hospital's website. The website also includes the names of the Board Members and members of the Executive Management Team.

38. The Hospital has implemented formal procedures for protected disclosure/good faith reporting (whistleblowing), details of which are made available to all employees.

Quality of Service

39. The primary focus of the Hospital is to provide high quality services. This requires that care be patient centred, with dignity, compassion and quality outcomes being the hallmarks of the Hospital's commitment to patients and their families. It means the Hospital needs to capture and listen to the patient voice and ensure meaningful engagement with users and the communities served.

40. To demonstrate the importance of putting the patient at the centre of its working, the Board opens each of its standard meetings with a section on patient feedback consisting of both compliments and complaints received from patients. The Hospital operates a patient advocacy and community engagement system which includes a Patient & Community Advisory Council. It also operates a formal patient complaints procedure. Tallaght University Hospital has a large volunteer community that have a long standing involvement in improving patients' experiences while at the Hospital.

41. The Hospital operates a risk escalation policy which clearly sets out the process for how staff should identify, assess, manage and escalate their risks. Hospital policy is that risk management should move from a reactive approach to a more proactive approach to continuous quality improvement, safety assurance, patient satisfaction and engagement, and risk identification and mitigation.

42. The Hospital strives to be a learning organisation, constantly striving for improvement. It has a clinical audit function which is part of its QSRM programme. Its policy is to acknowledge when things go wrong and disseminate why things went wrong and how to ensure they don't go wrong again in the future.

Legal disputes involving Other State Bodies

Where a legal dispute involves another State body, unless otherwise required by statues, every effort should be made to mediate, arbitrate or otherwise resolve before expensive legal costs are incurred. State bodies should pursue the most cost effective course of action in relation to legal disputes.

In addition to the annual reporting requirement concerning details of legal disputes with other State bodies, State bodies are required to provide details of such legal disputes involving expenditure of €25,000 or over to the parent Department and to the relevant Vote section of the Department of Public Expenditure and Reform, once a year by June 30th of each year including an estimate of the legal costs incurred up to the date of such information.

Section 5

Standing Orders to regulate the procedures and business of the Board

Meetings

1. The Board shall hold at least six meetings in each calendar year and such other additional meetings as it considers necessary for the performance of its functions.

2. The meeting will be held at such times and at such places within the State as the Board from time to time decides. Should circumstances arise which, in the opinion of the Chairperson, would make it inconvenient for a large number of members to attend a meeting he or she may direct that the meeting be deferred to a later date to be fixed by him or her.

3. The Chairperson may call a meeting of the Board at any time.

4. One third or more Board Members may demand a meeting in writing. If the Chairperson refuses, or fails to call a meeting within seven days of such a demand being presented, the Board Members signing the demand may forthwith call a meeting.

5. Provided that at least six meetings a year are held in person, certain meetings may be held via teleconference/videoconference for the purpose of holding urgent discussions. Board Members must undertake to ensure privacy during such calls.

Notice of meetings and the business to be transacted

6. Before each meeting of the Board a written notice specifying the business proposed to be transacted (i.e. agenda) shall be issued by the Board Secretary to every Member by a secure means so as to be available to Members at least four clear working days before the meeting. Failure to receive notice of a Board meeting will not invalidate that Board meeting or any business transacted at that meeting.

7. Papers relating to the business to be transacted at a meeting shall generally be issued by the Board Secretary to Members by a secure means along with the agenda but may where necessary be issued as soon as possible thereafter. Papers may, exceptionally, be tabled at a Board meeting with the Chairperson's permission (or, in his/her absence, the permission of the Vice Chairperson).

8. Reports, documents and briefings issued to members in relation to Board matters must be treated as confidential until such time as the Board has had an opportunity to discuss and make decisions on their contents including their distribution outside the Board membership.

Chair of meeting

9. The Chairperson of the Board shall, if he or she is present, be chairperson of the meeting. If the Chairperson is not present, or the office of the Chairperson is vacant, the Vice-Chairperson shall, if he or she is present, be chairperson of the meeting. If neither the Chairperson nor Vice-Chairperson of the Board is present, the Board Members who are present shall choose one of their number to be chairperson of the meeting.

Who should be driving Board Agendas

The Chairperson is responsible for the effective management of the Board's agenda and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues. The Chairperson and the CEO should meet in advance of the Board meeting to agree the agenda.

The Hospital Board approves its planned programme of work for the year at the January meeting. Known /proposed agenda items are identified, agreed and scheduled for specific meetings. It is agreed at the January Board meeting to review the Workplan at the July Board meeting reflecting on progression of the plan at that stage and any other Board matters that require attention. The Chairperson and CEO refer to the Board Workplan when agreeing the agenda for each Board meeting. The Hospital Board issues log is also considered when agreeing the Agenda for each Board meeting.

Quorum

10. In accordance with the bye-laws, the quorum for a Board meeting is six members. In the event that the Board is not quorate at the beginning or during a meeting; preliminary discussions may be held, but no business shall be transacted while it remains inquorate.

11. If the Chairperson or a Board Member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum.

Decision making

12. Decisions by the Board will normally be made by consensus rather than by formal vote. However, decisions will be made by a vote when:

    - the Chairperson feels that there is a significant body of opinion among Board Members at the meeting which disagrees with a proposal or has expressed reservations about it and no clear consensus has emerged, or

    - a Board Member who is present requests that a vote be taken and this is supported by at least one other Board Member, or

    - the Chairperson feels that a vote is appropriate.

13. When a vote is taken, a decision will be by simple majority. In the case of a tied vote, the Chairperson will have a casting vote in addition to his or her original vote.

Conflict of Interest

14. Each Board Member must comply with the procedure which has been approved by the Board for avoiding and dealing with conflicts of interests and which is included in this Corporate Governance Manual. Where individual Board Members become aware

of non-compliance with any such obligation, they should immediately bring this to the attention of the Chairperson with a view to having the matter rectified.

A Board member absent themselves

15. A Board member should absent themselves when the Board is deliberating or deciding on matters in which that Board member has declared a material interest. In such cases that Board member shall receive a redacted version of Board Minutes.

Documents withheld

Documents on any deliberations regarding any matter in which a Member of the Board has disclosed a material interest will not be made available to the Board member concerned.

Procedure for Disqualification/Removal from office of Board members

A Board member may be removed from office if they have not attended meetings for a consecutive period of six months without prior approval of the Chairperson.
The Board can, following a formal discussion and decision, remove a Board member from office at any time if:

1. The Board member has become incapable through ill-health
2. The Board member has committed stated misbehaviour or
3. The removal of the Board member appears to the Board to be necessary for the effective performance by the Board of its functions

The same procedure applies to External members of Board committees.

Procedure for obtaining Board approval between Board meetings

16. The powers which the Board has reserved to itself may when an urgent decision is required be exercised by the Chief Executive and the Chairperson after having consulted at least two Board Members. The exercise of such powers by the Chief Executive and Chairperson shall be reported to the next meeting of the Board for formal ratification.

Minutes of meetings

17. The minutes of the proceedings of a Board meeting shall be drawn up by the Board Secretary and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it. No discussion shall take place upon the minutes except upon their accuracy or where the Chairperson considers discussion appropriate. Minutes will be circulated in advance of the next meeting as soon as possible following the meeting to which they relate.

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

19. The names of the proposer and seconder for any decision arising at a meeting of the Board will be recorded in the minutes of the meeting.

20. The names of Board Members voting on any decision arising at a meeting of the

Board will be recorded in the minutes of the proceedings of the meeting and the record will show which Member(s) voted for and against that question and which Member(s) abstained.

21. When minutes of proceedings have been adopted and confirmed by the Board, it will not be in order for any Board Member to question their accuracy nor seek their amendment at subsequent meetings.

22. The meetings of the Board will be held in private. However, the minutes of a meeting which have been approved by the Board and signed by the Chairperson will be published on the Hospital's website.

Issue of statements on behalf of the Board

23. Only the Chairperson or the Chief Executive with the agreement of the Chairperson shall issue any statement on Board matters to the press or the public on behalf of the Board.

Attendance at meetings by persons other than Board Members

24. The Board Secretary may attend all meetings of the Board.

25. The Chief Executive and up to seven members of the Executive Management Team nominated by him/her with the agreement of the Chairperson may attend and participate fully in all Board meetings save that they may not participate in any vote.

26. The Chairperson may, at his/her absolute discretion, decide that the discussion on any matter should be confined to the Board Members, or to the Board Members and the Chief Executive, in which case any others persons shall absent themselves from that part of the meeting.

27. The Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to individuals, groups or organisations to attend and address any of the Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

Chair's ruling

28. The decision of the chairperson of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders at the meeting shall be final.

29. The Chairperson will have the power to decide upon any procedural matter arising and not covered by these Standing Orders.

Review and suspension of Standing Orders

30. Any Standing Order(s) may, at any time, by consent of not less than two-thirds of the Board Members present at the meeting of the Board be suspended for the purpose of any specific business before the Board, provided to do so would not contravene the Hospital Charter or any statutory provision.

Section 6

Formal schedule of matters reserved for Board decision

1. Good governance requires that there be a formal schedule of matters specifically reserved to the Board for decision in order to ensure that the direction and control of the Hospital is specifically and demonstrably in the hands of the Board.

2. Decisions in relation to the matters listed below are specifically reserved to the Board:

   (a) the Hospital's corporate/strategic plan and/or any similar significant policy documents;

   (b) the Hospital's annual service/operating plan and budget;

   (c) the annual accounts and annual report of the Hospital;

   (d) any significant change in accounting policies or practices, following consideration by the Audit Committee;

   (e) all proposals on individual contracts of a capital or revenue nature amounting to, or likely to amount to, more than €300,000 over a three year period or the period of the contract if longer;

   (f) all property leases of whatever value;

   (g) the disposal or acquisition of any land or property;

   (h) the establishment of any subsidiary or associated companies;

   (i) the opening of bank accounts;

   (j) the appointment, remuneration and assessment of, and succession planning for, the Chief Executive;

   (k) the arrangements governing the appointment and remuneration of the EMT and of all medical consultants; and

   (l) the HSE Annual Compliance Statement.

3. In addition to the foregoing, the Board shall:

   (1) approve the Standing Orders, Code of Governance, Code of Conduct and Schedule of matters reserved for Board decision;

   (2) approve proposals for managing risk, ensuring quality and developing clinical governance;

- Managing Risk: Take a strategic view of risks in the organisation and approve proposals for managing risk, ensuring that there are clear accountabilities for the management of risks. The Board will continuously assess and monitor risks ensuring that there are clear escalation processes in place. The Board shall receive regular reports from the QSRM Board Committee, CEO, Director of QSRM and Executive Management Team on the principal risks of the organisation and the effectiveness of risk management.
- Quality: The Board will approve proposals for the delivery of high quality, safe and reliable patient care. The Board shall receive regular reports from the Board Committee's, Clinicians, Director of QSRM, CEO and Executive Management Team in the context of organisation wide collaboration, innovation and standardised quality improvement.
- Clinical Governance: The Board will approve the structure for clinical governance, accountability and authority to ensure clear reporting lines and escalation processes. The Board will ensure a process for systematic monitoring of, learning from, safety incidents at local, regional and national levels.

