



IHM Healthcare Management Code

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The IHM Healthcare Management Code

For the Institute, weighing up the arguments for and against having a Code, what the content will be, how to implement and monitor it and the disciplinary process has been richly debated at a small number of short workshops the purpose of which was to

- Confirm understanding and agree the reasons for having a "Healthcare Management Code" at this time;
- Consult on the principles, process and implementation of a Code.

This document represents the collated comments, amendments and examples that members have put forward during the consultation period over the summer months of 2000 and during the pilot year.

The Context:

IHM National Council discussed management education and development themes at their annual workshop in April 2000 the outcome of which became known as the "Warwick Accord". Part of this Accord stated that the Institute would :

"Emphasize continuing professional development as a core function."

This revised document, which is in three parts, brings together the principles of this thinking:

[Part 1: Education and Development](#)

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Part I Education and Development

The Institute believes that all those who are Full Members should exhibit three characteristics ([Appendix A](#))

1. Competence

A baseline set of competencies relevant to the level of management at which they work. The Institute's entry criteria for full membership are specified as:

2 years' healthcare management experience or 5 years senior management experience outside of the health sector

and

a recognised professional or managerial qualification or demonstrable relevant experiential learning.

The Institute welcomes managers without the above baseline criteria to join as Associates and will encourage them to become Full members through recognised routes.

2. Continuing Learning

A willingness for members to keep their learning up-to-date - usually referred to as continuing professional development (CPD).: Learning is assumed to be derived from four main sources:

- Learning from experience in the workplace (e.g.: introduction of change, adoption of best practice, leading a major project)
- Learning from structured sources (e.g.: seminars, conferences, courses and materials)
- Learning from self-directed personal work (e.g.: reading of 'learned' journals library work or research)
- Learning from other environments that transfers into one's working life (e.g. secondment, voluntary work, public office, giving talks)

2.1 In order to demonstrate satisfactory CPD it is proposed that members should have to keep a record of personal learning against previously agreed learning objectives.

2.2 The auditing of this process to ensure compliance requires careful thought and resources. This is clearly something the Institute should seek to perform for its members in due course and to set a recognised standard of achievement. This is being evaluated in Wales currently and will be rolled out across the UK in the pilot year.

3. Behaviour

Consistent with high principles (a Code) irrespective of the sector in which the member is employed: The case for a Code and whether the Institute is right to lead the debate is set out in Part II and this is the main purpose of this document.

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Part II The Healthcare Management Code

Expectations about the role and quality of healthcare management whether in the public, private or independent sectors has been brought sharply into focus. Recent wide media coverage of exceptional cases of poor or bad healthcare professionals' performance has not merely dented public confidence in healthcare, it has also bruised individual managers and their confidence in a vocation, which had previously been held with such trust and conviction.

The importance of reflecting on such events as Shipman, Bristol, Alder Hey and other reports cannot be over emphasised and provides new opportunities to revisit the debates about a Healthcare Management Code. The need to revisit the question "why have a Code?" has been particularly timely and relevant to those who care passionately about improving the quality of healthcare management.

1. Background - Why have a code?

1.1 A Steering Group chaired by Lord Newton of Braintree (formerly known as Tony Newton) was convened by the DfEE in 1999. The Group brought together representatives from a wide range of professional, trade, commercial and industrial organisations to consider whether a national code for managers to cover ethics, social and environmental responsibility, diversity and respect for others and lifelong learning should be drafted. IHM was invited to join this Group and take part in these discussions.

1.2 The research carried out for the DfEE funded "Ethical Management Project -1999" [1] indicate that there is general support for the development of a nationally recognised source of guidance for a Management Code for all sizes of organisations in the UK. Furthermore, individual and focus group interviews revealed a general perception that codes were equally important to those in the voluntary, public and private/business enterprise sectors.

1.3 The majority of respondents to the DfEE telephone survey were positively disposed to the idea of a nationally recognised voluntary code. Over 70% of respondents rated a code as "essential", "very important" or "quite important". There was, however, real concern that the idea of a code was just lip service, and therefore, support for the idea was given if it could be assured that commitments would be translated into action.

1.4 There was a strong view that management codes should cover the areas of ethics, social and environmental responsibility (around 80% of respondents feeling it was "essential" or "very important" that these areas were covered).

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2. Where does Healthcare fit in?

