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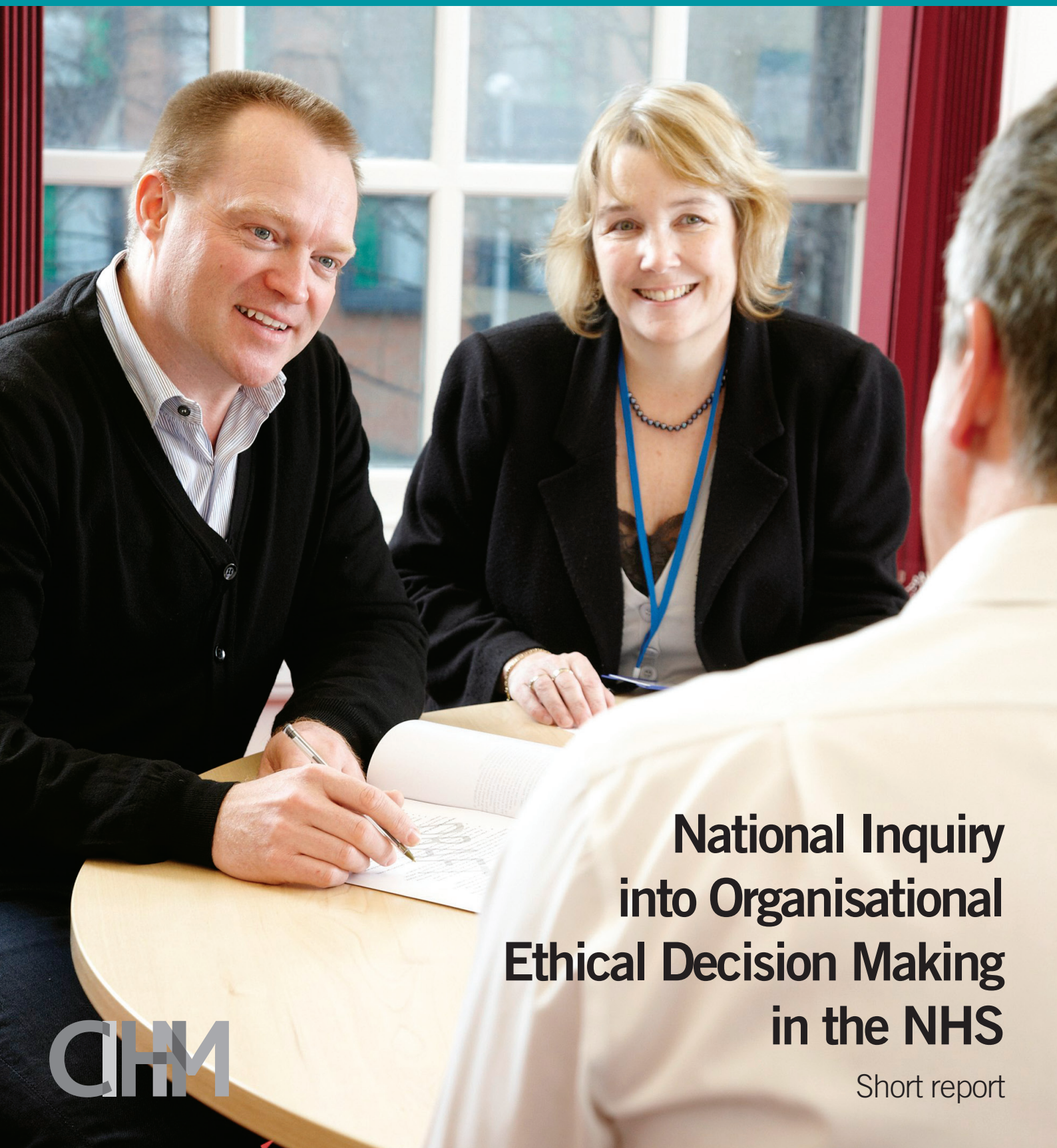

National Inquiry into Organisational Ethical Decision Making in the NHS

Short report

Introduction

Every day the NHS makes thousands of decisions, many of which have difficult and far-reaching ethical dimensions. Plans to pass commissioning to GPs in Clinical Commissioning Groups who until now have focused primarily on the needs of individuals; to provide 'joined-up' care across primary and secondary care; to move services traditionally provided by the NHS out into social enterprises, highlight the need for resources on ethical decision-making at a senior management level. This report aims to be such a resource.