(3) periodically review the organisation structures, processes and procedures to facilitate the discharge of business by the Hospital;

(4) approve the arrangements for developing and implementing the Hospital's personnel policies including those governing the appointment, removal and remuneration of staff;

(5) approve the Hospital's annual capital investment plan, any individual capital projects not specifically funded by the HSE in excess of €500,000, and any individual Public Private Partnership proposals;

(6) approve any individual compensation payments to members of the EMT and hospital consultants;

(7) periodically review the potential implications of legal actions being taken against or on behalf of the Hospital;

(8) periodically review the Board's own effectiveness, that of its committees and individual members; and

(9) take whatever decisions that the Board or the Chief Executive consider to be of such significance as to require to be taken by the Board.

4. The Board shall satisfy itself that there is a sound system of internal controls including financial, operational and compliance controls, and risk management processes within the Hospital. It shall undertake an annual assessment of the effectiveness of the internal control and risk management processes. It shall also approve statements for inclusion in the annual report concerning internal controls and risk management.

5. Those functions of the Board which have not been retained as reserved by the Board or delegated to a committee of the Board shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board. The Board shall satisfy itself that management arrangements are in place: (a) to enable responsibility to be clearly delegated to senior executives for the main programmes of action; (b) for performance against programmes to be monitored; and (c) for senior executives held to account. Members of the EMT may be required to report periodically to the Board or its committees on their assigned areas of responsibility.

6. The Board may at any time decide to withdraw delegated responsibility for any matter and reserve to itself decisions thereon.

7. As indicated in the Standing Orders, the powers which the Board has reserved to itself may when an urgent decision is required be exercised by the Chief Executive and the Chairperson after having consulted at least two Board Members. The exercise of such powers by the Chief Executive and Chairperson shall be reported to the next meeting of the Board for formal ratification.

8. Acquisition of Land or Buildings

The following procedures should be applied:

(i) Independent Valuation: Where land or property is being considered for acquisition an independent valuation must be obtained. These valuations should be obtained before any decision is taken by the Board to purchase or sell lands. The valuations should be obtained from professional property valuation surveyors.

(ii) Listing of Parties to Transaction: All parties to land and property transactions should be clearly reported to the Board when transactions are being considered. Any Board resolution related to the purchase of land or property should state the party or parties the asset is being purchased from.

(iii) Board Resolutions: Any Board resolutions regarding the purchase or sale of an asset should state the price the asset has been purchased or sold for.

(iv) Transparency: Purchase of land or property should be conducted in as transparent a manner as possible without compromising the negotiating position of the Hospital.

(v) Due diligence: A full due diligence report should be prepared for land or property that are being considered for acquisition.

(vi) Nominated Staff Member: A staff member should be nominated to have responsibility for the acquisition, management and sale of land or property. This staff member should report directly to the CEO regarding property issues.

(vii) Legal Matters: When dealing with the acquisition or sale of land or property there should be an active engagement with the solicitors involved and the nominated staff member shall ensure that the commercial and technical aspects of the transaction are fully addressed.

(viii) Title Registration: There should be a planned follow up with the solicitors involved to ensure that the title to any land or property acquired are properly registered with the Property Registration Authority.

(ix) Legal Obligations: There should be a planned follow up to ensure that any undertakings, obligations and other matters are completed following the acquisition or sale of land or property.

(x) Recording on State Property Register: All land and property should be recorded on the online State Property Register managed by the Office of Public Works.

Section 7

Committees of the Board

Appointment of committees

1. The Board may establish standing committees and ad hoc committees. Each committee must be chaired by a Board Member.

Established Committees

2. The standing committees established by the Board shall include, but are not limited to, the Audit Committee, the Staff & Organisation Development Committee, the Quality, Safety & Risk Management Committee, the Finance Committee, the Governance and Nominating Committee and the Research & Innovation Committee.

Approval of appointments to Committees

3. The Board will appoint Board Members to any committee it establishes and may also appoint persons who are not members of the Board (provided they are not employees of the Hospital) but have special knowledge and experience related to the purpose of the committee. Any person appointed to a committee is required to comply with the provisions of this Corporate Governance Manual.

4. Following notification by the Chair of a Committee of their intended nomination to the Governance and Nomination Committee the Board Secretary will hold an introductory meeting with the candidate to outline the following:

   - Term length & limit.
   - Governance Procedures.
   - Induction Dates.
   - Committee Dates.
   - Recommended publications for reading, including the Committee TOR.

5. The Chair of the Committee should then make formal contact with the candidate to outline the oversight responsibilities of the Committee and answer any queries.

6. Following appointment by the Governance and Nominating Committee, the Board Secretary will progress the required governance procedures.

7. On completion of the governance procedures the Board Secretary will provide the newly appointed member with relevant access to TUH material and Committee material.

8. The Executive Lead should hold a one-to-one meeting with the newly appointed member to provide context and guidance on TUH matters.

9. Following a two meeting period, or within a period of 6 months, the Chair of the Committee or the Board Secretary on the Chair's behalf should undertake a 'check-in' with the member to provide support and assist the member further in terms of induction.

10. Any member or members of a committee may at any time be removed by the Board and another or other persons appointed.

Terms of Reference

11. Each committee shall have such terms of reference and powers and be subject to such conditions as the Board shall from time to time decide.

12. Each committee will in the transaction of its business comply with any directions which the Board may give from time to time either in general or for individual committees.

13. Committee Chairs will report after each meeting to the Board. A copy of the minutes of each Committee meeting will be sent to the Chief Executive and the Chairman of the Board.

14. Content of Committee Reports to the Board

- Date
- Name of Committee
- Name of Committee Chair
- Name of Committee Members
- Objective of the Committee
- Summary of activity against the approved plan
- List of activities in progress and upcoming events
- Financial Impact
- Dissenting opinions
- Recommendations to the Board

Induction and CPD Programme for Committee members

Induction Programme

- Role of the Board and its Committees and how they work
- Role the Governance & Nominating Committee
- The role of the Chair of the Governance & Nominating Committee
- The role of the New Member
- Working with External Committee members and Executives who attend
- Committee Reporting to the Board and the AGM
- The Annual Workplan

Induction Programme for Committee Chairs

- Introduction to the Terms of Reference by the Chair of the Board.

- The role of the Committee Chair.
- The importance of minutes.
- Interaction with other committees where appropriate.
- Committee reporting to the Board and to the AGM.
- How to run effective meetings.
- How to get the most value from External members.
- How to work with Executive members who attend Committee meetings.

CPD Programme

A CPD programme for the Committee should cover the following over an agreed period of time:

- Market for NEDs and how to source them.
- Update on best practice
- Regulation and compliance
- The Boards role in the culture of TUH
- Feedback on exit interviews from departing board members and senior executives

Roles of Executives on committees

Each committee of the Board should have an Executive Lead.

Among the matters the Executive Lead should be responsible for are:

1. The overall management and effective and efficient running of the committee.
2. Lead discussions at meetings and be fully informed of matters listed on the Agenda.
3. Act as a liaison between the Board committee and the EMT when necessary and follow up directly on matters discussed at the meeting for action by the EMT.
4. Liaise directly with the Chair of the committee to agree the Agenda and papers for each committee meeting, well in advance of the next meeting.
5. Assist the Chair in preparing the Annual Report from the committee to the Hospital Board.
6. Closely monitor the Terms of Reference of the committee and ensure the committee is operating in accordance with same and suggest updates if necessary/appropriate.
7. Ensure that all actions listed on the Issues Log are managed appropriately by the relevant person especially if the person is not in attendance at the meeting.
8. Ensure papers for committee meetings are circulated to the committee in advance of the meeting in accordance with the timeframe agreed in the terms of reference.

General provisions applying to committees

15. All committees, including the Chair and members thereof, established by the Board shall be evaluated and reviewed by the Board on an annual basis.

16. Committees can invite other Board Members to attend a meeting or meetings and may procure advice and support from individuals or bodies outside of the committee or Board membership.

17. Any disclosure of interests by any member of a committee must be discussed with, and reported to, the Chairperson of the Board.

18. The Chief Executive or another designated employee of the Hospital will attend the committee meetings, unless considered inappropriate by the Chair of the Committee.

19. The Board Secretary or another employee of the Hospital designated by the Chief Executive shall act as the secretary to each committee.

20. A committee secretary's main functions are to oversee the committee's day to day management and help it ensure that it observes its terms of reference and standing orders.

21. The committee secretary must exercise due care, skill and diligence that can be reasonably expected from a person with their level of knowledge and experience.

22. Depending on the size of the committee, the committee secretary will have administrative duties which may include the following:

    - keeping minutes of the committee;
    - compiling the agenda, in consultation with the chair;
    - ensuring that arrangements for meetings are met (room booking, facilities, refreshments etc.)
    - providing legal and administrative support to members of the committee;
    - sending notices of meetings, agenda and supporting documentation in a timely fashion;
    - maintaining a log of unexecuted decisions;
    - tracking the execution of action points agreed at meetings;
    - ensuring that a quorum is maintained;
    - managing voting/ballots as set out in the standing orders:
    - ensuring that draft minutes are circulated to members as soon as possible after meetings;
    - supporting the chair in ensuring the smooth functioning of the committee;
    - ensuring that the draft minutes are approved, signed and a file copy maintained in good order;
    - maintaining an up to date record of committee membership and contact details of members;
    - ensuring that copies of approved minutes are transmitted to the appropriate bodies;
    - acting as archivist for all documentation relating to the work of the committee;
    - responding to all committee correspondence; and
    - preparing an annual report of the committee's activities as required.

Section 7(a)

Audit Committee

Tallaght University Hospital

Terms of Reference

March 2024

1.1.1 Constitution

The Board of Tallaght University Hospital (the Hospital) has formally established an Audit Committee to assist the Board in fulfilling its oversight responsibilities. [i]

1.1.2 Main Functions

The main functions of the Audit Committee (AC) are to review the significant financial reporting issues and judgements made in connection with the Hospital's financial statements and reports; to review the scope and effectiveness of the Hospital's internal financial controls, as they pertain to the financial statements, including financial risk controls; to report the Board annually in respect of the HSE's Annual Compliance Statement; and to monitor the independence and performance of the Hospital's external and internal auditors.

