
Ethical standards for NHS Board Members in England: interim report

Policy review

October 2011

About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies¹ that set standards for training and conduct of health professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We monitor policy in the UK and Europe and advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

Our aims

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

Our values and principles

Our values and principles act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our stakeholders.

Our values are:

- Patient and public centred
- Independent
- Fair
- Transparent
- Proportionate
- Outcome focused

Our principles are:

- Proportionality
- Accountability
- Consistency
- Targeting
- Transparency
- Agility

Right-touch regulation

Right-touch regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. It is the minimum regulatory force required to achieve the desired result.

¹ General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), General Pharmaceutical Council (GPhC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI)

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1. Executive Summary

- 1.1 In July 2011, the Council for Healthcare Regulatory Excellence (CHRE) was commissioned by the Department of Health to develop a set of high-level ethical standards for executive and non-executive NHS board members.²
- 1.2 This commission emerged from the debate about the regulation and quality assurance of NHS managers that was sparked by a number of high-profile failures in the NHS. While there is no clear consensus on how the quality of managers could or should be assured, a set of ethical standards could be used to underpin a number of different solutions to the problem(s), such as recruitment, training and performance management.
- 1.3 The planned reforms to the NHS add weight to the argument for quality assuring NHS board members. As part of the clinical commissioning arrangements, many GPs are likely to be taking responsibility for managing large organisations with accordingly large budgets, and those taking on executive and non-executive roles in the new structures will need clear guidance and to be help to account for ethical decision-making.
- 1.4 Ethical issues around conflicts of interest are also emerging as a key and seemingly unavoidable risk resulting from the fact that many GPs will be both providing care and making decisions about where, how and by whom it is provided.
- 1.5 The question of what action to take in response to these risks needs to be viewed in the context of any existing standards. The NHS Constitution, various sets of standards for NHS staff, managers and board members, the Nolan Principles of public life, and the Treasury standards for accounting officers all set out principles and values that some or all board members should abide by. There are of course variations across these documents, but a relatively consistent picture emerges from them of an individual who:
 - Operates with honesty and probity in relation to the use of public money
 - Operates with integrity and impartiality with respect to appointments, appraisals, references and procurement puts patient welfare first, and understands that he/she and the NHS are there to serve the public
 - Operates with openness and transparency as a means of being accountable to the public and Parliament
 - Seeks value for money for the organisation and the public.
- 1.6 Many NHS board members are also professionals who are subject to statutory professional regulation, with doctors, solicitors, accountants, nurses and allied health professionals being the most common. By and large the standards by which these professions have to conform are congruent with the other standards for NHS managers, with probity, honesty and integrity forming a constituent part of what it is to be a professional. Guidance issued by the General Medical Council (GMC) on

² Board member in this document refers to the chief executive and executive director posts, such as directors of nursing, medical directors, and finance directors, as well as chairs and non-executive directors.

management for doctors adds strength of character to this list, explaining that managers need to be able to challenge behaviour they believe to be wrong.

- 1.7 A number of other schemes, frameworks and resources are available to NHS managers, not restricted to board members, including the Institute of Healthcare Management's (IHM) Code of Conduct, the Chartered Management Institute code of practice, the National Leadership Council (NLC) competency framework, and board development work. Again, the ethical themes that are referred to in these documents are consistent with those identified above: honesty, openness, transparency, accountability and challenging impropriety are all present. In addition, the NLC guidance on good governance highlights the complexity of the task of the NHS board: sticking to principles may not always be sufficient, because making the 'right' decision often requires careful use of judgement and acumen.
- 1.8 This policy and literature review found no shortage of ethical standards and frameworks for NHS board members, and the themes of honesty, patient-centeredness, integrity, and probity were common to many of them. However, on the basis that existing standards are perceived not to be working under current arrangements and in the light of the NHS reforms, the need for further work in this area would seem to be even greater than before.
- 1.9 The project that CHRE is taking forward will concentrate on how board members can apply values in their decision-making, rather than simply setting out statement of values. In line with the commission from the Department of Health it will set out the application of values in personal behaviours, technical competence and business practice.

2. Background

- 2.1 Following the report of the Mid Staffordshire NHS Foundation Trust Inquiry in February 2010, and subsequent recommendation from the Advisory group chaired by Ian Dalton, the Government made a commitment to commission work to 'agree consistent standards of competence and behaviour for senior NHS leaders' in the *Enabling Excellence* Command Paper published in February 2011.³
- 2.2 On 8 July 2011, Sir David Nicholson, Chief Executive of the NHS in England, announced that the Council for Healthcare Regulatory Excellence (CHRE) had been asked to develop a set of high-level ethical standards for executive and non-executive NHS Board members⁴ in England.
- 2.3 Through consultation across the healthcare sector, and building on work already done in this area, CHRE will develop a set of high-level ethical standards for executive and non-executive NHS Board Members. They will be consistent with the Nolan Principles on Public Life and other regulatory frameworks that apply to professionals working in the NHS.
- 2.4 The Standards will cover the ethical dilemmas relating to three domains:
 - Technical competence and ability to carry out the job
 - Personal behaviours and accountability
 - Business practices including financial probity.
- 2.5 The key stages of the project are as follows:
 - July–November 2011: policy review and discussions with key stakeholders leading to development of a first draft of Standards
 - November–February 2012: first consultation on draft standards
 - February 2012: development of second draft of Standards
 - February–March 2012: peer review of second draft
 - March–April 2012: development of final statement of Standards and submission to the Department of Health.
- 2.6 The approach to this project and the expected outcomes may evolve in consultation with the Department of Health as we gather the views of stakeholders and extend our knowledge and understanding of the context, problems and potential solutions.