The major output from this research is a checklist for ethical decision-making, which we recommend implementing in real situations. It is only through practice that NHS staff can improve their ethical decision-making.

Values in the NHS

Decision-makers in the NHS are guided by sets of values and principles that are set out in legal statutes (e.g. the pending Health and Social Care Bill 2011-12), the NHS Constitution, professional regulation and guidelines, and published values and principles at trust level. This report recommends moving from identifying values to implementing them in practice, and challenges managers to become better at recognising, analysing and responding effectively to the ethical dimensions of decisions. The responsibility of NHS staff is not merely to make and implement decisions, but to *deliver* through decision-making. This makes effectiveness an ethical imperative.

Methodology

We carried out a series of semi-structured, one-to-one interviews with managers in a set of NHS trusts. We then analysed the interviewees' use of value terms, and the organisational context that surrounds and influences decision-making. An inquiry panel comprising an NHS chief executive, a medical director, an NHS chair, a chief executive of a social enterprise, a union leader and an academic in industrial relations supported the core inquiry team. The panel contributed to the design of the inquiry, the analysis of the evidence and the writing of the report. The panel formally met twice and their contribution was supplemented by regular feedback virtually and face to face.

Intended Audience

This report is particularly relevant for NHS senior managers and board members although all those within the NHS who are making strategic and organisational decisions may find it of value. The checklist in the report can be used to influence decision making at all levels of the organisation. Wherever there is an element of ethical complexity to the decision in question, we think these considerations are important, and the checklist is intended to be flexible enough to be used in a number of different contexts.

This is an executive summary of a longer report which can be found at **www.cihm.leeds.ac.uk**

If you would like a printed copy please contact us at **j.l.paglia@leeds.ac.uk**

Acknowledgements

Our thanks go to all of those who contributed to this report in particular to our inquiry panel, to members of the CIHM network who contributed at CIHM's Network Days and above all to everyone who agreed to be interviewed for this research.

Authors:

Jim Baxter,
Professional Ethics Development Officer, Inter-Disciplinary Ethics Applied, A Centre for Excellence in Teaching and Learning, University of Leeds

Martin Fischer,
Associate, Centre for Innovation in Health Management, Leeds University Business School

Rebecca Malby,
Director, Centre for Innovation in Health Management, Leeds University Business School

In addition on the inquiry panel:

Juliet Brown,
Programme Manager, Centre for Innovation in Health Management, Leeds University Business School

Gail Cartmail,
Assistant General Secretary, Unite the Union

Lance Gardner MBE,
Chief Executive, Care Plus Group

Dr Ian Greenwood,
Lecturer, Division of Work and Employment Relations, Leeds University Business School

Angela Monaghan,
Chair, NHS Calderdale

Professor Chris Welsh,
Medical Director, NHS East of England

Diane Whittingham,
Chief Executive, Calderdale and Huddersfield NHS Foundation Trust

Making more effective ethical decisions

One interviewee described ethical decision-making as *"that real… hard slog of thinking things through"*, but our research suggested this frequently does not happen. Here we set out ways to make that *'slog'* less daunting.

A checklist for ethical decision-making

Through analysis of the interviews, a set of observations emerged with regard to two aspects: the ethical *content* of decisions and the organisational *context*. We have distilled them into a checklist. Each item on the checklist is designed to help the dialectical process – a method of constructive debate which can improve clarity in decision-making, particularly where values are involved alongside scientific or otherwise empirical data.

While dialectic works by considering different and sometimes opposing viewpoints, it is not necessarily about resolving disagreements between people. It is important that a variety of credible answers to a question are considered, not that members of the group thrash out their personal differences.