1.2 Main roles and responsibilities

The main roles and responsibilities of the AC are as follows:

A EXTERNAL AUDIT

1. To make recommendations to the Board on the appointment of the external auditor and to approve the remuneration and terms of engagement of the external auditor insofar as they relate to the Hospital;
2. To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration the relevant professional and regulatory requirements, insofar as these matters relate to the Hospital;
3. To develop, implement and review policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical and other guidance regarding the provision of non-audit services by the external audit firm and its international networked associates;
4. To discuss with the external auditors before the audit commences, the nature and scope of the audit; and to discuss with the external auditors any matters of concern or emphasis the AC wishes to draw to their attention.
5. To review with the external auditors the draft financial statements before publication, focussing on any changes in accounting policies, major judgemental areas, significant adjustments arising from the audit and compliance with accounting standards relevant to the Hospital, reviewing the appropriateness of the going concern concept.
6. To assure appropriate qualification of the External Auditors in compliance with S. 27 Companies (Statutory Audits) Act 2018

B INTERNAL AUDIT/INTERNAL CONTROL

7. To review the Hospital's internal financial controls and financial risk management systems.

8. To monitor and review the effectiveness of the internal audit function, insofar as it relates to the Hospital;
9. To receive regular reports from the Internal Auditor and to meet with him/her, at least once a year, without other members of the Executive being present;
10. To approve the Internal Audit Department's Charter.
11. To approve the risk based Internal Audit Plan
12. To approve the Internal Audit Department's Budget and Resource Plan.
13. Receive communications from the Head of Internal Audit on the Internal Audit department's performance relative to its plans and other matters.
14. Approve the decisions regarding the appointment and removal of the Head of Internal Audit.
15. Make appropriate enquiries of management and the Head of Internal Audit to determine whether there is appropriate scope or resource limitations.
16. To receive an annual report (more frequently if felt necessary) from the Procurement Officer;
17. To keep under review the effectiveness of the internal financial control systems and, in particular, to review the external auditor's management letter and the executive's response, monitoring agreed actions to comply with recommendations of the external auditor.
18. To receive from the DOF, at least twice yearly, a statement of his/her assurance that no matters relating to fraud have come to his/her attention which have not, in the ordinary course of reporting to the AC, been notified.

C RISK MANAGEMENT

19. To assess and report to the Board the major financial risks and uncertainties impacting on the Hospital. The specific risks will be identified through the medium of the Hospital's Risk Management System;
20. To liaise with the QSRM Committee to cross-inform on key areas of risk management and to take a view on the totality of the risk management system and to have at least one joint meeting each year with the QSRM to discuss matters of common interest:
21. To be satisfied that assurances relating to financial risk and internal controls provided by the EMT (Executive Management Team) and external and internal auditors is appropriate;
22. To review periodic status reports provided by the Executive Management Team, Internal Auditor, External Auditor , which summarise the status of key initiatives and key compliance issues;

D FINANCIAL GOVERNANCE/GENERAL

23. To review the procedures by which staff and other stakeholders of the Hospital may, in confidence, raise concerns about possible fraud or improprieties in matters of financial reporting or other material matters in accordance with the Hospital's Protected Disclosure Policy. To review material outcomes of investigations into Protected Disclosures.
24. To report to the Board, identifying any matters in respect of which AC considers that action or improvement is needed, and to make recommendations as to the steps to be taken.
25. To include in the annual report a section describing the work of the AC in discharging its responsibilities;
26. To report to the Board on how it has discharged its responsibilities in the form of an Annual Report.
27. The Committee should review its own performance, periodically in the context of its terms of reference and to report its conclusions and recommend any changes it considers necessary to the Hospital Board. A full external review of the AC should take place every three years.

28. To consider such other topics, as the AC may be requested by the Board to consider from time to time;
29. To review the annual HSE Annual Compliance Statement and advise the Board;

E FINANCIAL REPORTING OVERSIGHT

30. To monitor the integrity of the financial statements of the company, reviewing significant financial reporting judgements contained in them;
31. To review, prior to formal submission to the Board, the annual financial statements and, in particular, any significant issues arising from the audit, the accounting policies, any issues requiring a significant exercise of judgement, the clarity of disclosures, compliance with applicable accounting, corporate governance and the statements on internal control; To review the appropriateness of the Accounting Framework used.
32. To advise the Board as to the appropriateness of the application of the Going Concern Concept;

Scope and Objectives

While all Members of the Board (directors) have a duty to act in the interests of the Hospital, the AC has a particular role, acting independently from the Senior Management Team (EMT), to ensure that the interests of stakeholders are properly protected in relation to financial reporting oversight, internal control, internal and external audit, financial risk management and financial corporate governance. However the overarching principle is that of a unitary Board and all directors remain equally responsible for the Hospital's affairs as a matter of law. The AC, like other committees to which particular responsibilities are delegated, remains a committee of the Board. Any disagreement within the Board, including disagreement between the audit committee's members and the rest of the Board, should be resolved at Board level.

The Terms of Reference describe the responsibilities and the nature of the relationship between the AC and the Board, the EMT, the internal and the external auditors. The Terms of Reference will be reviewed each year by the AC and appropriate amendments approved by the Board. There is an underpinning assumption that there will be a frank, open working relationship and a high level of mutual respect, particularly between the AC Chairman and the Board Chairman, the Chief Executive Officer and the Director of Finance. It is, furthermore assumed that the AC is prepared to take a robust stand and all parties (AC Chairman, Board Chairman, the Chief Executive Officer and the Director of Finance) must be prepared to make information freely available to the AC, to listen to their views and to talk through issues openly.

It is not the duty of the AC to carry out functions that properly belong to others, such as the EMT, the QSRM Committee, Finance Committee or the auditors. Its major role is to exercise a high-level oversight function; exercising detailed reviews (perhaps with independent advice) only in circumstances where there are signs that there is something amiss.

1.2.1 **TERMS OF REFERENCE**

1.2.2 **Membership and Appointment**

Appointments to the AC should be made by the Board on the recommendation of the Governance and Nominating Committee (G&NC), in consultation with the AC Chairman. Audit Committee members will be appointed by the Board, taking into account the recommendations of the G&NC. It will comprise a Chairman, who will be a Board member and at least one other Board member. Up to three external members may be appointed to the AC in order to achieve an appropriate competency mix. These members will be independent of the Chairman of the Board, the EMT and of the external auditors. The period of appointment to the AC is three years. Members may be re-appointed for a maximum of one further term, to a maximum of six years in total, subject to the proviso that membership of the AC

will depend on the term of office of the Board. In the absence of the Chairman, the AC shall appoint one of the members to chair the meeting from which the Chairman is absent.
A letter of appointment will be issued to each new member of the AC, which will include: information regarding the Terms of Reference of the AC, duration of appointment, support and training to be provided, time commitment expected, rules regarding conflict of interest and performance management arrangements.

The Director of Finance and one of his/her colleagues shall attend meetings of the AC and provide executive and technical support to the Audit Committee. As per the TUH Corporate Governance Manual, the Board Secretary shall act as secretary to each Committee, unless otherwise directed by the Chief Executive. The AC should have access to the services of these officials of the Hospital (or their nominees) on all AC matters including: assisting the Chairman in planning the AC's work, drawing up meeting agenda, maintenance of minutes, drafting of material about its activities for the annual report, collection and distribution of information and provision of any necessary practical support.
The AC may temporarily co-opt other directors to the AC as and when deemed necessary. Additionally members may be co-opted, as appropriate, from outside the Board.

A quorum shall consist of two members (at least one of whom should be a Board member).
Copies of approved minutes of the meetings of AC will be circulated to all members of the Board in addition to members of the AC. Meetings may be facilitated virtually if necessary. Other members of management may attend meetings of AC from time to time as determined by the AC to assist in the attainment of its objectives.

A formal induction will be provided for new members of the AC.

1.2.3 **Conduct of Meetings**

Notice of each meeting confirming the venue, time and date, together with an agenda of matters to be discussed will normally be forwarded to each member of the AC five working days in advance of the meeting, via a secure platform

Meetings of the AC will be held not less than four times annually to coincide with the financial reporting and audit cycles. All meetings shall be convened by the Chairman. The Chair may convene ad-hoc (special) meetings if and when required. They will normally be held in the Hospital however may be facilitated virtually if necessary. However it is recommended that Committees meet in person at least once per year.

Decisions will normally be taken by achieving consensus, but where necessary, a simple majority of those members present will carry a motion. The Chairman shall have a casting vote in the event of a tie.

The draft minutes of the AC meetings will be sent for approval to the Chairman and other members as soon as possible following each meeting. Once the minutes have been approved (which can be electronically), they will be circulated to members of the Board.

An annual work programme will be approved by AC and submitted to the Board for consideration.
AC will present a written report annually to the Hospital Board, summarising the work of the Committee in the previous year. A summary report of the work of AC will be included in the Annual Financial Statements.

At least one joint meeting should be held each year with the QSRM to cross-inform members of both committees of the work of the other.

AC shall act as a channel of communication between the Board, management and the External Auditors and shall report to the Board with its recommendations, where it considers action or improvement is

needed in any area under its remit. The Chairman of the AC will meet with the Chairman of the Board at least once during the year and more often if necessary, to discuss relevant issues.

AC is authorised by the Hospital Board to:

a) Investigate any activity within its terms of reference and
b) Seek any information that it requires from any employee of the Hospital. All employees are directed to cooperate with any request made by the AC.

The AC will have as an agenda item, at least once a year, a discussion without management, with the External Auditors to ensure that there are no issues of concern and to review matters arising from the audit.

The External Auditors may request a meeting of AC or with the Chair of the AC at any time if they consider that one is necessary to discuss a specific item or items.

Subject to Board approval, where the AC considers it necessary, it may obtain legal, accounting or independent professional advice at the Hospital's expense and secure the attendance of external professionals with relevant experience and expertise.

Authority

AC shall operate under delegated authority from the Board, which is ultimately responsible for all matters relating to the presentation of Financial Statements and all issues arising from Internal and External Financial Audits in the Hospital.

1.2.4 **Review**

AC will review these Terms of Reference periodically and, following appropriate consultation will advise the Board as to appropriate amendments.

G & NC Approved February 2024

Section 7(b)

Quality, Safety & Risk Management Board Committee
Tallaght University Hospital

Terms of Reference

June 2023

Constitution
The Hospital Board has resolved to establish a Committee of the Board, to be known as the Quality Safety & Risk Management (QSRM) Board Committee, to assist the Board in fulfilling its oversight responsibilities.