³ Department of Health. 2011. *Enabling Excellence*. The Stationery Office: London

⁴ Board member in this document refers to the chief executive and executive director posts, such as directors of nursing, medical directors, and finance directors, as well as chairs and non-executive directors.

3. About this policy review

- 3.1 The concept of performance standards specific to NHS managers is not a new one, and if this project is to produce something that is meaningful, relevant and useful, it must operate in full cognisance of any existing standards frameworks. This paper is necessarily a snapshot of the situation at the point at which it was written in September 2011, and should be read with that in mind.
- 3.2 This review begins by setting out the policy directions from which this project emerged, and some of the key documents that have defined the context.
- 3.3 It then looks at the present and future policy contexts – namely the major reforms planned for the NHS in England, and notes any key policy documents that set out the challenges that NHS senior managers may face under the reforms.
- 3.4 It goes on to examine any existing standards and codes that bear a relevance to this project, namely anything that pertains to ethics, codes of behaviour, and/or financial probity. Common themes will be identified, and anything else of particular interest will be highlighted for possible use in the development of the standards.

4. The policy history

- 4.1 In recent years, concerns have been voiced in a number of authoritative reports about the quality of managers and senior managers⁵ in the NHS. What follows in this section is not an exhaustive account of the inquiries, investigations, recommendations and subsequent policy commitments that have led to the commissioning of this project, but instead focuses on the ‘landmark’ reports that have brought us to this point.
- 4.2 The final report by Lord Darzi on the NHS Next Stage Review, *High quality care for all*, noted that a small number of managers had performance issues. The report called for arrangements to prevent ‘poorly performing managers from moving on to other NHS organisations inappropriately’⁶ and new standards to replace the existing *Code of Conduct for NHS Managers*, that had been developed by a group chaired by Ken Jarrold in 2002.
- 4.3 The main outcome from this recommendation was the creation of a project group to look at options for assuring the quality of senior NHS managers. The group, chaired by Ian Dalton, then Chief Executive of the North East SHA, commissioned PriceWaterhouseCoopers to write a literature review on the topic.⁷ Their report identified a three-strand framework of options for assuring the quality of managers:
- Strand 1: recruitment, vetting and employment
 - Strand 2: corporate governance
 - Strand 3: accreditation, licensing and regulation.
- 4.4 The cornerstone of the first strand was a revised NHS Code of Conduct, while the second strand focused on strengthening the role of the Board in relation to scrutiny of overall performance, as well as that of the remuneration committee.
- 4.5 The third strand, which the research showed as more contentious than the other two, consisted of options for accrediting, licensing and regulating senior managers. However, the report was clear that ‘ideally, the options from Strands 1 and 2 would be implemented before looking to introduce a model of regulation identified with Strand 3’.⁸
- 4.6 The final report of the working group⁹ further highlighted the dual need to improve the quality of senior managers, while developing a framework to address poor performance. The framework of options identified in this report added a further tier to the PWC model, namely a set of standards and ethics to underpin the three PWC strands. This was to be an updated version of the current *Code of Conduct for NHS Managers*.
- 4.7 The NHS Next Stage Review also resulted in the development of the National Leadership Council (NLC), which was set up to support and promote good quality

⁵ For the purposes of this report, ‘senior managers’ should be read as ‘executive and non-executive board members’.

⁶ Department of Health. 2008. *High Quality Care for All – NHS Next Stage Review*. The Stationery Office: London. Part 6, para 28

⁷ PriceWaterhouseCoopers. 2009. *Assuring the quality of senior NHS managers*. PWC

⁸ Ibid. para 3.30

⁹ Department of Health. 2010. *Assuring the quality of senior NHS managers*. DH

leadership in the NHS, filling a gap in national oversight identified by Lord Darzi. The NLC issued guidance on good governance in February 2010, which aimed to improve board members' understanding of the role of the board, its position in the wider health system, ways to improve its effectiveness, and what is expected of individual board members.¹⁰ This guidance will be discussed in more detail in Section 7.

- 4.8 The publication of Ian Dalton's report and the NLC guidance coincided with that of the first report of the inquiry into the failures at Mid-Staffordshire Foundation Trust, led by Robert Francis QC.¹¹
- 4.9 Among its findings were serious failings by senior managers. It argued that 'given the importance of the role of senior managers and directors in a hospital trust, whether or not a foundation trust, the standards to be expected of managers should be similar [to the sort of guidance that doctors and nurses have to comply with in order to maintain their registration]'.¹² It went on to advocate a review of arrangements for 'the training, appointment, support and accountability' of directors in the NHS, and recommended the failings be addressed through standards 'formulated and overseen by an independent body given powers of disciplinary action'.¹³
- 4.10 The Department of Health responded to this Inquiry with a letter from the NHS Chief Executive, David Nicholson, to all NHS Chairs, copied to NHS Chief Executives, Medical Directors, Nurse Directors, Directors of HR / personnel, NHS Foundation Trusts, Monitor, and the Care Quality Commission.¹⁴ The letter stated that the Government had accepted a recommendation for the implementation of a system of professional accreditation for senior managers, and that it would begin consulting with the profession and the public on how to take this forward.
- 4.11 Following the General Election in May 2010, the Government's Command Paper, *Enabling Excellence* set out how professional regulation would be reformed.¹⁵ It referred to concerns about 'instances where senior managers who have let people down appear to have avoided significant consequences for their actions', and committed to commissioning 'independently led work to agree consistent standards of competence and behaviour for senior NHS leaders'.¹⁶
- 4.12 It is this commitment that resulted in the commission for CHRE to advise on a 'code of conduct and draft standards of probity, behaviour and competence for executive and non-executive NHS board members'.
- 4.13 The commission, specifies that the standards should draw on CHRE's 'right touch regulation principles'¹⁷, which advocate the use of the minimum regulatory force