2.1 In the UK, the public debate on professional and public accountability particularly within the NHS began after the publication of the Cadbury Report in 1992.[2] Other documents followed including The Code of Conduct for NHS Boards,[3] The Code of Practice on Openness in the NHS,[4] The Accountability Framework for GP Fundholding: Towards a Primary Care led NHS[5] and The Caldicott Committee Report [6]. These documents provided key requirements for demonstrating accountability for NHS resources in the four areas: management accountability, accountability to patients and the wider public, financial accountability and clinical and professional accountability.

2.2 The Institute of Directors spelt out the corporate responsibilities for Directors, to individual executive role, in their 1995 publication "Good Practice for Directors - Criteria for NHS Boards" :

'Clarity of role and clear sense of directors' contributions to the board is the basis for an effective top team. This places a particular responsibility on the chairman to see that board members understand and can make the contributions expected of them' [7].

2.3 New guidance followed the change of government in 1997. 'The New NHS: modern and dependable' [8] described a ten year plan for re-organising general practices into Primary Care Groups and eventually Trusts. Separate arrangements were introduced in Wales - Local Health Groups; and in Scotland - Local Health Co-operatives. A fresh focus was placed on quality through clinical governance and the procedures were published in a further document [9].

2.4 The NHS Plan [10] notes "the current lack of national standards" and the introduction of the National Service Frameworks (NSFs) and National Institute for Clinical Excellence (NICE). It is also stated that NHS staff want to see more "training and improved management skills for staff.

2.5 The issues surrounding the effectiveness of self-regulation for the health professions, have captured the headlines. The Medical (Professional Performance) Act 1995 gave new powers to the General Medical Council. Further radical changes are now underway to bring outdated procedures into line with public requirements for swifter action.

2.6 The GMC publications "Duties of a Doctor" [11] and more recently "Management in Health Care: The Role of Doctors" [12] are valuable new models for practising doctors. The Royal College of General Practitioners and the General Practitioners Committee of the BMA have jointly issued an expanded version "Good Medical Practice for General Practitioners" [13], which clearly states the expected standards for an acceptable GP and what is unacceptable. This is important for both patients and managers. An example is appended and set a good model for the IHM to emulate (Appendix B)

2.7 The UKCC, the regulatory body for nurses is reviewing its own Code of Professional Conduct. The Code requires each registered nurse, midwife and health visitor to act at all times in such a manner as to :

- Safeguard and promote the interests of individual patients and clients
- Serve the interests of society
- Justify public confidence
- Uphold and enhance the good standing and reputation of the profession. [14]

2.8 Nurses are required to keep a portfolio of continuing professional development to demonstrate 5 days learning within a 3-year period.

2.9 A new UK Council of Health Regulators is to be established to co-ordinate health regulatory bodies across the healthcare professions[10]

2.10 Other professions are, therefore, moving this whole agenda forward and for those who manage them it becomes unacceptable not to take this on board.

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3. Healthcare Managers - the IHM approach

3.1 Managers, who are members of IHM Council, hold Director's responsibilities in particular for corporate governance of the Institute. It was an important founding principle of the new Institute that a Code was formulated for its members and that the Institute should take the lead for all healthcare managers by developing the original IHM Code of Conduct and the AMGP Code of Principles into a single Healthcare Management Code and agreeing its content and standards. Both former organisations had published work setting the scene in a primary and secondary care context. These included "Principles into Practice" [15], Ethics and Probity [16], The Healthcare Management Handbook [17] and The Primary Healthcare Management Handbook [18]. In addition the IHM journal "*Health Management*" recently published a series of articles on ethical dilemmas following an item "A shared statement of ethical principles for those who share and give healthcare" from the work of the Tavistock Group. [19]

3.2 Managers are faced with ethical dilemmas every day. The consequences of the Shipman trial, the Bristol Inquiry, the events at Kent and Canterbury Hospital and Alder Hey Hospital in Liverpool have been traumatic for all those involved. Previously well defined roles have changed. Doctors now have major managerial responsibilities, sometimes working in unchartered waters with little or no managerial training or education. With luck, the role and its responsibilities are learnt from an experienced colleague, or role model. Ethical dilemmas are commonplace.

An example of similar dilemmas faced by managers might be:

Conflicts may arise when doctors are called upon to make decisions about the use of resources and about patients' care, when the needs of an individual patient and the needs of a population of patients cannot be fully met. Dilemmas of this kind have no simple solution. When taking such decisions Doctors should take into account the priorities set by the Government and the NHS and/or their employing or funding body.... As managers, doctors must allocate resources in the way that best serves the interests of a community or population of patients.... [12]

"Fast tracking" of cancer patients above others with equally or more life threatening conditions due to 'politically' inspired initiatives.