Main Function
The Quality, Safety and Risk Management Board Committee is responsible for the overall policies, systems and structures for risk management across the Hospital. The main functions of the QSRM Board Committee are to:

- oversee the development of a QSRM programme for the Hospital and any subsequent amendments deemed necessary by the executive;

- recommend to the Board a QSRM programme and organisation structure that clearly articulates roles and responsibility, reporting lines, authority and accountability for quality, safety and risk management across the organisation;

- ensure that the executive is implementing the QSRM programme and that its outcomes are monitored and assessed through regular reporting; with a focus on the key performance indicators;

- review annually the risk information that is being reported to the Committee and to the Board to ensure it is fit for purpose

- seek documentary evidence and assurance from the executive that the hospital is conforming with all regulatory and legal requirements to assure quality, safety and risk management; and

- act as advocates at Hospital Board level for QSRM issues which cannot be resolved by the Executive Management Team

- provide oversight on behalf of the Hospital Board of non-financial risks and the risk management process

Membership

Members of the Committee shall be appointed by the Board. The Committee shall be made up of two Board Members. Subject to Board approval, the two Board Members may appoint up to three additional external members with the appropriate skills and relevant expertise.

The Board should appoint at least two members and up to three external members to this committee on the advice of the Governance and Nominating Committee after consultation with the Chair for the QSRM Board committee.

One of the two Board Members appointed to the Committee shall be appointed by the Board as Chair of the Committee. In his/her absence the Committee shall appoint one of their members to chair the meetings from which he/she is absent.

Membership of the Committee shall be structured to achieve an appropriate balance of recent and relevant experience taking account of the full range of the Committee's activities. Members of the committee will be provided with suitable induction and training.

Membership of the Committee shall dependent on the term of office of the Hospital Board. As Board membership is reviewed and changed, so too will the membership of the Committee be reviewed and changed. The general aim of changing membership is to ensure an appropriate balance between continuity and fresh perspectives.

The duration of appointment should be clearly set out at time of appointment and that the first appointment be for a period of three years, to a maximum of six years in total.

The Chair of the Board is authorised to attend all committee meetings, as an ex officio member.

The Director of QSRM shall be the executive lead for this Committee.

A letter of appointment will be issued to each new member of the committee, which will include: information regarding the terms of reference of the committee, support and training to be provided, time commitment expected, rules regarding conflict of interest and performance management arrangements.

A formal induction will be provided for new members the committee. Additionally, the committee will seek additional training and development from time to time as appropriate.

Meetings and Quorum

The Committee shall meet on at least four occasions a year. All meetings shall be convened by the Chair. The Chair may convene ad-hoc (Special) meetings if and when required. Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee Chair.

The quorum for meetings shall be two (2) members one of whom must be a Board member. Meetings may be facilitated virtually if necessary. However, it is recommended that the Committees meet in person at least once per year.

The Director of QSRM and the Director of Nursing & Integrated Care, while not members of the Committee, shall normally attend meetings.

As per the TUH Corporate Governance Manual, the Board Secretary shall act as the secretary to each Committee, unless otherwise directed by the Chief Executive.

Other hospital employees shall attend meetings by invitation for specific agenda items. The Chair or Vice Chair of the Board and the Chief Executive will attend a minimum of one meeting each year. The Chair of the Audit Committee will attend a minimum of one meeting each year. The Committee may also invite any employee of the Hospital, or other person to attend any meeting(s) of the Committee, as it may from time to time consider desirable, to assist the Committee in the attainment of its objectives.

A joint yearly meeting should take place between the QSRM Board committee and the Audit committee with a shared Agenda agreed between the Chair of the respective committee, Executive Lead and CEO. This agenda should include the Annual Internal Audit Plan.

The Chair shall present a written report annually to the Hospital Board summarising the work of the Committee in the previous year.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, via a secure platform, and any other person required to attend no later than five working days before the date of the next meeting. Supporting papers shall be sent to the Committee members and other attendees as appropriate at the same time.

Decisions will normally be taken by achieving consensus, but where necessary, a simple majority of those members present will carry a motion. The Chair of the Committee shall have a casting vote in the event of a tie.

The approved minutes of the QSRM Committee shall be circulated to the members of the Committee, to the Chair of the Board, other members of the Board and the Chief Executive as soon as possible following each meeting. The Committee Chair shall report to the Board on key aspects of the proceedings of each Committee meeting.

Authority

The Committee shall operate under delegated authority from the Hospital Board which is ultimately responsible for all matters relating to Quality, Safety and Risk Management. The Committee shall act as a channel of communication between the Hospital Board and Executive Management Team.

The Committee is authorised by the Hospital Board to:

(a) investigate any activity within its terms of reference;

(b) seek any information that it requires from any employee of the hospital: all employees are directed to cooperate with any request made by the Committee

Subject to Hospital Board approval, where the Committee consider it necessary, it may obtain outside independent professional advice, at the hospital's expense, and secure the attendance of external professionals with relevant experience and expertise**.**

Duties

In pursuance of its objectives, the Committee shall seek documentary evidence in how the Hospital is performing against its approved key targets for the six quality dimensions below.

Patient safety

Seeking assurances that wherever possible harm is avoided to patients from the care that is intended to help them. This includes the following:

- having sufficiently robust surveillance systems in place to capture and monitor patient safety concerns;
- appropriate responsiveness to patient safety concerns; and
- tracking and implementation plans to reduce patient safety risks

Effective care

Seeking assurances that the most effective care is provided to patients wherever possible within allocated resources. This includes the following:

- providing services based on scientific knowledge which provide a clear benefit;
- ensuring that services are aligned with the national clinical care programmes;
- ensuring that the effectiveness of a service/intervention is considered alongside cost effectiveness to ensure value for money;
- on-going auditing and evaluation of services to ensure continuous improvements in the effectiveness of care

Person-centred care

Seeking assurances, that wherever possible, care is provided that is respectful of the individual and responsive to the individuals needs and values. This includes the following:

- ensuring that patients have a very good user experience when using the hospital and that they are treated with respect and dignity a in a manner consistent with the hospital’s values and culture;
- ensuring that patients have tailored care which is responsive to their own individual needs, characteristics, attitudes and circumstances

Timely care
Seeking assurances, that wherever possible, care is provided in a manner that reduces unnecessary waits and harmful delays. This includes the following:

- ensuring that plans are in place and implemented to improve the speed and level of access to all services in the Hospital;
- where delays are inevitable, that systems/solutions are in place to minimise the impact on the patient's health

Equitable care
Seeking assurances, that care is provided consistently irrespective of a person's characteristics (includes origins, sex, gender, deprivation level, education, ethnicity or creed) wherever possible,

Efficient care
Seeking assurances, that care is provided in the most efficient manner with the least cost and waste wherever possible,

Licensing and regulation
As part of its role to assure high quality safe care the Committee shall have regard to seeking assurance that the Hospital is:

- compliant with all relevant regulations and
- assessing itself against the HIQA quality standards with a view to driving improved performance against such standards

Risk and incident management
In addition, the Committee shall seek documentary evidence of how the hospital is performing against its approved risk and incident management targets, particularly with respect to quality and patient safety. This includes the following

- having a robust risk identification, assessment, mitigation and escalation system in place which includes the on-going use of a risk register to record, review, rate and prioritise risks;
- having appropriate systems in place to review risks and prioritise activities and resources to minimise the overall level of risk;
- having a robust system in place for capturing, controlling and reporting incidents; and
- having systems in place to review and analyse incidents as well as implementing recommendations to reduce the chance of recurrence.

Performance Evaluation
The Committee shall, at least once a year, review its own performance in the context of its terms of reference and shall report its conclusions and recommend any changes it considers necessary to the Hospital Board. A full review of the committee should take place every three years. Any formal amendments to the Terms of Reference will be reviewed by the Governance and Nominating committee for approval by the Hospital Board.
G&N Approved May 2023

Section 7(c)

Staff and Organisation Development Committee Tallaght University Hospital

Terms of Reference

June 2022

Constitution

The Hospital Board has resolved to establish a Committee of the Board to be known as the Staff and Organisation Development Committee (the "Committee") to assist the Board in fulfilling its oversight responsibilities in regard to staff & organisation development and related issues.

Main Function

The functions of the Committee are to:

a. oversee the development and implementation of the HR Strategy and hospital policies, procedures and systems to recruit, retain, develop, motivate and equip hospital staff to continuously improve the services they provide to patients;

b. to oversee the remuneration and terms of service of members of the Executive Management Team (i.e. those reporting directly to the CEO). In ensuring oversight of these matters on behalf of the Board, the SODC will have due regard to the interests of the Hospital and taxpayers in general. Where pre-existing vacancies within the EMT are filled, providing they do not involve any change in the remuneration, terms or conditions of the posts concerned, and are in accordance with HSE Policy and compliance with Public Sector Pay Policy, the HR Director will ensure these are presented to SODC for noting. Only items which fall outside of this remit may require a recommendation by the Chair of SODC to the Hospital Board for approval; and,

c. undertake such other matters as are ancillary to the functions specified above or as are delegated by the Board to the Committee from time to time

Membership

The Board should appoint at least two board members and up to three external members to this committee on the advice of the Governance and Nominating Committee, following consultation with the Chair of the SODC.

One of the two Board Members appointed to the Committee shall be appointed by the Board as Chair of the Committee. In his/her absence the Committee shall appoint one of their members to chair the meetings from which he/she is absent.

The Committee shall comprise members with recent and relevant experience in order to achieve an appropriate balance of skills and experience and to reflect the full range of the Committee's activities. Members of the committee will be provided with suitable induction and training.

Additionally the committee will seek additional training and development from time to time as appropriate.

Membership of the Committee shall depend on their term of office on the Board. As Board membership is reviewed and changed so too will the membership of the Committee be reviewed and changed. The general aim of changing membership is to ensure an appropriate balance between continuity and fresh perspectives.

The duration of appointment should be clearly set out at time of appointment and that the first appointment be for a period of three years, to a maximum of six years in total.

The Chair of the Board is authorised to attend all committee meetings as an ex officio member.

The Director of Human Resources is the executive lead to this Committee.

A letter of appointment will be issued to each new member of the committee. This will include: information regarding the terms of reference of the committee, support and training to be provided, time commitment expected, rules regarding conflict of interest.

Meetings and Quorum

The Committee shall meet on at least four occasions a year. All meetings shall be convened by the Chair. The Chair may convene ad-hoc (Special) meetings if and when required. Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee Chair.

The quorum for meetings shall be two (2) members one of whom must be a Board member. Meetings may be facilitated virtually if necessary. However it is recommended that Committees meet in person at least once per year.

The Director of Human Resources, while not a member of the Committee, shall normally attend meetings.

As per the TUH Corporate Governance Manual, the Board Secretary shall act as the secretary to each Committee, unless otherwise directed by the Chief Executive.

Other Executive Management Team (EMT) members shall attend meetings by invitation for the duration of any given meeting or for specific agenda items only as determined by the Committee. The Chair or Vice Chair of the Board and the Chief Executive will attend a minimum of one meeting each year. The Committee may also invite any employee of the Hospital, or other person, to attend any meeting(s) of the Committee as it may from time to time consider desirable in order to assist the Committee in the attainment of its objectives.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, via a secure platform, and any other person required to attend no later than five working days before the date of the next meeting. Supporting papers shall be sent to the Committee members and other attendees as appropriate at the same time.