¹⁰ National Leadership Council. 2010. *The Healthy NHS Board – Principles for Good Governance*.

¹¹ The Mid Staffordshire Foundation Trust Inquiry. 2010. *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005–March 2009*. The Stationery Office

¹² Ibid, Section F, para 29

¹³ Ibid, Recommendation 9

¹⁴ Department of Health. *Dear colleague letter: Robert Francis QC Mid-Staffs Inquiry Report, 24 February 2010*. Available at:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_113094.pdf [accessed 10 October 2011]

¹⁵ Department of Health. 2011. *Enabling Excellence*. The Stationery Office

¹⁶ Ibid, para 4.14

¹⁷ CHRE. 2010. *Right-touch regulation*. CHRE

required to achieve the desired outcome, and the mitigation of risks by the use of existing mechanisms where possible.

Summary

- 4.14 The documents discussed in this section set out a variety of concerns alongside a number of solutions, and it is important at this stage to clearly identify these. The problems which are more or less clearly articulated in the literature are as follows:
- Pre-recruitment training – where junior staff are unable to access the quality of training and development needed to produce high-calibre board members¹⁸
 - Recruitment and vetting – where the calibre of staff recruited to board-level posts is or is perceived to be inadequate¹⁹
 - Accountability on the job – where shortfalls in board members' performance are not identified and remedied or otherwise addressed²⁰
 - Accountability across the NHS – where managers who have failed can move freely on to other jobs in the NHS.²¹
- 4.15 The solutions on offer mirror the problems to an extent:
- Leadership initiatives to develop high calibre candidates for board-level posts²²
 - More robust recruitment mechanisms both to raise calibre of staff recruited to the posts and to prevent managers who have failed in previous jobs to be recruited to further management posts²³
 - More robust performance management mechanisms as a lever for improving performance²⁴
 - An independent body to hold managers to account on the job and across the NHS²⁵
 - Clear standards for managers to underpin training, recruitment and accountability on the job and across the NHS.²⁶

¹⁸ Department of Health. 2008. *High Quality Care for All – NHS Next Stage Review*. The Stationery Office: London. Section 5, para 35

¹⁹ Department of Health. 2010. *Assuring the quality of senior NHS managers*. DH. para 22

²⁰ The Mid Staffordshire Foundation Trust Inquiry. 2010. *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005–March 2009*. The Stationery Office. paras 42, 45

²¹ Department of Health. 2010. *Assuring the quality of senior NHS managers*. DH. para 24

²² Department of Health. 2008. *High Quality Care for All – NHS Next Stage Review*. The Stationery Office: London. Section 6, para 28

²³ Department of Health. 2008. *High Quality Care for All – NHS Next Stage Review*. The Stationery Office: London. Section 5, para 37

²⁴ The Mid Staffordshire Foundation Trust Inquiry. 2010. *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005–March 2009*. The Stationery Office. Recommendation 9

²⁵ Department of Health. 2010. *Assuring the quality of senior NHS managers*. DH. para 24

²⁶ The Mid Staffordshire Foundation Trust Inquiry. 2010. *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005–March 2009*. The Stationery Office. Recommendation 9

²⁶ Ibid.

- 4.16 The ethical standards that CHRE has been asked to produce come under this latter bullet point, and should not be seen as a solution in themselves – rather they may be used to underpin systems for training, recruiting, employing or disciplining senior managers.

5. The NHS reforms

- 5.1 The Government is implementing major reforms of the NHS in England, and therefore the context in which NHS executive and non-executive board members are operating is going to change, as some of the tasks that they are required to undertake. The standards need to be responsive; they must foresee to an extent the risks and challenges that are likely to arise as a result of these changes, while avoiding becoming too context specific.
- 5.2 Because of the timing of this policy review the fact that the Health & Social Care Bill is before Parliament, the following section covers the reforms as they stand at 1 September 2011.
- 5.3 The Health and Social Care Bill²⁷ puts 'clinical commissioning groups' (CCGs) in charge of commissioning local care services, and their boards²⁸ are expected to include at least one nurse and one specialist doctor.²⁹
- 5.4 CCGs will be responsible for the delivery of local health care, and for spending approximately 80 per cent of the total NHS budget.
- 5.5 Each CCG will be required to appoint an accountable officer (AO),³⁰ who will be responsible for ensuring that the CCG complies with its duties under the Health and Social Care Act, and for ensuring that it provides value for money, and who will also be a member of the board.³¹ The concept of clinical leadership is central to the reforms, as a means of bringing together 'responsibility for clinical decisions and for the financial consequences of these decisions'³² – making it likely that many GPs and other clinicians will take on this accountable officer role.³³
- 5.6 The BMA's GP Committee guidance on clinical leadership estimates that the average large consortium will be responsible for the care of 500,000 people with a budget of over £600 million³⁴, and that their 'competency as leaders of a large organisation will be essential'.
- 5.7 The Nuffield Trust has highlighted other things, including the need for 'skills development and training for GPs engaging in budget-holding, for these new responsibilities will require sophisticated analytical, planning and other managerial skills.'³⁵
- 5.8 There is also recognition that conflicts of interest are likely for decision-makers in the new arrangements and that these need to be managed. The BMA guidance on