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4. Developing an IHM Healthcare Management Code.

In developing the Code members stressed importance of ensuring that the key principles were founded upon relevant existing standards, such as the "Seven Principles of Public Life" (the Nolan Principles) identified and elaborated by the Committee on Standards in Public Life in 1995 [20] - Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership.

Based on the above, and using examples suggested by members, it is felt that the key themes of our Code should be:

4.1 Integrity

Members should act in such a way as to generate and maintain the trust and confidence of the patients and clients at all times and are not expected to further their own interests to the detriment of those whose trust is placed in them. This includes the rejection of any gifts, favours or hospitality, which might be interpreted as seeking to extend influence. Members will, in addition, safeguard personal information and keep it confidential.

The excellent manager

- Is helpful, co-operative and constructive in all dealings with patients, staff and colleagues
- Will represent views of patients where appropriate
- Will hold all personal information in confidence
- If patients wish to express their gratitude will advise them on procedures to make donations

The unacceptable manager

- Is obstructive and impatient to his/her own advantage
- Will expect gifts, favours or hospitality for co-operation
- Will gossip and spread rumours

4.2 Honesty and Openness

Sir Adrian Cadbury said "*Openness and ethics go together. What is out in the open may not always be ethical but what is concealed is almost certain not to be*", [21] Members should be as open and honest as possible about all the decisions and actions they take. Lack of information leads to suspicion.

The excellent manager

- Is honest, open in all dealings with patients, staff and colleagues
- Does not use knowledge of proposals or events as a means of exerting influence
- Shares information freely with those involved or who enquire.

The unacceptable manager

- Is devious and self promoting
- Only tells others what they have to know
- Uses information as a power tool

4.3 Probity -

In the healthcare context this means using resources responsibly and efficiently and safeguarding all assets placed with members for safekeeping. It implies loyalty at all times to the employing or contracting organisation but embraces the right to challenge decisions and actions that are believed to be against the patients' or clients' interests.

The excellent manager

- Seeks to avoid waste of resources by careful planning and effective operation
- Is prepared to champion causes in the patients' interest even against financial constraint

The unacceptable manager

- Imposes indiscriminate spending cuts without careful planning
- Ignores the consequences of constraints
- Ignores the needs of patients
- Acts without a conscience

4.4 Accountability -

Ensuring that members are able to justify their actions, or lack of action, under political or public scrutiny. Or there should be sufficient transparency to promote and maintain confidence by those affected by the decisions.

The excellent manager

- Acts after careful consideration of the consequences in the best interests of patients and the organisation
- Complies with statutory requirements but utilises discretion
- Consults widely before taking action with major impact

The unacceptable manager

- Acts by reflex without considering the consequences
- Is very superficial in approach to planning
- Dismisses the effect on others

4.5 Respect -

Respecting ones colleagues, employers and employees, patients and the public by recognising that their cultures, beliefs, race, lifestyles sexuality, age or their professional culture may be different from one's own. It also means respecting others by giving of one's best at all times and keeping up to date with best practice.

The excellent manager

- In all dealings with patients, staff, colleagues and the public, treats others with respect and equality
- Is prepared to listen to the views of others even if conflicting
- Uses reasoned argument and evidence to persuade a change of view

The unacceptable manager

- Treats others as of no consequence
- Is discriminatory
- Uses intimidation rather than logic

In addition every member has a *responsibility* towards:

4.6 The environment -

with an awareness of energy and environment conservation and that decisions for eliminating waste and recycling are made in the wider context and in partnership with the community as a whole and could be beyond the minimum requirements of the law.

The excellent manager

- Believes in supporting and carrying out the spirit of the Health and Safety at Work Act as well as complying with the letter of the regulations
- Always has safety in mind when planning change
- Encourages and enacts improvement in conditions
- Where necessary seeks safer alternatives

The unacceptable manager

- Pays lip service to safety requirements
- Only does what is demanded by law

- Avoids or delays necessary action which has a cost without seeking viable alternatives

4.7 Society -

respecting and understanding the impact of one's actions, not only on the immediately surrounding society in which they live and work but also within the community with whom they may negotiate and purchase.

The excellent manager

- Considers with priority the impact of proposals upon the environment and the community
- Actively addresses environmental issues
- Is prepared to invest resources to reduce impact without expecting an immediate payback
- Considers public opinion as a valuable asset

The unacceptable manager

- Ignores environmental and community concerns
- Dogmatically insists on cuts in expenditure and refuses investment
- Only does the absolute minimum to avoid prosecution

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5. How does whistleblowing fit in?