Decisions will normally be taken by achieving consensus, but where necessary, a simple majority of those members present will carry a motion. The Chair of the Committee shall have a casting vote in the event of a tie.

An annual work programme will be prepared by the Committee and submitted to the Board for consideration at its January meeting.

The Chair shall present a written report annually to the Hospital Board summarising the work of the Committee in the previous year.

The approved minutes of the SODC shall be circulated to the Hospital Board as soon as possible for noting and/or discussion as necessary. The Committee Chair shall report to the Board on key aspects of the proceedings of the Committee as required. The Committee may redact minutes of any given meeting of the Committee prior to such minutes being circulated to the Board if such redaction is necessary in the opinion of the Committee in order to comply with confidentiality obligations or to comply with applicable law.

The approved minutes of the committee shall be circulated to the members of the Committee to the Chair of the Board, other members of the Board and the Chief Executive as soon as possible following each meeting. The committee Chair shall report to the Board on key aspects of the proceedings of each committee meeting.

Authority

The Committee shall operate under delegated authority from the Board, which is ultimately responsible for all matters relating to the remuneration and terms of service of the Management Team including the EMT.

The Committee is authorised by the Hospital Board to: investigate any activity within its terms of reference and seek any information that it requires from any employee of the hospital; all employees are directed to cooperate with any request made by the Committee

Subject to Hospital Board approval, where the Committee consider it necessary, it may obtain independent professional advice, at the Hospital's expense, and secure the attendance of external professionals with relevant experience and expertise**.**

Duties

In pursuance of its objectives, the Committee shall be responsible for ensuring the development, implementation and evaluation of the HR Strategy and seek documented assurances from management that the Hospital’s policies and practices in relation to recruitment, promotion, staff training & development, staff engagement, internal communication and other human resource issues are such that they:

- supports the Hospital’s strategic objectives;
- accords with the espoused culture and values of the hospital;
- supports ongoing change, innovation and excellence in the delivery of services;
- supports high levels of staff morale; and
- helps make the hospital an employer of choice for potential recruits.

The Committee shall be responsible for ensuring that the remuneration and terms of service of members of the EMT (i.e. those reporting directly to the CEO) are in accordance with the Public Sector Pay Policy, HSE Circulars, third party reports and employment legislation generally. Items which fall outside this remit will require a recommendation by the Chair of this committee to the Hospital Board for approval.

The Committee shall seek to assure itself that:

(a) issues relating to the remuneration and terms of service of all employees of the Hospital are managed appropriately by the CEO and EMT in accordance with public sector pay policy;
(b) an appropriate EMT structure is in place at the Hospital;
(c) an organisation development plan is implemented within the Hospital; and
(d) the remuneration and human resource policies and practices generally of Tallaght University Hospital are of the highest possible standard and comply with national policies in that regard.
(e) vacancies are filled in a fashion that conforms with Tallaght University Hospital determined staffing complement and protects continuity of services

The Committee will also be responsible for:

- reviewing, from time to time, such elements of the hospital's human resource strategy, policies, procedures and practices as it considers appropriate or as requested by the Board;
- reviewing arrangements established by management for compliance with all human resource legislative and regulatory requirements and Department of Health, HSE and Board policies; and
- making a recommendation or issuing an advisory to the Board where committee members are satisfied that such a course of action may be considered appropriate in particular circumstances.

Performance Evaluation
The Committee shall, at least once a year, review its own performance in the context of its terms of reference and shall report its conclusions and recommend any changes it considers necessary to the Hospital Board. A full review of the committee should take place every three years. Any formal amendments to the Terms of Reference will be reviewed by the Governance and Nominating committee for approval by the Hospital Board.
.

G&N approved May 2023

Section 7(d)

Finance Committee Tallaght University Hospital

Terms of Reference September 2023

Constitution

The Hospital Board has resolved to establish a Committee of the Board to be known as the Finance Committee to assist the Board in fulfilling its oversight responsibilities in relation to financial planning and management.

Main function

The main function of the Finance Committee is to oversee the processes for securing and applying hospital revenue and capital funding including issues relating to budgetary management, value for money, immediate, medium and longer term financial planning, capital expenditure and income collection, as well as strategic issues affecting the hospital's funding (such as activity based funding) or income. The Committee shall also deal with such other specific issues in relation to financial management that are referred to it by the Board and with any other related issues that it considers appropriate.

Membership

The Board should appoint at least two of its members and up to three external members to this committee on the advice of the Governance and Nominating Committee after consultation with the Chair of the Finance committee.

One of the two Board Members appointed to the Committee shall be appointed by the Hospital Board as the Chair of the Committee. In his/her absence the Committee shall appoint one of their number to chair the meetings from which he/she is absent.

The composition of the Committee shall be such so as to achieve an appropriate balance of recent and relevant accounting and finance experience taking account of the full range of the Committee's activities. Members of the Committee will be provided with suitable induction and training.

Membership of the Committee shall depend on their term of office on the Board. As Board membership is reviewed and changed so too will the membership of the Committee be reviewed and changed. The general aim of changing membership is to ensure an appropriate balance between continuity and fresh perspectives.

The duration of appointment should be clearly set out at time of appointment and that the first appointment be for a period of three years, to a maximum of six years in total.

The Chair of the Board is authorised to attend all committee meetings, as an ex officio member.

The Director of Finance is the executive lead to this Committee.

In the absence of the Chair, the Finance committee shall appoint one of the members to chair the meeting from which the Chair is absent.

A letter of appointment will be issued to each new member of the committee, which will include: information regarding the terms of reference of the committee, support and training to be provided, time commitment expected, rules regarding conflict of interest and performance management arrangements.

A formal induction will be provided for new members of the committee. Additionally, the committee will seek additional training and development from time to time as appropriate.

Meetings and quorum

The Committee shall meet on at least four occasions a year. All meetings shall be convened by the Chair. The Chair may convene ad-hoc (Special) meetings if and when required.

The quorum for meetings shall be two (2) members one of whom must be a Board member. Meetings may be facilitated virtually if necessary. However, it is recommended that Committees meet in person at least once per year.

The Director of Finance, while not a member of the Committee, shall normally attend the meetings.

As per the TUH Corporate Governance Manual, the Board Secretary shall act as the secretary to each Committee, unless otherwise directed by the Chief Executive.

Other Hospital employees shall attend meetings by invitation for specific agenda items. The Chairman or Vice Chair of the Board and the Chief Executive will attend a minimum of one meeting each year. The Committee may also invite any employee of the Hospital, or other person to attend any meeting(s) of the Committee, as it may from time to time consider desirable, to assist the Committee in the attainment of its objectives.

Unless otherwise agreed, an agenda of items to be discussed, shall be forwarded to each member of the Committee, via a secure platform, and any other person required to attend no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and other attendees as appropriate, at the same time.

Decisions will normally be taken by achieving consensus, but where necessary, a simple majority of those members present will carry a motion. The Chair of the Committee shall have a casting vote in the event of a tie.

An annual work programme will be prepared by the Committee and submitted to the Board for consideration at its January meeting.

The Chair shall present a written report annually to the Hospital Board summarising the work of the Committee in the previous year.

The approved minutes of the committee shall be circulated to the members of the Committee, to the Chair of the Board, other members of the Board and the Chief Executive as soon as possible following each meeting. The committee Chair shall report to the Board on key aspects of the proceedings of each committee meeting.

Authority

The Hospital Board retains full ultimate responsibility for all matters relating to the fiscal stability and long-term financial health of the hospital. However, the Committee Chair shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities and the Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

The Committee is authorised by the Hospital Board to: (i) investigate any activity within its terms of reference; and (ii) seek any information that it requires from any employee of the hospital: all employees are directed to cooperate with any request made by the Committee.

The Committee shall have access to sufficient resources to carry out its duties, including access to the Hospital's secretariat for assistance as required and shall be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

Subject to Hospital Board approval, where the Committee consider it necessary it may obtain independent professional advice at the Hospital's expense and secure the attendance of external professionals with relevant experience and expertise**.**

Duties

In pursuance of its objectives, the main duties of the Finance Committee shall be

1. Monitor the financial stability of the organisation;
2. Review and recommend to the Board the adoption of the Hospital's budget, based on the HSE Service Level Agreement (SLA), to include revenues and costs and capital budget.
3. Review the Annual Financial Statements and make a recommendation on their adoption.
4. Evaluate capital investment projects and make recommendations to the Board.
5. Evaluate and consider the longer term financial impact of the Hospital's Strategy and other prospective developments.

Specifically the Committee shall keep under review:

- the annual budget following the allocation from the HSE
- the monthly management accounts, comparing expenditure against budget, and projected year end outturn.
- cash projections for the year;
- the balance sheet – analysis of key assets and liabilities.
- the Hospital's financial strategy including remedial action in relation to budget difficulties;

- the relationship between costs and activity levels.
- cost saving/value for money initiatives;
- issues relating to income generation/collection;
- the financial implications of the Hospital's Corporate Strategy.
- the Hospital's capital development programme including minor capital, equipment replacement and the revenue implications of capital expenditure plans.
- The Finance function, its structure, its resources and how these resources are benchmarked against other entities to demonstrate performance at an operational level.
- All communication with the HSE in respect of discussions and interactions that the hospital has with the HSE in relation to funding and cashing of the Hospital.
- Financial support for the Tallaght University Hospital Foundation (TUHF).

In addition, the Committee shall consider matters of a strategic financial nature such as changes in funding systems, major capital development projects, the annual service arrangement with the HSE, and any developments with potential significant financial implications for the hospital. The Committee shall also provide a level of support and advice to the Director of Finance and the Financial Team.

Performance evaluation

The Committee shall, at least once a year, review its own performance in the context of its terms of reference and shall report its conclusions and recommend any changes it considers necessary to the Hospital Board. A full review of the committee should take place every three years. Any formal amendments to the Terms of Reference will be reviewed by the Governance and Nominating committee for approval by the Hospital Board.

G&NC Approved May 2023

Section 7(e)

Governance and Nominating committee Tallaght University Hospital

Terms of Reference

September 2023

Constitution

- The Hospital Board has resolved to establish a Committee of the Board to be known as the Governance and Nominating Committee to assist the Board in fulfilling its oversight responsibilities in relation to the overall governance of the Hospital.

Main Functions

The main function of the Governance and Nominating Committee is to ensure that the organisation has the appropriate governance structures and supporting processes and a fit for purpose board to support the future direction of the organisation.

Membership

The Committee shall comprise the Chair, Vice Chair and one other member of the Board. The composition of the Committee shall be structured as to achieve an appropriate balance of recent and relevant experience taking account the full range of the Committee's activities. Subject to Board approval, the committee may appoint up to three additional external members with the appropriate skills and relevant expertise.