The checklist items are not meant as simple *'yes'* or *'no'* questions, nor an exhaustive list of considerations which, when checked off, will inevitably lead to an ethical outcome. Rather, the intention is to prompt constructive discussion of ethical decisions.

We recommend the checklist be used as a reference tool in meetings at which decisions are taken. It applies particularly to board meetings and meetings of executive teams. However, we recommend that organisations spend some time considering their approach to ethical decision-making at all levels.

As an exercise, we suggest that the board or executive team should identify a key decision that has an element of ethical complexity and important consequences for the trust, then devote a significant amount of time to it. Use the checklist to ensure the context is optimised for effective decision-making, and to guide the discussion. We recommend this should be a real decision, as this is the only way the real complexities of decisions can be made to emerge. Record your answers to each checklist question, and at the end of the meeting, you should hopefully have a decision with as complete an ethical justification as you can achieve.

Table 1: A checklist for ethical decision-making

Decision-making content
1. Have you agreed on the aims of the decision?
2. Do you understand the separate roles of values and data in your decision?
3. Have you considered and defined the key value terms involved in the decision?
4. Do you have access to the relevant data, and are you interpreting it correctly?
5. Have you fully considered your roles and responsibilities?
Organisational context
6. Are you spending enough time on this decision, proportionate to its impact and difficulty?
7. Are you involving enough people, and the right people, in the decision?
8. Has consultation been genuine, and clear and honest in terms of its role and the expectations of those consulted?
9. Is the process set up in a way that is genuinely conducive to challenge and debate?
10. Have you fully considered the relevant guidance, regulations and legislation?
Delivery
11. Have you set up systems/measures to show that you have delivered and not simply implemented?

Explanation of checklist items

Have you agreed on the aims of the decision?
For example a decision about the distribution of healthcare among a population – is the aim to maximise the equity of the distribution, to make the most effective use of resources, or something else?

Do you understand the separate roles of values and data in your decision?
Interviewees were much more comfortable talking about data than values. The assumption seemed to be that if all the relevant data were known, the right decision would become obvious. In fact values always affect the decision, so bring them to the surface.

Have you considered and defined the key value terms involved in the decision?
Having identified the key value terms, try to articulate what they mean.

Do you have access to the relevant data, and are you interpreting it correctly?
Having separated values and data, it is as important that all of the relevant data is available.

Do you understand your roles and responsibilities?
There may sometimes be tensions between responsibilities. Be aware of these tensions and clear about the role one is playing in the decision-making process, since responsibilities are defined by roles to a great extent.

Are you spending enough time on this decision, proportionate to its impact and difficulty?
Often a decision affecting one person, who is easy to imagine and sympathise with, gets more time than a decision affecting a large impersonal group. Correct this tendency by trying to think objectively about the complexity and impact of the decision.

Are you involving enough people, and the right people, in the decision-making process?
More ethical decisions will tend to be made when a variety of viewpoints are represented. Take particular care to listen and respond to those who depart from the consensus view. The standard executive team represents a wide range of viewpoints, but this may not be enough for every decision.

Has consultation been genuine, and clear and honest in terms of its role and the expectations of those consulted?
Try to ensure that consultation is real, and not just lip service to a regulatory requirement. Try to maximise the usefulness of consultation by looking for informed, reflective opinions. Inevitably, the opinions of stakeholders form only one consideration among many, and may be outweighed in the eventual decision. Be honest and open about this.

Is the process set up in a way that is genuinely conducive to challenge and debate?
Senior decision-makers must show they value reasonable disagreement and challenge. Consider the unconscious power relationships that exist and how these might impede the transmission of potentially important insights.

Have you fully considered the relevant guidance, regulations and legislation?
The complex network of responsibilities in the NHS is frequently open to interpretation. Careful consideration is required.

Have you set up systems and measures to know if you have delivered and not simply implemented?
Managers have a central ethical responsibility to ensure that the aims of decisions are achieved through delivery. This means ensuring the decision is properly communicated, paying attention to implementation at all points along the chain, and putting in place measures to ensure delivery is effective on the terms of the decision itself.