²⁷ House of Commons. 19 January 2011. *Health and Social Care Bill*

²⁸ The Health and Social Care Bill refers to CCG boards as 'governing bodies' but to avoid confusion, we will continue in this paper to use the term 'board'.

²⁹ Department of Health. 2011. *Government response to the NHS Future Forum report: Briefing notes on amendments to the Health and Social Care Bill*. DH. Para 38 to 40.

³⁰ House of Commons (18 July 2011) *Health and Social Care Bill*. Part 1, Chapter A2, para 14B (3) (b); Schedule 2, Part 2, para 11

³¹ Department of Health. 2011. *Government response to the NHS Future Forum report: Briefing notes on amendments to the Health and Social Care Bill*, DH. Para 40

³² Department of Health. 2010. *Equity and excellence: Liberating the NHS*, The Stationery Office. Para 4.4

³³ Department of Health. 2010. *Liberating the NHS: Legislative framework and next steps*, The Stationery Office. Para 4.31

³⁴ BMA. 2011. *Leadership in Clinically-led Commissioning Consortia*. BMA

³⁵ Nuffield Trust. 2010. *Giving GPs budgets for commissioning: what needs to be done?* Nuffield Trust

ensuring transparency and probity, says: 'Where GPs are both providing care and deciding where that care takes place, how it is provided and who provides it, there is a real risk that a doctor's probity may come into question.'³⁶ It goes on to set out the different ways in which conflicts of interest could arise:

- Where clinical commissioning leaders have a financial interest in a provider company
- Where GPs may refer their patients to a provider company in which they have a financial interest
- Where GPs make decisions regarding the care of their patients to influence the 'quality premium' they receive through their consortium
- Where enhanced services are commissioned that could be provided by member practices
- Where Local Medical Committee (LMC) officers are also key officials in the consortium.³⁷

5.9 The GMC's *Good Medical Practice*, sets out some guiding principles on how doctors should approach the problem of conflicts of interest. *Good Medical Practice* will be discussed in more detail in Section 6.

5.10 The RCGP and NHS Confederation jointly produced a paper in July 2011 on how conflicts of interest these can be managed, again with reference to *Good Medical Practice*. Most of the guidelines focus on declaring and monitoring conflicting interests, but they also recommend that CCGs should have 'a clear statement of the conduct expected of those involved in its governance (potentially based on the Nolan Principles, and reflecting any requirements that are set out in the CCG's authorisation process).'³⁸

5.11 The responsibility for preventing any abuses of position lies both with the individual and with the organization. Processes must be in place to deal with them, but the onus is on individuals to be not only open about their interests, but also willing to forego certain potential advantages for the sake of probity.

Summary

5.12 The NHS reforms are likely to present new challenges for senior managers. Some of them will be clinicians with limited experience of managing operations on this scale. On this basis, the need for a system for improving and assuring the quality of NHS Board members continues to be important. Some of the most influential organisations in the sector have already identified the need for additional guidance and training and for a code on dealing with conflicts of interest.

³⁶ BMA GP Committee. 2011. *Ensuring Transparency and Probity*, BMA

³⁷ Ibid, p3

³⁸ RCGP and NHS Confederation. July 2011. *Managing conflicts of interest in clinical commissioning groups*, RCGP and NHS Confederation

6. Existing standards for NHS managers

- 6.1 Under current arrangements, senior NHS managers are bound by many different codes, standards and regulations, be it by virtue of being an NHS employee, an NHS manager, an NHS board member, a holder of public office, an Accounting Officer, a CQC-registered manager, or a registered professional. In addition, there are a number of voluntary frameworks for improving standards in leadership and management that managers may choose to adopt.
- 6.2 The *Oxford English Dictionary* defines ‘ethics’ as a set of moral principles or rules of conduct,³⁹ and we will use this as a baseline for examining these many frameworks for their ethical dimensions and identifying what might be meant by ‘ethical behaviour’ for a senior manager in the NHS. Each of the documents set out below is based on a set of values or principles, from which more specific requirements or guidelines emerge. Crudely speaking, the values/principles set out in these documents pertain to ethics, in that they describe the moral basis on which decisions about how to act and behave should be made.

NHS standards

- 6.3 All NHS staff are bound by the *NHS Constitution*, the creation of which was a key recommendation in Lord Darzi’s NHS Next Stage Review.⁴⁰ Darzi believed that the Constitution would improve accountability by establishing ‘the principles by which decisions are made’.⁴¹
- 6.4 The Constitution itself is a value-led document, based on the seven values of the NHS. They describe the principles on which the NHS operates, in terms of both what it delivers and how it is delivered. It stipulates that:
- NHS services should be free and available to everyone on the same basis
 - Designed to meet the needs of patients and the public
 - The NHS should aspire to the highest standards of excellence and professionalism
 - The NHS should work in partnership with other organisations to better serve the public
 - It should provide value for money and be accountable to the public.