Only members of the committee have the right to attend committee meetings. However, other individuals such as the chief executive, who is the Executive lead on the committee, the head of human resources and external advisers may be invited to attend for all or part of any meeting, as and when appropriate and necessary.

Membership of the Committee shall depend on the term of office of the Board. As Board membership is reviewed and changed so too will the membership of the Committee be reviewed and changed. The general aim of changing membership is to ensure an appropriate balance between continuity and fresh perspectives.

The duration of appointment should be clearly set out at time of appointment and that the first appointment be for a period of three years, to a maximum of six years in total.

The Board shall appoint the committee Chair who should be either the Chair of TUH, Vice Chair or a Board member. In the absence of the committee Chair and / the Vice Chair, the remaining members present shall elect one of themselves to chair the meeting from those who would qualify under these terms of reference to be appointed to that position by the Board. The Chair of the Board shall not chair the committee when it is dealing with the matter of succession to the Chair.

A letter of appointment will be issued to each new member of the committee, which will include: information regarding the terms of reference of the committee, support and training to be provided, time commitment expected, rules regarding conflict of interest and performance management arrangements.

A formal induction will be provided for new members of the committee. Additionally, the committee will seek additional training and development from time to time as appropriate.

Meetings and Quorum

The Committee shall meet on at least four occasions a year. All meetings shall be convened by the Chair. The Chair may convene ad-hoc (Special) meetings if and when required.

The quorum for meetings shall be two (2) members one of whom must be a Board member. Meetings may be facilitated virtually if necessary. However it is recommended that the Committees meet in person at least once per year.

An annual work programme will be prepared by the Committee and submitted to the Board for consideration at its January meeting.

- The Chair shall present a written report annually to the Hospital Board summarising the work of the Committee in the previous year.
- Executive Management Team members shall attend meetings by invitation for the duration of any given meeting or for specific agenda items only as determined by the Committee.
- The Committee may also invite any employee of the Hospital, or other person to attend any meeting(s) of the Committee, as it may from time to time consider desirable, to assist the Committee in the attainment of its objectives.
- Draft minutes of committee meetings shall be reviewed in the first place by the Chair of the Committee before being circulated promptly to the other members of the committee. Once approved, minutes should be circulated to all other members of the Board unless in the opinion of the committee Chair it would be inappropriate to do so.
- The approved minutes of the Governance and Nominating Committee shall be circulated to the Hospital Board as soon as possible for noting and/or discussion as necessary. The Committee Chair shall be available to report to the Board on key aspects of the proceedings of the Committee as required.

As per the TUH Corporate Governance Manual, the Board Secretary shall act as the secretary to each Committee, unless otherwise directed by the Chief Executive.
Meetings of the committee shall be called by the Board secretary of the committee at the request of the committee Chair.

The Board secretary shall minute the proceedings and resolutions of all committee meetings, including the names of those present and in attendance for all or part of the meeting.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the committee, via a secure platform, and any other person required to attend no later than five working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

Decisions will normally be taken by achieving consensus, but where necessary, a simple majority of those members present will carry a motion. The Chair of the Committee shall have a casting vote in the event of a tie. The approved minutes of the committee shall be circulated to the members of the Committee to the Chair of the Board, other members of the Board and the Chief Executive as soon as possible following each meeting. The committee Chair shall report to the Board on key aspects of the proceedings of each committee meeting.

Authority

The Committee shall operate under the delegated authority from the Hospital Board.

The committee is authorised by the Board to obtain, at TUH's expense, outside legal or other professional advice on any matters within its terms of reference subject to Board approval.

The Committee shall assist the Board Chair in setting performance targets for, and evaluating the performance of, the Chief Executive.

Governance Duties

Develop and recommend appropriate policies and procedures to ensure Tallaght University Hospital has the appropriate governance structures in place and recommend revisions as required, to assist TUH in fulfilling its oversight responsibilities of the Hospital at all levels.

Review [annually] the adequacy and effectiveness of governance documents including; policies, procedures, and committee terms of reference, making recommendations for change, as appropriate, to the Board.

Advise and make recommendations in relation the decision making authority of the Board, its Committees and the CEO.

Advise and make recommendations as appropriate to ensure TUH is compliant with legislation, regulation, public policy, relevant codes, statutory obligations and the Charter and other requirements from external bodies.

Review annually the time required from Board members. The Board performance evaluation should be used to assess whether Board members are spending enough time to fulfil their duties or have the time to do so.

Responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any governance consultants who may advise the committee within an agreed budget set by the Board.

Work and liaise as necessary with all other Board committees as appropriate.
Ensure that proper orientation and induction, support and continuing professional education is provided to the Board and its committee members in liaison with the Board Secretary.

Maintain a watching brief for the latest governance developments, best practices, and other opportunities relevant to TUH.

Advise and make recommendations as appropriate to ensure TUH is compliant with legislation, regulation, public policy, relevant codes, statutory obligations and the Charter and other requirements from external bodies

Ensure that a performance evaluation is carried out every 12 months of the Board, its committees, Chair and the CEO. An external evaluation should be conducted every three years by organisations / individuals qualified to do so, and that the report from the external reviewer will be sent to the Board, the Governance & Nominating Committee.

Support the Chair in the performance of his/her governance duties.

Nominating Duties

Review annually the size, roles, responsibilities, composition, diversity and structure of the Board and its committees with regard to competencies and skills of its members as related to the current and future needs of TUH and making recommendations to the Board as appropriate with regard to any changes.

Give full consideration to succession planning for Board and Committee members, the CEO and other senior executives in the course of its work, taking into account the challenges and opportunities facing TUH, and the skills and expertise needed on the Board to support its future direction.

Keep under review the leadership needs of the organisation, both at Board, committee and executive level with a view to ensuring the continued sustainability of the organisation.

Keep up to date and fully informed about strategic issues and commercial changes affecting TUH and the environment in which it operates

Be responsible for identifying and nominating for the approval of the Board, candidates to fill Board and Committee vacancies (including Externs to Board Committees) as and when they arise

Before any appointment is made by the Board, evaluate the balance of skills, knowledge, experience and diversity on the Board and its Committees, the results of the previous Board performance evaluation process that relates to the composition of the Board and, in the light of this evaluation, prepare a description of the role, capabilities and profile required for a particular appointment. In identifying suitable candidates the committee shall:

- consider using the appropriate promotional channels / or the services of external advisers to facilitate the search
- consider candidates from a wide range of backgrounds
- consider candidates on merit and against objective criteria and with due regard for the benefits of diversity on the Board, including gender, ethnicity, skill and personality mix, taking care that appointees have enough time available to devote to the position.

For the appointment of a Chair, the committee should prepare a job specification, including the time commitment expected. A proposed Chairs other significant commitments should be disclosed to the

Board before appointment and any changes to the Chairs commitments should be reported to the Board as they arise.

Prior to the appointment of a member of the Board, the proposed appointee should be required to disclose any other business interests that may result in a conflict of interest and be required to report any future business interests that could result in a conflict of interest.

Ensure that on appointment to the Board, or a Committee, new Board / Committee members receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside of board meetings

Work and liaise as necessary with all other Board committees.

The committee shall also make recommendations to the Board concerning:

Formulating succession plans for members of the Board and in particular for the key roles of the Board Chair, Committee Chairs and CEO.

Suitable candidates for the role of Vice Chair.

Membership of all Committees in consultation with the Chairs of those committees.

The re-appointment of any Board member at the conclusion of their specified term of office having given due regard to their performance and ability to continue to contribute to the Board in the light of knowledge, skills and experience required

Any matters relating to the continuation in office of any Board member at any time including the suspension or termination of service of a Senior Executive of TUH subject to the provisions of the law and their service contract.

The appointment of any Board member.

Reporting responsibilities

The committee Chair shall report to the Board on its proceedings after each meeting on all matters within its duties and responsibilities

The committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed

The committee shall produce a report to be included in TUH's annual report about its activities, the process used to make appointments and explain if external advice or open advertising has been used.

Other matters

The committee shall:

Have access to sufficient resources in order to carry out its duties, including access to the Board secretariat for assistance as required.

Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

Give due consideration to laws and regulations, the provisions of any relevant Code as appropriate.

Arrange for periodic reviews of its own performance and, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

Additional duties as may be delegated to the Committee by the Board from time to time that are with the Terms of Reference of the Committee

Performance evaluation

The Committee shall, at least once a year, review its own performance in the context of its terms of reference and shall report its conclusions and recommend any changes it considers necessary to the Hospital Board. A full review of the committee should take place every three years. Any formal amendments to the Terms of Reference of any Board Committee will be reviewed and approved by the Hospital Board.

G&NC Approved September 2023

Section 7 (f)

Research & Innovation Board Committee
Tallaght University Hospital

Terms of Reference

September 2023

Constitution
The Hospital Board has resolved to establish a Committee of the Board, to be known as the Research and Innovation Board Committee, to assist the Board in fulfilling its oversight responsibilities.

Background.

Tallaght University Hospital identified Research and Innovation as of one of its key priority areas in the Hospitals Corporate Strategy 2019-2024. The Hospital aims to develop new ways of organising and delivering health care to better meet people's increasingly diverse health and care needs.

To make research and innovation 'core business', the Hospital aims to create an organisational readiness for innovation and mobilise teams and individuals – this means developing our leaders, building improvement skills across the organisation, ensuring senior support for new thinking and creating opportunities of time and space for all staff and the people who come into contact with our services to generate and develop new ideas and to extend what works.

The Hospital has established a Research and Innovation Governance Committee, which is chaired by the Deputy CEO, which aims to proactively work to promote research and Innovation in TUH and to build a strong culture in this area. The Committee supports the activities undertaken by the Research and Innovation Offices.

Main Function
The Research and Innovation Board Committee is responsible for the overall policies, systems and structures for research and innovation management across the hospital.

The main functions of the Research and Innovation Board Committee are to:

1. Oversee the development of a Research and Innovation programme for the Hospital

2. Recommend to the Board a Research and Innovation programme and organisation structure that clearly articulates roles and responsibility, reporting lines, authority and accountability for Research and Innovation management across the organisation;

3. To advise the Board on issues relating to Research and Innovation in support of the Hospitals strategic priorities, with a focus on research and innovation excellence and integrity in line with the Hospital Strategy.

4. To promote a vibrant research and innovation culture across all departments and ensure the Hospital delivers good practice in research that meets the standards and governance requirements of funders and regulators.

5. To oversee the development of the Hospital policy and strategy regarding impact and commercialisation.

6. To ensure that the Hospital has a clear understanding of research horizons, needs and strategy, and to oversee the deployment of strategic funding made available by the Hospital to realise its vision for growth in Research and Innovation and its commercial applications.