Case studies

The following two case studies are included as an illustration of how attending to the particular aspects of decision-making we have highlighted can make a difference to the process and potentially the outcomes of a decision.

Case study 1: Discontinuing a service

This case concerns a decision whether to discontinue a service which an acute trust had provided for many years in one of its hospitals.

Have you agreed on the aims of the decision?
The phrasing of a decision can have a profound effect. In this case, it could have been phrased in a range of ways, each of which would lead the discussion in a different direction:

- Should we discontinue this service in part or altogether?
- How should we address the problems with this service?
- How do we understand what the real problems are, e.g. an underperforming senior person?
- How do we best ensure that the area's patients' needs are met with regard to this type of service?
- How do we ensure that we as a trust are providing services to as high a standard as possible?

It is possible that presenting the decision in a particular way can bias the outcome of the decision, a concern raised by one interviewee with regard to this case.

Do you understand the separate roles of values and data in the decision?
These include:

Value questions:

- Does the trust have a responsibility to ensure that a particular kind of service is provided?
- Does the trust have a duty to consult with patients before making a decision?
- What would the effect of each option be in terms of fairness, equity and/or equality?
- Would each option be in the public interest?
- What does 'value for money' mean in this context, and would value for money be provided by each option?

Data questions:

- What is the cost of the service?
- Is the service sustainable?
- Is the service meeting its objectives?
- Is the service meeting a minority need?
- Are alternative providers available?

The interviewees did not make this distinction and tended to emphasise data, but when pressed were able to use value concepts with some fluency.

Have you considered and defined the key value terms involved in the decision?
Value terms were raised by interviewees, and there was evidence that efforts had been made to consider their meaning, but not systematically.

Do you have access to the relevant data, and are you interpreting it correctly?
There was a concerted effort to gather the relevant data before making the decision, but no patient consultation. Interviewees disagreed over whether other providers in the area would be able to step in; suggesting research on this point was needed.

Do you understand your roles and responsibilities?
The commissioner argued that the provider trust had a responsibility to continue providing the service: "If you don't provide it, nobody else will and patients will suffer." This only makes sense if a) the trust really does have a responsibility to make sure the service is provided, and b) alternative providers with sufficient capacity are not available. If a) is accepted, then the question of whether someone else can provide the service becomes crucial, warranting extra investigation.

Are you spending enough time on this decision, proportionate to its impact and difficulty?
This decision was a complex one and would potentially affect a large number of patients. It warranted a substantial time commitment and appears to have got that.

Are you involving enough people, and the right people, in the decision?
Consultants drove the decision, but there was also involvement from other groups through the membership of the trust board, which included a chief nurse, medical director etc.

Has consultation been genuine, and clear and honest in terms of its role and the expectations of those consulted?
Initially there was no patient consultation. The commissioner asked the provider to postpone the decision until after a consultation with patients.

Is the process set up in a way that is genuinely conducive to challenge and debate?
There does appear to have been a very strong steer from leadership. This is not necessarily a bad thing provided there is plenty of opportunity for challenge. Interviews suggested more openness would have been desirable.

Have you fully considered the relevant guidance, regulations and legislation?
Interviewees were well acquainted with the trust's statutory and contractual obligations with regard to the decision.

Case study 2: Board membership selection policy

Two provider trusts were brought together to be overseen by a single new merged board. The merger was orchestrated by a PCT which was itself being brought together with other local PCTs to form a cluster. As a result, the Strategic Health Authority was able to influence the selection of board members. Problems began when some directors from one of the existing provider trusts were told they would not be eligible to apply for posts on the new PCT board. In the meantime, people who had been in head roles at the PCT were moved into director positions, thereby becoming eligible to apply for the new positions. It was communicated that those who were not selected would be made redundant. Later this was rescinded, and unsuccessful candidates told they would instead be required to work their notice or move into other roles. This almost led to an employment tribunal – luckily a settlement was reached, albeit after three months of legal argument.

Have you agreed on the aims of the decision?
The decision was how to recruit a new merged board, but decision-makers might have added in other aims:

- How do we ensure the process represents value for money for taxpayers?
- How do we ensure the process complies with law and regulations?
- How do we ensure the process is equitable, fair, transparent, etc.?
- How do we get the best people for each role?