These principles define the task of the leaders of the NHS, not just in terms of what they are ultimately there to do, but also how they should do it – working to the highest standards, working in partnership, providing value for money and being accountable, and working to meet the needs of the public.

- 6.5 NHS Board members are also subject to the *Code of Conduct for NHS Managers*⁴² produced in 2002 by a working group chaired by Ken Jarrold CBE, *The Standards*

³⁹ Oxford University Press. 1998. *The Concise Oxford Dictionary of Current English – Ninth Edition*, OUP

⁴⁰ Department of Health. 2008. *High Quality Care for All – NHS Next Stage Review*, The Stationery Office, chapter 7

⁴¹ Ibid, chapter 7, para 13

⁴² Department of Health. 2002. *Code of Conduct for NHS Managers*, DH

*of business conduct for NHS staff*⁴³ and *the Code of Conduct and Code of Accountability in the NHS* produced for Board Members by the Department of Health and the Appointments Commission.⁴⁴

- 6.6 *The Standards of business conduct for NHS staff* are based on principles of conduct that put the interests of patients first, require impartiality and honesty in conduct of NHS business, and value for money.⁴⁵ They also make staff responsible for not abusing their position for personal gain, or to further private interests, business or otherwise.⁴⁶ The Standards then go on to set out in specific terms how these principles should be implemented in policy.
- 6.7 *The Code of Conduct for NHS Managers* is also principle-based but has a broader focus than the business standards. It emphasises the primacy of the care and safety of patients; respect; honesty and integrity; taking responsibility for one's own work and the people one manages; working as part of a wider team and organisation; and taking responsibility for learning and development. Again, these are then transposed into more specific requirements.
- 6.8 *The Code of Conduct for Board Members* (which underpins the associated *Code of Accountability*) is mostly quite procedural, but it too is based on values, which are described as 'public service values which must underpin the work of the health service': namely accountability, probity and openness.⁴⁷
- 6.9 *The Code of Conduct for NHS Managers* was singled out in 2010 as needing updating on the grounds that the context within which the NHS is governed had fundamentally changed since 2002.⁴⁸ By the same logic a revision of the *Standards of business conduct* is long overdue, and the *Code for Board Members* would be due for revision shortly.
- 6.10 This does not mean, however, that there is nothing to be learnt from these less recent documents. By and large these principles and values may still be pertinent by virtue of being uncontroversial and relatively context-neutral (although the emphases may have changed).

Non-NHS standards

- 6.11 In addition to NHS specific standards, NHS Board Members are bound by a number of other frameworks. Firstly, non-executive Board Members are required to demonstrate their commitment to Lord Nolan's *Seven Principles of Public Life* in order to be appointed.⁴⁹ These principles apply not just to NHS Board members, but to anyone holding public office.

⁴³ Department of Health. 1993. *Standards of business conduct for NHS staff*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/HealthServiceGuidelines/DH_4017845

⁴⁴ Department of Health, NHS Appointments Commission. 2004. *Code of Conduct and Code of Accountability in the NHS*, DH

⁴⁵ Department of Health. 1993. *Standards of business conduct for NHS staff*. Para 5

⁴⁶ Ibid, para 6

⁴⁷ Department of Health, NHS Appointments Commission. 2004. *Code of Conduct and Code of Accountability in the NHS*, DH. p 2

⁴⁸ Department of Health. 2010. *Assuring the quality of senior NHS managers*, DH. p 16, para 10

⁴⁹ Commissioner for Public Appointments. 2009. *Code of Practice for Ministerial Appointments to Public Bodies*, CPA

6.12 The values are as follows:

- Selflessness - acting in the public interest
- Integrity - not being influenced by any obligations from outside their official duties
- Objectivity - making choices on merit
- Accountability - being accountable to the public and submitting themselves to scrutiny
- Openness - being open about decision-making
- Honesty - declaring and resolving conflicts of interest
- Leadership - promoting these principles.

These broadly reflect the themes identified in the previous section, although the wording is of course not NHS-specific.

6.13 Secondly, NHS trust⁵⁰ accounting officers take on specific responsibilities in relation to public money, making them accountable under the HM Treasury requirements set out in *Managing Public Money*.⁵¹ This document includes a section on the personal responsibilities of accounting officers. While this does not pertain to ethics in the detail, the overriding principle is that the accounting officer should be able to demonstrate to parliament and the public the organisation's high standards of probity. It picks up on the themes of openness, accountability, and probity identified both in the Nolan Principles and the various NHS standards.

Summary

6.14 This section shows that concerns about the misuse of public money and conflicts of interest are not new, indeed they form a substantial part of the existing standards for NHS managers. The picture of the ideal board member that emerges from these documents is of an individual who:

- Operates with honesty and probity in relation to the use of public money
- Operates with integrity and impartiality with respect to appointments, appraisals, references and procurement puts patient welfare first, and understands that he/she and the NHS are there to serve the public
- Operates with openness and transparency as a means being accountable to the public and parliament
- Seeks value for money for the organisation.