7. To identify strategic and organisational issues resulting from interdisciplinary and multidisciplinary research; to promote synergies and funding opportunities at the institutional level, and to recommend appropriate organisational structures to capitalise on these opportunities.

8. To recommend to the Board the establishment of the Hospital's Research and Innovation Centre, and to recommend appropriate structures through which the performance of the centre can be assessed.

9. To receive reports and minutes from the Research and Innovation Governance Committees, and consider strategic and policy issues relating to Research and Innovation and where appropriate to make recommendations to the Board arising from the operations of these committees

10. To ensure that the Research and Innovation Committees are implementing the Research and Innovation programme and that the outcomes are monitored and assessed through regular reporting; with a focus on the key performance indicators; review annually the Research and Innovation activity that is being reported to the Committee and to the Board to ensure it is fit for purpose and as advocates at Hospital Board level for Research and Innovation issues which cannot be resolved by the Research or Innovation Operational Committees

11. To ensure that policies and procedures introduced by the Hospitals central structures contribute to the research and innovation agenda.

Membership

Members of the Committee shall be appointed by the Board. The Committee shall be made up of two Board Members. Subject to Board approval, the two Board members may appoint up to three additional external members with the appropriate skills and relevant expertise.

The Board should appoint at least two members and up to three external members to this committee on the advice of the Governance and Nominating Committee after consultation with the Chair for the Research and Innovation Board Committee.

One of the two Board Members appointed to the Committee shall be appointed by the Board as Chair of the Committee. In his/her absence the Committee shall appoint one of their members to chair the meetings from which he/she is absent.

Membership of the Committee shall be structured to achieve an appropriate balance of recent and relevant experience taking account of the full range of the Committee's activities. Members of the Committee will be provided with suitable induction and training.

Membership of the Committee shall be dependent on the term of office of the Hospital Board. As Board membership is reviewed and changed, so too will the membership of the Committee be reviewed and changed. The general aim of changing membership is to ensure an appropriate balance between continuity and fresh perspectives.

The duration of appointment should be clearly set out at time of appointment and that the first appointment be for a period of three years, to a maximum of six years in total.

The Chair of the Board is authorised to attend all committee meetings, as an ex officio member.

The Deputy CEO shall be the executive lead for this Committee.

A letter of appointment will be issued to each new member of the Committee, which will include: information regarding the terms of reference of the committee, support and training to be provided, time commitment expected, rules regarding conflict of interest and performance management arrangements.

A formal induction will be provided for new members the committee. Additionally, the Committee will seek additional training and development from time to time as appropriate.

Meetings and Quorum

The Committee shall meet on at least four occasions a year. All meetings shall be convened by the Chair. The Chair may convene ad-hoc (Special) meetings if and when required.

The quorum for meetings shall be two (2) members one of whom must be a Board member. Meetings may be facilitated virtually if necessary. However it is recommended that the Committees meet in person at least once per year.

The Deputy CEO, Head of Innovation and Research Manager, while not members of the committee, shall normally attend meetings.

As per the TUH Corporate Governance Manual, the Board Secretary shall act as the secretary to each Committee, unless otherwise directed by the Chief Executive.

Other Hospital employees shall attend meetings by invitation for specific agenda items. The Chair or Vice Chair of the Board and the Chief Executive will attend a minimum of one meeting each year. The Committee may also invite any employee of the Hospital, or other person to attend any meeting(s) of the Committee, as it may from time to time consider desirable, to assist the Committee in the attainment of its objectives.

A joint yearly meeting should take place between the Research and Innovation Board Committee and the QSRM Board committee with a shared Agenda agreed between the Chair of the respective committee, Executive Lead and CEO. This agenda should include the Annual Internal Audit Plan.

The Chair shall present a written report annually to the Hospital Board summarising the work of the Committee in the previous year.

Unless otherwise agreed, an agenda of items to be discussed, shall be forwarded to each member of the Committee, via a secure platform, and any other person required to attend no later than five working days before the date of the next meeting. Supporting papers shall be sent to the Committee members and other attendees as appropriate at the same time.

Decisions will normally be taken by achieving consensus, but where necessary, a simple majority of those members present will carry a motion. The Chair of the Committee shall have a casting vote in the event of a tie.

An annual work programme will be prepared by the Committee and submitted to the Board for consideration at its January meeting.

The approved minutes of the Research and Innovation Committee shall be circulated to the members of the Committee, to the Chair of the Board, other members of the Board and the Chief Executive as soon as possible following each meeting. The Committee Chair shall report to the Board on key aspects of the proceedings of each Committee meeting.

Authority
The Committee shall operate under delegated authority from the Hospital Board.

The Committee shall act as a channel of communication between the Hospital Board and Executive Management.

The Committee is authorised by the Hospital Board to:

(c) Investigate any activity within its terms of reference;

(d) seek any information that it requires from any employee of the hospital: all employees are directed to cooperate with any request made by the Committee

Subject to Hospital Board approval, where the Committee consider it necessary, it may obtain outside independent professional advice, at the hospital's expense, and secure the attendance of external professionals with relevant experience and expertise**.**

The Committee shall have access to sufficient resources to carry out its duties, including access to the Hospital's secretariat for assistance as required and shall be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

Duties
In pursuance of its objectives, the Committee shall seek documentary evidence in how the Hospital is performing against its approved key targets for the six quality dimensions below.

Performance Evaluation
The Committee shall, at least once a year, review its own performance in the context of its terms of reference and shall report its conclusions and recommend any changes it considers necessary to the Hospital Board. A full review of the committee should take place every three years. Any formal amendments to the Terms of Reference will be reviewed by the Governance and Nominating committee for approval by the Hospital Board.

G&NC Approved September 2023

Section 8

Code of Conduct

5.1 ETHICS

In carrying out duties one must operate ethically to:

5.1.1 Provide high quality, safe health care to patients

The Hospital, within the constraints of resources available to it, provides services which will protect and enhance the physical and mental health of all its patients. When difficult decisions have to be made relating to the treatment of a specific patient, the Hospital will endeavour to ensure that all the pertinent parties are consulted. When something does go wrong, the response must be quick and honest. The Hospital will endeavour to provide open disclosure with emphasis on the promotion of patient safety at all times, in preference to a culture of requiring the patient to prove fault.

5.1.2 Provide evidence based medicine to our patients

The Hospital provides testing, medicine and treatment based on the evidence elicited by its practitioners, acting in utmost good faith, to ensure the best possible outcomes for its patients, regardless of their medical insurance status or the perceived risk of subsequent litigation arising from treatment/ testing (or withholding thereof).

5.1.3 Provide scientific data that is based on rigorous, high-quality enquiry

Hospital practitioners and researchers are engaged in providing trustworthy analysis and data. In this area the Hospital relentlessly focuses on good science. Hospital stakeholders must have the confidence to rely on its data and on the medical exploration techniques used.

5.1.4 Comply with the spirit as well as the letter of the law

The work of the Hospital is based on compliance with many of the laws of the State and the EU. The Hospital always ensures, by seeking the best legal advice, that its actions are based on faithful compliance with the laws and not based on avoidance strategies to enhance its own interests.

5.1.5 Treat employees fairly

Treating people with fairness and respect goes hand-in-hand with trust. Everyone deserves an equal chance to reach their own potential, based on hard work, talent, and commitment to the Hospital's values. The Hospital values a diverse workplace and recognises that it benefits from it. Diversity requires that the Hospital be open-minded and welcoming to people regardless of race, colour, religion, gender, age, ethnic or national origin, membership of the traveller community, disability, sexual orientation or preference, gender identity, marital status, citizenship status, genetic information, or any other legally protected personal characteristic or status. Through a shared commitment to an open and inclusive culture at the Hospital, it creates a good place to work, one that is capable of attracting the best people and

achieving the best outcomes. The Hospital supports the right of any of its staff to make protected disclosure of any issues of wrongdoing that they think they detect.

5.1.6 Respect the environment

The Hospital conducts a service operation utilising scarce natural resources. It is nevertheless, a good steward for the environment. The Hospital works hard to prevent pollution, minimise waste, and reduction in its use of natural resources. The Hospital is focused on sustainability minimising our long-term effect on the environment.

5.1.7 Deal honestly with the Government

In its dealings with the Government and with other States (including the EU) the Hospital does not bribe, lie, mislead or hide information from government inspectors. Neither does it in any way falsify or occlude its documents and records.

5.1.8 Keep honest books and records

Hospital financial statements and records are complete, timely, accurate, and fair, and they comply with appropriate accounting standards. The Hospital won't hide liabilities, overstate earnings, and keep things off its balance sheets that belong there, or disguise its transactions. In addition, the Hospital recognises its responsibility to help promote full, fair, accurate, timely, and understandable disclosure in documents and financial statements and will endeavour to ensure that it updates its disclosures in line with current best practice from time to time.

5.1.9 Give the Hospital complete loyalty

The Hospital works hard to earn the trust of staff, and in turn expects loyalty from staff/Board members. Work decisions must always be based on what's best for the Hospital and the patient, not for staff/Board members personally. Staff/Board members should not have undisclosed business, clinical or personal interests that conflict with those of the Hospital.

5.1.10 Where rules don't clearly address a situation

No set of rules could answer every question faced at work. When these rules do not address a situation, the situation should be analysed by reference to the Hospital's Philosophy. Always do the right thing – integrity matters. Also, questions should be asked if someone is not sure what to do. CEO or other appropriate confidante should be contacted.

5.1.11 Where something seems wrong

Sometimes things go wrong. It happens in every organisation at some point. Everyone is human. Honest mistakes can be made and sometimes there can be an adverse outcome for patients or staff. If something wrong is noticed at the Hospital try prevention, then look for investigation within Hospital policies, in confidence, if necessary. It must not be ignored. Be a champion for Hospital values and lead others to follow them and management will regard you well. If someone breaks the rules, they can suffer disciplinary action, including dismissal.

5.1.12 Procedure for Disqualification/Removal from office of Board Members.

Please refer to section 5.