Do you understand the separate roles of values and data in the decision?
These include:

Values:
- What does a fair and equitable process look like?
- What does an open and transparent process look like?
- What outcome would represent value to the public?

Data:
- Who might be eligible for inclusion in the new board?
- What are the relevant items of employment law?
- Contractual information, including salaries, etc.
- What other positions are available to those involved in the process?

Have you considered and defined the key value terms involved in the decision?
There is at least prima facie reason to believe this case was not handled entirely fairly, equitably and openly. There would have been a benefit in defining these terms.

Do you have access to the relevant data, and are you interpreting it correctly?
It would have been beneficial to consider in detail the potential impact of the process on the relevant staff, to ensure they were not being unfairly treated.

Do you understand your roles and responsibilities?
Perhaps the most important set of responsibilities to consider here is towards the applicants who missed out on roles in the new structure. The fact that the organisation changed its original plan to make them redundant suggests these responsibilities had not been thoroughly considered in advance.

Are you spending enough time on this decision, proportionate to its impact and difficulty?
It is not known how long this decision took. Such decisions are often more complex than they appear, and ethical dimensions can be easily missed. The unfortunate fallout from this decision, which nearly escalated to an employment tribunal, illustrates the importance of tackling issues rigorously at the time to avoid worse consequences later on.

Are you involving enough people, and the right people, in the decision?
There may have been good ethical reasons, such as conflicts of interest, why particular groups could not have been directly involved. However, consultation could have compensated for this.

Has any consultation been genuine, clear and honest in terms of its role and the expectations of those consulted?
There was consultation on the form of the new organisation which, according to the contributor, "felt genuine". However, there was apparently no consultation on the process for recruiting the new board.

Is the process set up in a way that is genuinely conducive to challenge and debate?
Issues with the process were only raised afterwards, with unfortunate consequences for all concerned. This illustrates the importance of challenge at the time of the decision.

Have you fully considered the relevant guidance, regulations and legislation?
Since the decision is of a unique kind, guidance will not provide a complete answer – what is fair, equitable, open and transparent in this case requires individual judgement.

Evidence from the interviews: decision-making content

In this section, we discuss approaches to interpreting some key value terms drawn from the philosophical literature, and compare these to evidence from the interviews.

Table 2: Data and value considerations in ethical decisions

Addressing inequities in access to healthcare	
Data considerations	**Value considerations**
What is the current availability of services?	What is the operative interpretation of equity/fairness/justice?
What is the relative take-up of services between different groups?	What interventions are justified in order to drive up take-up?
What factors explain low take-up among particular groups?	What is the relative importance of equitable take-up compared to other ways in which resources might be used?
	What are the (role or liability) responsibilities of the trust? Of individuals?
Completing Quality Accounts	
Data considerations	**Value considerations**
What is the data on quality of services within the trust?	Is the information presented an honest representation of the state of affairs in the trust?
Have the objectives from the previous account been met?	Where information is left out, are the reasons for this openly communicated?
	Are the objectives sufficiently challenging?
	What are the (role or liability) responsibilities of the trust? Of individuals?
Decommissioning/discontinuing services	
Data considerations	**Value considerations**
What is the cost of the service?	What would represent value for money in provision of the service?
Is the service sustainable?	Does the trust have a (role) responsibility to ensure provision of the service?
Is the service meeting its objectives?	What responsibilities does the trust have in respect of service users?
Is the service meeting a minority need?	What responsibilities does the trust have to the commissioner?
Are alternative providers available?	Would decommissioning/discontinuing the service be in the public interest?
Covering staff shortages	
Data considerations	**Value considerations**
What skills and abilities are required?	Are demands placed on staff fair and reasonable?
What skills and abilities are available among remaining staff?	Is there a responsibility to consider the development of those asked to cover shortages?
What is the availability of staff to cover shortages, through various channels?	Is communication with staff open and honest?