⁵⁰ It was not clear at the time of writing whether CCG *accountable* officers would also be *accounting* officers as defined by the Treasury, although the Health and Social Care Bill does make them responsible for the CCG's use of money and resources and for its duties relating to accounts and auditing.

⁵¹ HM Treasury. 2007. *Managing Public Money*, The Stationery Office

7. Professional standards

- 7.1 The other sets of standards to consider are the professional standards to which many NHS Board Members will be bound by virtue of being registered professionals. The King's Fund noted in a recent publication on the future of leadership in the NHS that clinical and finance directors are 'already subject to professional standards and discipline', and indeed a small number of professionals have been disciplined for falling foul of these standards in management roles.⁵² In addition, the relevant professional Colleges for doctors and other healthcare professions produce guidance for their members on best practice in many different areas.
- 7.2 No overarching data could be found on the professional backgrounds of board members in the NHS, but a quick survey of NHS trust⁵³ websites confirms that many board members are doctors, nurses, chartered accountants, solicitors, and allied health professionals. All of these professions are bound by standards, and the following paragraphs look at those aspects of these standards that could apply to senior managers in the NHS, and sit within the realms of ethics.

Standards for health professionals

- 7.3 Taking these professions in turn, the GMC's *Good Medical Practice* sets out the standards expected of doctors.⁵⁴ As was highlighted in Section 4, many doctors, and GPs in particular will be taking on board-level roles under the CCG arrangements, making these standards particularly crucial. The GMC standards and guidance reflect the fact that many doctors already work in positions of responsibility in their careers, whether in a clinical or non-clinical role.
- 7.4 For the most part, *Good Medical Practice* deals specifically with the practice of medicine as the title would suggest, but the section on probity includes a number of ethical principles that could also apply to board-level positions in the NHS. Under this heading, the standards set out the different ways in which doctors must behave with probity, including in their financial dealings, when dealing with conflicts of interest, and when writing and signing reports and documents – all of which are pertinent to board-level posts, although the detail here is quite specific to the medical context. *Good Medical Practice* goes so far as to state that probity, which is defined as 'being honest and trustworthy, and acting with integrity' lies at the heart of medical professionalism.⁵⁵
- 7.5 It is worth noting that CHRE recommended the GMC strengthen its statements around conflicts of interest in our most recent Performance Review report. This was on the grounds that declaring an interest does not remove it and does not do

⁵² King's Fund (2011), *The future of leadership and management in the NHS – No more heroes*, The King's Fund. p30

⁵³ NHS North East SHA <http://www.northeast.nhs.uk/board/>, Guy's and St. Thomas's Foundation Trust <http://www.guysandstthomas.nhs.uk/about/organisation/organisationalstructure/boardofdirectors/boardofdirectors.aspx>, Leeds Teaching Hospital <http://www.leedsteachinghospitals.com/corporate/directors/index.php>, Yorkshire Ambulance Trust <http://www.yas.nhs.uk/AboutUs/Governance.html>

⁵⁴ GMC. 2009. *Good Medical Practice*, GMC

⁵⁵ *Ibid*, para 56

enough to 'provide assurance to the public that the decisions of doctors involved in consortia will be free of conflicts of interests' in the context of the proposed commissioning arrangements.⁵⁶

- 7.6 The RCGP publishes guidance to support *Good Medical Practice* that sets out how it should apply to GPs.⁵⁷ It follows the same structure as GMP, elaborating on the meaning of each GMP subsection, and giving examples of what an 'exemplary' and an 'unacceptable' GP would do. However for the purposes of this paper, it does not add significantly to the ethical content already identified in *Good Medical Practice*.
- 7.7 The GMC also publishes *Guidance on Good Management Practice* which has no statutory force, but does state that doctors should 'make every effort to follow [it], where it is [their] responsibility and within [their] power to do so.'⁵⁸
- 7.8 It refers to the Nolan Principles, and stresses the primacy of patient welfare, and the importance of being personally responsible and accountable, speaking up (as a board member or not) about and taking action in response to concerns about risks to patient care, and making decisions – especially difficult decisions about resource allocation – based on sound evidence about efficiency and efficacy.
- 7.9 The following statement is particularly important:
- You are accountable to the GMC for your own conduct and for any medical advice you give, including while you serve on a hospital board or other corporate body. If you are concerned that a board decision would put patients or the health of the wider community at risk of serious harm, you must ask for your objections to be formally recorded and you should consider taking further action.*⁵⁹
- 7.10 This is interesting in that it goes one step further than the standards that have been covered so far, which set out the minimum standards of behaviour that are expected of a board member. The GMC guidance on the other hand identifies the extra mile that managers should go to challenge decisions and overcome situations that pose a threat to patient welfare, particularly in adverse conditions.
- 7.11 The standards for nurses and midwives,⁶⁰ are much more succinct than *Good Medical Practice*, as are the *Standards of Conduct, Performance and Ethics* for allied health professionals⁶¹, and neither standard explicitly covers financial probity. They do both stress the importance of such qualities as honesty and integrity, and the Nursing and Midwifery Council standards also address abuses of position and the influence of commercial interests on professional judgement.