Section 9

Procedures for avoiding/dealing with conflicts of interest

1. Tallaght University Hospital is one of the public bodies covered by the Ethics in Public Office Acts 1995 and 2001.
2. Accordingly, each Board Member is legally required to furnish a statement, in writing, of (i) the interests of the person, and (ii) the interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.
3. Such statements must be provided to the Chairperson of the Board (Chief Executive in the case of the Chairperson) and the Standards in Public Office Commission.
4. A statement is required in respect of each year or part year during which a person is a member of the Hospital Board. The statement covers the period up to 31 December each year, must be signed after that date and must be returned to the Commission by January 31st of the subsequent year.
5. A statement of interests is not legally required where the interests could not materially influence the person in, or in relation to, the performance of his or her official functions.
6. In addition to the foregoing legislative requirements, the Board has adopted the procedure outlined below for the management of conflicts of interest, and potential conflicts of interest.
7. The procedure is designed to prevent conflicts of interest from arising in so far as possible and ensure that any conflicts of interest that do arise are managed in such a way that the independence and integrity of the decisions of the Board are neither compromised nor perceived as being compromised.
8. It is not possible to provide a comprehensive list of all of the conflicts of interest that might arise. Accordingly, this procedure must be interpreted with regard to its spirit and purpose and Board Members must comply with it in spirit as well as in letter. If there is any doubt as to whether a matter amounts to a conflict of interest, it should be presumed to be a conflict of interest until a decision is made to the contrary by an appropriate person.
9. The objectives of this procedure are to:

   - protect the Board corporately and each Board Member individually against impropriety or the appearance of impropriety, including risk to the Hospital's or his/her reputation;
   - protect the Board corporately against any conflicts of interest that may be detrimental to the exercise of its functions;

- ensure in so far as possible that Board Members make decisions free from any external influences, whether personal or financial, whilst recognising that it is precisely their position and expertise external to the Board that enables some of the Board Members to make valuable contributions to its work; and

- adhere to the principle that Board Members should not make a personal profit as a result of their membership of the Board.

10. On appointment, each Board Member should furnish the Secretary with a signed declaration containing details relating to his/her employment and all other business or professional interests including shareholdings, directorships, professional relationships etc., that could involve a conflict of interest or could materially influence the member in relation to the performance of his/her functions as a member of the Board.

11. The employment and any business interests of a Board Member's family of which he/she could be expected to be reasonably aware or a person or body connected with the Member which could involve a conflict of interest or could materially influence the member in the performance of his/her functions should also be disclosed.

12. For this purpose, persons and bodies connected with a member should include:

    (a) a spouse, parent, brother, sister, child or step-child;

    (b) a body corporate with which the member is associated;

    (c) a person acting as the trustee of any trust, the beneficiaries of which include the member or the persons at (a) above or the body corporate at (b) above; and

    (d) a person acting as a partner of the member or of any person or body who, by virtue of (a) - (c) above, is connected with the member.

13. These details should be maintained by the Board Secretary in a confidential register. Only the Chairperson, Board Secretary and Chief Executive shall have access to the register.

14. If a Board Member is in doubt as to whether a particular matter should be declared, he or she should declare it, and the Board Secretary (in consultation with the Chairperson if appropriate) shall decide whether it is a matter that is required to be included on the register.

15. A Board Member shall advise the Board Secretary of any new matter that is required to be included on the register as soon as possible after it arises.

16. Board Members may be required at any time to confirm to the Board Secretary that their current entries on the register are accurate and up to date, and the Board Secretary shall ask them to do so at least once in each year.

17. Where a question arises as to whether or not a case relates to the interests of a Board Member or a person or body connected with that member, the Chairperson of the Board should determine the question.

18. The Chief Executive and members of the EMT are required to complete a register of interests in line with the above.

19. When a matter arises which might involve a conflict of interest the Chief Executive is required to inform the Chairperson. Similarly any potential conflict of interest by a member of the EMT is to be notified to the Chief Executive.

20. Documents relating to dealings with interests of a Board Member are not made available to the Member concerned. In the event that a Member receives documents relating to his/her interests or of those connected with him/her, he/she should return the documents to the Board Secretary at the earliest opportunity.

21. Before any item is discussed at a Board meeting, each Board Member must disclose any conflict of interest that he or she believes may arise in relation to that item. If a Board Member is in doubt as to whether a particular matter amounts to a conflict of interest and should be disclosed, he or she should disclose it.

22. The Chairperson (or in his/her absence the Vice-Chairperson) will decide at his/her discretion whether any matter disclosed by a Board Member (other than the Chairperson or in his/her absence the Vice-Chairperson), amounts to a conflict of interest that should prevent that Board Member from participating in the discussion of the relevant item.

23. The Vice-Chairperson (or in his or her absence a chair elected by Board Members from amongst their numbers) will decide whether any matter disclosed by the Chairperson amounts to a conflict of interest that should preclude the Chairperson from participating in the discussion on the relevant item.

24. Should the Vice-Chairperson be chairing the meeting, the Board Members will decide by taking a vote.

25. The decision as to whether to disclose any matter and whether that matter amounts to a conflict of interest should be made having regard to the terms, spirit and purpose of the policy for dealing with conflicts of interest.

26. Where the Chairperson decides that a Board Member does have a conflict of interest in relation to any item that Board Member may not participate in any discussion relating to that item or in any vote taken in relation to it. If requested to do so by the Chairperson the Board Member must also absent himself/herself from any discussion of the item.

27. In the event that a Board Member, committee member or hospital employee receives any written paper in relation to any matter on which he or she believes that a conflict of interest may arise, they must disclose that conflict of interest to the Chairperson, or Chief Executive as appropriate, at the earliest opportunity.

Section 10

Procedure for recording concerns of Board Members that cannot be resolved through the normal processes at Board or committee level

1. Section 3.5(Professional Advice) of the Code of Practice for the Governance of State Bodies 2016, states that:

   "the Board should have in place a procedure for recording the concerns of Board Members that cannot be resolved".

2. Where a Board Member has a concern which s/he considers cannot be resolved through the normal processes at Board or committee level and wishes to escalate this concern, s/he should advise the Chairperson accordingly and outline what actions s/he considers would be required to address the concern.

3. If the matter is not resolved by the Chairperson to her/his satisfaction, the Board Member may raise it at the next scheduled Board meeting. In that event, the Board Member should specify if s/he wants it recorded in the minutes along with any actions agreed by the Board to address the concern.

4. If the matter is not resolved to his/her satisfaction, the Board Member may, at a subsequent meeting of the Board, formally request the Chairperson to raise the matter with the Director General of the HSE and/or Secretary General of the Department of Health, and that the request be noted in the minutes.

5. The Chairperson shall confirm to the Board Member in writing within 14 days that the matter has been raised as requested.

6. Should the Chairperson not do so, the Board Member should inform the Board that s/he will raise the matter with the Director General of the HSE and/or Secretary General of the Department of Health and have this noted in the minutes.

7. The outcome of any communication, by either the Chairperson or the Board Member, with either the Director General of the HSE and/or Secretary General of the Department of Health should be noted in the minutes of the subsequent Board meeting.

Section 11

Procedure for obtaining independent professional advice

1. Section 3.5 (Professional Advice) of the Code of Practice for the Governance of State Bodies 2016, states that:

   "the Board should, in a Board resolution, lay down formal procedures, whereby Board members, in the furtherance of their duties, may take independent professional advice, if necessary, at the reasonable expense of the state body".

2. At its meeting on 26 November 2014 the Board adopted the following procedure.

3. When any Board Member (or group of Board Members) considers that circumstances have arisen where it would be inappropriate for him/her/them to consult the Hospital's internal staff or professional advisers and he/she/they consider that, in the furtherance of his/her/their duties, there is a need for independent professional advice the following procedure will be used: -

   a. He/she or they will advise the Chairman of the Board of the need to obtain independent professional advice, the circumstances requiring advice, the Board Member's choice of professional adviser and the likely cost of the advice;

   b. The Chairman shall, if he/she considers it appropriate, approve the request to take separate professional advice at the Hospital's expense subject to the initial fees not exceeding €5,000. Should the fees exceed this sum then the Chairperson may increase the limit at his/her discretion or refer the matter to the Board for prior approval.

   c. In the event that the Chairperson needs to obtain separate professional advice then this should be agreed by no less than two Board Members.

   d. The Chairman shall, in consultation with the Board Secretary, communicate with the selected professional advisor and indicate that the requesting Member/s will contact him/her directly to seek advice and that the Hospital will underwrite fees up to a maximum as indicated in b. above.

   e. A report shall be made to the next meeting of the Board setting out the circumstances and reasons why independent professional advice was sought.

   f. Any dispute arising from a Board Member's request to seek independent professional advice shall be considered by the Hospital Board whose decision shall be final.

   g. Independent professional advice for the purpose of this document shall include legal advice, the advice of accountants and other professional financial advisers on matters of law, accounting and other regulatory matters but shall exclude advice concerning the personal interests of the Board Member(s)

unless these personal interests coincide, in the view of the Chairman, with the interests of Tallaght University Hospital.

h. Any advice obtained under this procedure shall be made available to other Board Members, if the Board so requests.

i. If the matter which gave the Board Member cause for concern cannot be resolved then that fact should be recorded in the Board minutes.

Section 12

Hospital Seal and signature of documents

Custody of Hospital seal

1. The seal of the Hospital shall be kept by the Board Secretary in a secure place.

Sealing of documents

2. The Hospital seal shall be used only where same has been approved by a decision of the Board.

3. A request for the affixing of the seal to a document or other instrument shall be made to the Board Secretary and shall be accompanied by:

    - the original document which requires to be sealed (together with as many original counterparts as require to be sealed);
    - a description of the document to be sealed;
    - three copies of the document;
    - the reason why the document requires to be sealed, including reference to any legislative or legal provision requiring the document to be sealed; and
    - an indication of the timescale within which the document requires to be sealed.

4. Following receipt of such a request, the Board Secretary shall place a request for the Board to consider and approve the sealing of the document on the agenda for the next scheduled meeting of the Board.

5. Where, in exceptional circumstances, the sealing of a document is required prior to the next scheduled meeting of the Board, the Board Secretary shall promptly bring this requirement to the attention of the Chairperson and the Chief Executive for consideration pursuant to Standing Order 15 (Procedure for obtaining Board approval between Board meetings).

6. Following Board approval, the seal shall be affixed to the relevant document in the presence of:

    (a) the Board Secretary or any member of staff as may be designated by the Chief Executive to act in that behalf; and

    (b) the Chairperson of the Hospital or any Board Member authorised by the Board to act in that behalf

    and the seal shall be authenticated by the signature of them both and they shall both also sign the Register of Sealing.

Register of sealing

7. The Board Secretary shall keep a register in which s/he or in her/his absence another Hospital employee authorised by the Chief Executive enter a record of the sealing of every document or other instrument. The register shall be known as the “Register of

Sealing". An entry of every sealing shall be made and numbered consecutively in the Register of Sealing.

8. The Register of Sealing shall also record:

   (a) such Members of the Board as are authorised by the Board from time to time; and

   (b) such members of staff of the Hospital as are designated by the Chief Executive from time to time

   to authenticate the use of the seal and the Board Secretary shall attach to the Register of Sealing a copy of the dated decision of the Board and the Chief Executive, as the case may be, relating to such authorisation or designation.

Signature of documents

9. Where any document will be a necessary step in legal proceedings on behalf of the Board, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or in his/her absence any member of the EMT.

10. All contracts or other legal instruments relating to decisions which are reserved to the Board can be signed by the Chief Executive once formal Board approval to do so has been secured.