Equity, equality, justice

Meaning

Equality as set out in the NHS's core principles can be interpreted in several different ways:

- Equality of outcome (levels of health across socio-economic groups).
- Equality of take-up of services (factors beyond the scope of trusts may affect outcomes).
- Equality of availability (factors beyond the scope of trusts may affect both take-up and outcome).

Distributive justice

This is the type of justice perhaps of most interest to the NHS. There are several approaches to it in the literature:

- **Equality view** – it is bad if some people are worse off than others.
- **Priority view** – *"Benefits to the worse off matter more, but that is only because these people are at a lower absolute level. It is irrelevant that these people are worse off than others. Benefits to them would matter just as much even if there were no others who were worse off."* [1]
- **Sufficiency view** – what matters is that everyone should be guaranteed a certain 'sufficient' level of goods. Beyond this level, inequalities cease to be important.

Utilitarianism

Broadly speaking this is the view that the just act maximises the total amount of some value in the world. A common objection is that it neglects the interests of minorities. Without further development, utilitarianism does not look like a promising approach to distributive justice in healthcare.

Equity and distribution according to need

Here, the idea is that the distribution of services should reflect need, and primarily be determined by levels of health and illness. This is also known as the 'use-per-need view'.

Application

To take an invented example, imagine in trust X people in low income families are far less likely to take up hip replacement operations than people in wealthier families. How might ethical models affect a decision?

Equality:

- **Equality of outcome** – data needed on population's general level of health. Managers should drive up hip replacements among low-income groups to equalise outcomes across whole population.
- **Equality of access** – action to increase take-up not needed, as long as lower-income groups are able to access operations if they choose.
- **Equality of take-up** – action needed to drive up operations among lower-income groups. Success measured by data on number of operations, not health outcomes.

Distributive justice:

- **Priority view** – the interests of the worse off matter more because of their position in absolute terms. The relevant data would demonstrate the individuals' interests, not general health levels or take-up of operations across socio-economic groups.
- **Sufficiency view** – what matters is that everyone has a sufficient level of the resource. This again suggests focusing on the needs of individuals, and determining whether the level of resource directed at them is sufficient.

Equity on the 'use-per-need' model:

- This conception of equity would recommend directing resources at increasing take-up among the groups that most need the intervention.

This is not merely an abstract philosophical exercise, but a process with real implications for practice. It is clear that values play a role alongside data. In the above example, the data around health outcomes, availability and take-up of services could be exactly the same, but a different interpretation of the value of equity, say, or justice, would result in a different decision.

[1] Parfitt, Derek, 1998, Equality and Priority, in Ideals of Equality, ed. A. Mason, Oxford: Blackwell.p13

Understanding
We found a range of interpretations of ethical concepts in the same trust. One interviewee thought of equity as implying equality of availability. Another defined equality as availability, and defined equity as equality of take-up. Despite this, we found that the actual model underlying decisions was, with exceptions, more consistent – most interviewees were implicitly employing a use-per-need model, or the closely related idea of equality of outcomes.

Openness, honesty and transparency

Meaning
Honesty is the absence of deception, openness and transparency are much more. Imagine a company that fails to publish its financial accounts. The company would not be guilty of deception, but could certainly be accused of a lack of openness or transparency. Openness and transparency entail a willingness to reveal facts that have implications for others of which they are not aware.

Application
The requirement to produce Quality Accounts provides an interesting case study. Their purpose is to make trusts accountable and transparent to the public in terms of quality. In order to ensure consistency, much of the content is mandated. However, trusts decide how to present this data so that it can be readily understood by the public, and how open to be in setting objectives for the coming year.

Understanding
One interviewee recognised that openness and transparency are not simply a matter of providing large amounts of information, and worried that too much data might make Quality Accounts harder to understand. Another interviewee had recommended what should be included in a Quality Account, then found that without any explanation the final version left out some of this recommended content. The interviewee felt this was a failure of openness, if not honesty. A third interviewee spoke of including challenging targets in the accounts. The interviewee recognised the risk of bad publicity if the trust did not meet these targets, but saw their inclusion as an integrity issue.