Other professional standards

- 7.12 Chartered accountants are members of the Institute of Chartered Accountants in England and Wales (ICAEW), which is the professional body that registers

⁵⁶ CHRE. 2011. *Annual Report Volume II: Performance review report - Changing regulation in changing times 2010-2011*. The Stationery Office. Para 7.20

⁵⁷ RCGP. 2008. *Good Medical Practice for General Practitioners*. RCGP

⁵⁸ GMC. 2006. *Management for Doctors*, GMC. Para 7. The GMC is in the process of revising this guidance but a recent draft seen by the authors of this policy review emphasises similar themes to those identified in the current version: http://www.gmc-uk.org/guidance/news_consultation/8851.asp,

⁵⁹ Ibid, para 24

⁶⁰ NMC. 2008. *The code: Standards of conduct, performance and ethics for nurses and midwives*, NMC

⁶¹ HPC. 2008. *Standards of Conduct Performance and Ethics*, HPC

accountants and holds them to account against standards. Its *Code of Ethics* is based on a set of values: integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.⁶² It also sets out the factors that might have a perverse effect on practice: self-interest, not reviewing work to learn from mistakes, become too familiar with one's client or employer and losing objectivity as a result, and being intimidated by one's client or employer. The accountancy standards emphasise that good practice requires strength of character, although they are written in terms that remain very specific to accountancy. This echoes the points made in the GMC guidance on good management.

- 7.13 Solicitors in England and Wales are bound by the Solicitors Regulatory Authority (SRA) *Code of Conduct*.⁶³ The Code is very detailed and specific to legal practice, however, it is based on a set of overarching principles, described as the Core Duties: justice and the rule of law, integrity, independence, best interests of clients, standard of service, public confidence.⁶⁴ While the language is a little different, these duties nevertheless echo what is set out in most of the documents listed above, namely integrity, resisting influences that might compromise professionalism, and working in the interests of the end user.

Summary

- 7.14 The above shows that the ethical standards expected of professionals in many ways reflect those that are generally expected of NHS managers – probity, honesty, integrity are all common features of what could be called 'professionalism'. However, we have also identified a further quality that had not previously been referred to – that is, the strength of character to actively challenge decisions, behaviour, or situations that they believe to be wrong, or detrimental to patient welfare.

⁶² ICAEW. 2011. *Code of Ethics*, ICAEW

⁶³ SRA. 2007. *Solicitors' Code of Conduct 2007*, SRA

⁶⁴ *Ibid*, Rule 1

8. Voluntary schemes and frameworks for NHS managers

- 8.1 There are a number of schemes and guidance documents in place to train and support good quality managers in the NHS, some of which have emerged as government responses to recommendations following NHS failures, while others are independent of government.
- 8.2 The Institute of Healthcare Management (IHM) is a long-established independent membership body for managers in both health and social care, and has a 4000 strong membership. It has its own *Code of Conduct* and holds its members to account against it through a complaints process.⁶⁵ Again, reference is made to the Nolan Principles in the development of the code, which is based on the values of integrity, honesty and openness, probity, accountability and respect. These echo the themes we identified in the NHS-owned standards, the professional standards, and other standards applicable to NHS board members.
- 8.3 The Chartered Management Institute (CMI), which operates across all sectors, also has a code of practice against which it holds members to account.⁶⁶ It encompasses a number of competence standards, but also picks up on the now familiar themes of honesty, openness, respect, and taking action in response to matters perceived as improper or as falling below professional standards.
- 8.4 The NLC that emerged from the Darzi review (see para 2.7) was set up to support the development of high quality leaders for the NHS, and has recently launched its *Leadership Framework*, which emerged from the existing *Leadership Qualities Framework* and the *Medical and Clinical Leadership Competency Frameworks*.⁶⁷ The framework is designed to support the development of leadership from the bottom up, and as such consists of five core principles that apply to all, with an additional two for senior managers only.
- 8.5 The *Leadership Framework* mainly deals with competencies rather than ethics, however, it does stress the importance of acting with integrity, (sensitively) upholding personal and professional ethics and values, and taking action when ethics and values are compromised.
- 8.6 The NLC also has a Board Development workstream, which has generated a series of guidance documents. In July this year, the NLC published a 'development tool' on CCG governance arrangements, to aid the design of CCGs, and to inform the debate about how to 'ensure the effective governance of Clinical Commissioning Groups'.⁶⁸ The paper identifies four key areas of board performance:
- Building effectiveness
 - Strategy and planning
 - Accountability
 - Culture.

⁶⁵ Institute of Healthcare Management. *Code of Conduct*, IHM

⁶⁶ Chartered Management Institute. *Code of Practice for Professional Managers*, CMI

⁶⁷ National Leadership Council. 2011. *NHS Leadership Framework*, NLC

⁶⁸ National Leadership Council. 2011. *A development tool to support emerging Clinical Commissioning Groups with their governance arrangements*, NLC. p6

- 8.7 For the most part, the document looks at governance processes, but a number of ethical issues are also raised, particularly in the sections on accountability and culture, which again echo what we have found in other standards.
- 8.8 The development tool refers to both the Nolan Principles and the *NHS Constitution* as definitions of good governance culture, and suggests developing of a code of conduct to frame the relationship between GPs/ practices and the CCGs.⁶⁹ It also highlights the difficulty of ensuring that CCGs are fully accountable, referring in particular to the risks around conflicts of interests, which it believes can be mitigated by ensuring there is probity, openness and transparency, choice for patients, public confidence in decision-making, and consistency with GP practice standards.⁷⁰
- 8.9 In February 2010, the NLC published generic guidance for NHS Boards on good governance.⁷¹ This document focused mainly on the key characteristics of an effective board, but included a section on the exercise of judgement, which lists some of the dilemmas likely to be faced by boards. It is worth noting that the document provides no answers to the questions it raises, rather it encourages debate, and goes so far as to state that ‘the optimal board responses to these issues cannot sensibly be mandated in guidance’.⁷²
- 8.10 This section⁷³ is of particular interest because it alludes not only to the strength of character required of good leaders – ‘how does the NHS board remain self-directed and retain an internal locus of control?’, ‘how do board members retain a sense of their purpose and value in a context that may, at times, feel highly constrained?’ – but also to their judgement and finesse: knowing when to accept and when to challenge reliance on regulatory assurances; knowing when to listen to director concerns about board competence and when to ‘let go of concerns’,⁷⁴ and understanding the boundaries between the executive and the non-executive.
- 8.11 All these questions are fundamental questions for Boards to answer, and their response to them may well determine the success or failure of a service. They illustrate the profound complexity of the role of a board member, and the importance of knowing when to abstain as well as when to act. The job requires not just a strong moral compass and strength of character, but also flexibility, and ‘good judgement and acumen’.⁷⁵

Summary

- 8.12 The above covers some of the key resources and voluntary schemes that are available to NHS board members, and while it may not add significantly to the list of ethical qualities previously identified in this paper, it reinforces the universality of honesty, openness, transparency, accountability, and challenging impropriety. It also hints at the complexity of the task faced by board members whose decisions have such an impact, and implies that sticking to the basic ethical qualities required

⁶⁹ Ibid, pp 18, 44

⁷⁰ Ibid, pp 38-39

⁷¹ National Leadership Council. 2010. *The Healthy NHS Board – Principles for Good Governance*, NLC

⁷² Ibid, para 138

⁷³ Ibid, para 142

⁷⁴ Ibid, para 144

⁷⁵ Ibid, para 137

of a board member is not sufficient to ensure that they make the 'right' decisions – this also requires the careful use of judgement.

9. Summary

- 9.1 This paper attempts to summarise the policy drivers (past and present) for developing a set of ethical standards for board members in the NHS. Lessons learnt from past mistakes indicate that a consistent approach to standards could help to prevent service failings. Looking to the future, the need for a set of standards could be seen to be even greater in the light of the heavy responsibilities (financial and otherwise) soon to be taken on by doctors and other health professionals.
- 9.2 The summary of existing standards relevant to this project (see Table 1 below) is interesting on two counts. First, it shows that NHS board members are already subject to a plethora of requirements, standards and codes that pertain to ethics. Second, it demonstrates that there is broad consistency across these many frameworks about the ethical qualities required of a good manager, and that they generally reflect what is required of a professional: honesty, patient-centredness, integrity, probity, accountability, openness and transparency.

Table 1: Incidence of values and ethical terms in key documents

| Standards | Terms and values | | | | | | |
|--|------------------|-------------------------------|-----------|---------|---------------------|---------------------------|---|
| | Honesty | Patient/ public centred | Integrity | Probity | Account- ability | Openness/ Transparency | Other |
| <i>Code of conduct for NHS Managers</i> | Honesty | Patient-centred | Integrity | | | | Respect Committed Responsible |
| <i>Code of Conduct for NHS Board Members</i> | Honesty | | Integrity | Probity | Account- ability | Openness/ Transparency | |
| <i>Standards of business conduct for NHS staff</i> | Honesty | Patient-centred | | | | | Impartiality |
| <i>Good Medical Practice</i> | Honesty | Patient-centred | Integrity | Probity | | | Trustworthy |
| <i>Nolan Principles</i> | Honesty | Public-centred | Integrity | | Account- ability | Openness | Selflessness Objectivity Leadership |
| Incidence rate | 5/5 | 4/5 | 4/5 | 2/5 | 2/5 | 2/5 | n/a |

- 9.3 Two pertinent questions arise here – why, when there are so many existing standards, do some board members fail to comply? And how can standards (existing or new) address the challenges that the NHS reforms will bring to senior managers? The answer to the first is undoubtedly complex, and begs the question of enforcement, which is not touched on in this paper. Competence is also key, but again this is not within the scope of our advice. Part of the answer may lie in the

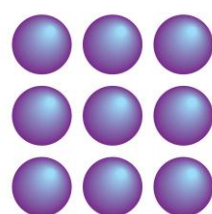
findings above: being a senior manager in the NHS is a job that requires a high level of skill and fortitude. Sticking to principles that are on the face of it incontrovertible no doubt requires courage in the face of adversity. Furthermore, the application of these principles is most certainly more complex than it seems from the outside, with many decisions being choices between lesser evils, rather than between a right and a wrong.

- 9.4 As for the second question, we found no shortage of requirements relating to financial probity and conflicts of interest, but if the existing frameworks are not doing the job now, they are unlikely to do so under the reforms. Significant amounts of training may be required to give doctors and other clinicians the competencies to manage CCGs, but courage and judgment are not qualities that can easily be taught.
- 9.5 Perhaps where the ethical standards can add value to the complex matrix of existing standards and frameworks is by providing not another exhortative statement of values, but an aid to decision-making based on sound values – a tool to give board members the courage to stick to what they know is right, and to help them hone their judgement.

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