Responsibilities

Responsibility to the public interest
The central responsibility of the NHS is to the public interest but how should this be defined? We have focused on decommissioning and discontinuing services as a prism through which to view public interest. For example, if a service is not delivering on its objectives, the provider may wish to discontinue it, and it may be legally entitled to do so. However, given the public interest remit of the NHS, it is likely that managers, clinicians and other staff within the trust will be reluctant unless they are confident the service can be provided effectively elsewhere.

The political context also generated discussion. Managers need to navigate between their own judgement of the public interest, and government direction. Elected government has a clear role in defining the public interest, but its distance from decisions can mean it is not always best placed to guide them. This is a perennial source of frustration which can perhaps be mitigated somewhat by open discussion.

Ethical and legal/contractual responsibilities
Legal responsibilities arise either from statutory laws, or from contractual relationships, and their existence is a matter of record. Ethical responsibilities on the other hand can be much more wide ranging, and can only be discerned with judgement. In Case Study 1, the provider trust had no legal or contractual responsibility to provide the service. However, as we saw, this did not settle the question of its ethical responsibility to continue the service.

Evidence from the interviews: organisational context

Clarity and openness

A key part of the dialectic process involves working towards a shared understanding of concepts, and the first step in this process is articulating one's own understanding. Values are often implicit rather than explicit, and many are not clearly aware of their own value set until they articulate it in the context of a decision.

Representation

The make-up of executive teams and boards is designed to represent different views. But we found the role of members to be ambiguous – whether they were there as representatives, or as experts.

In both of the trusts to whom we spoke about Quality Accounts, the people who gathered the data for them were not present at the final decision about what to keep in and what to leave out. We would question whether this is likely to produce a more ethical decision.

Challenge

The level of challenge in decision-making was varied according to our interviewees. One GP and medical adviser prized challenge and described being *"comfortable with my discomfort"*. Some saw it as the duty of individual board or executive team members to challenge. In discussions about staff shortages, challenge emerged as a way of avoiding intuitive and unexamined decisions. Another interviewee, a director, felt there needed to be more *"challenge in the system"* to force decision-makers to consider staffing decisions in more depth.

Time

Lack of time was seen as a distorting influence:

"You can't effectively scrutinise fifty or sixty proposals properly [so] you kind of resort to your gut instinct." (Director)

However, there are approaches that can help:

- Ethical decision-making skills can be developed so that informed decisions can be made more quickly. Train decision-makers using case studies to develop these skills.
- Time is not always apportioned rationally. A couple's request for a third round of IVF might be agonised over. Halving a budget which affects many people is less emotionally vivid but needs the same consideration.

Consultation

The interviews raised two important points.

- It is vital to be clear about the influence of consultation on the decision. Consultation reveals patients' attitudes to services, but knowing this will not completely settle the question of whether the *status quo* is ethically acceptable. This also requires judgement by decision-makers.
- There is an ethical responsibility for decision-makers to be open and honest with those with whom they are consulting. It may be, for example, that even if the consultation reveals that service users are happy with the service, the trust will still quite properly decide to discontinue it.

Summary and conclusions

We have set out some simple, practical advice that can help NHS organisations to make better, more effective ethical decisions. We have also have looked in detail at specific ethical issues – fairness, justice, equity, equality, openness, honesty, transparency – which will play a role in decisions made by all trusts at some point.

But this is just a starting point. Trusts will need to spend time considering what are the key ethical concerns that drive their own decisions, and to practise applying them in real decisions. Taking this seriously can not only help organisations to avoid ethical pitfalls, but also be a positive influence on staff morale and organisational culture.

Centre for Innovation
in Health Management
Leeds University Business School
Maurice Keyworth Building
University of Leeds LS2 9JT
Tel: 0113 343 5599
j.l.paglia@leeds.ac.uk
www.cihm.leeds.ac.uk

Design by roomfordesign.co.uk

UNIVERSITY OF LEEDS

University of Leeds
Leeds, United Kingdom
LS2 9JT
Tel. 0113 243 1751
www.leeds.ac.uk
Doc No: 978 0 85316 306 0