5.1 Whistleblowing in the public sector was widely publicised under "sleaze" headlines in the mid 90s. The charity Public Concern at Work [22], which is totally independent of government, promotes good practice and compliance with the law in public, private and voluntary sectors by focusing on the accountability of those in charge and the responsibility of those at work.

5.2 Challenging professional conduct or competence in healthcare is a highly sensitive topic. The dilemmas facing those working in healthcare when they are concerned about malpractice include whether to keep quiet, or to raise the concern internally, or to whom to turn outside.

5.3 The Public Interest Disclosure Act 1998 provides a statutory framework which

- Reassures workers with genuine concerns that there is a safe alternative to silence
- Promotes better accountability and more efficient regulatory oversight
- Makes risk management an issue for all staff and managers.

5.4 The scope of the Act ensures that it applies to almost every worker in the UK. and that dismissal of an employee for raising a concern is automatically treated as unfair, particularly if the concern is raised internally or there is a wider disclosure and it is not acted upon properly. The Act also prohibits gagging clauses.

5.5 It is important to change the culture to make it safe and acceptable for managers and staff to raise concerns. The whistleblower should be seen as a witness not as a complainant. It is important to encourage organisations to clarify who is responsible for what and to whom, to introduce whistleblowing policies and to avoid anything which could be construed as a cover-up. The Institute has an influential role to play in promoting the message and changing the culture. It began this process by holding a day seminar "Acting on Concerns at Work " in London [23]

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6. How will a Healthcare Management Code work?

6.1 *"Both AMGP and IHSM defined how they expected members to conduct themselves. There was no compulsion about it and no sanctions effectively deployed. IHM believes this must change. Members of the Institute will adhere to the highest management standards. The public expect it and members want it. This is not a threat, it is a badge to be worn with pride "[24]*

6.2 As already stated in Part I the Institute is committed to the principle of life long learning through continuous professional development (CPD). A Code will encourage all members to take part in appropriate CPD activities as an integral part of their professional life and will support them

in this undertaking.

6.3 *"Those managers not willing to get involved in CPD will retain Associate membership, and those who do not subscribe to the Institute's Code will be advised to seek an alternative organisation" [24]*

6.4 It has become clear from comments received and at the IHM workshops that members felt strongly in favour of linking a Code to a CPD framework as described in Appendix A. The words "long overdue" were reiterated throughout the consultation period.

6.5 In the first instance it was proposed that the Code be voluntary. A "shadow year" was organised to test the processes and expected costs involved in establishing a robust procedure in the future. The implications of this are that the IHM will look for its members to act as exemplars by making sure their behaviour is in accordance with the principles of the Code and reaffirming their commitment to CPD requirements.

6.6 The IHM Education Development Group is reviewing the Accredited Prior Learning (APL) criteria and Accredited Prior Experiential Learning (APEL) procedures and the implications of CPD being an integral part of the proposed IHM Healthcare Management Code.

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Part III IHM Disciplinary Procedure and Appeal system

1. Members have discussed and recognised the implications for introducing an IHM Healthcare Management Code and the ramifications that this could have on existing members and the potential future membership. Having procedures to censure members and change their membership grade from Full to Associate if future individual CPD requirement were not complied with was considered necessary but to be used only as a last resort. CPD and Code are about development not punishment. The Institute has a leading role to play in promoting the positive aspect of providing members with a set of standards and a framework for their working careers.
2. Whilst the Healthcare Management Code is targeted at individual managers, the Chairman, Directors and Chief Executive of the Institute will review rigorously the IHM's own corporate and personal governance procedures as required by company law and good practice, to guarantee they meet the same principles and standards that are expected of the members.
3. The Institute has explicit disciplinary and grievance procedures for employed staff. The Chief Executive is directly responsible to the Institute's Chairman of Council with annual appraisal of objectives set against a Business Plan which is agreed by National Council.
4. The Institute has within its Articles of Association appropriate procedures to remove members who are found to be "guilty of improper or dishonorable conduct or conduct which in the opinion of the Council renders him or her worthy of censure or unfitted to remain a member of the Institute" [25] in the unlikely event this would be required.
5. These procedures include a complaints and appeal procedure the details of which can be obtained from the Chief Executive/Deputy Chief Executive.

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Conclusion

The support members have voiced about introducing an IHM Healthcare Management Code have been very positive. This is right and timely. What the Institute cannot afford to do is ignore the signals. It must lead the debate to ensure its members are exemplars of good management and that employers will acknowledge as best practice. It is believed this document and the commitment to CPD start this process.

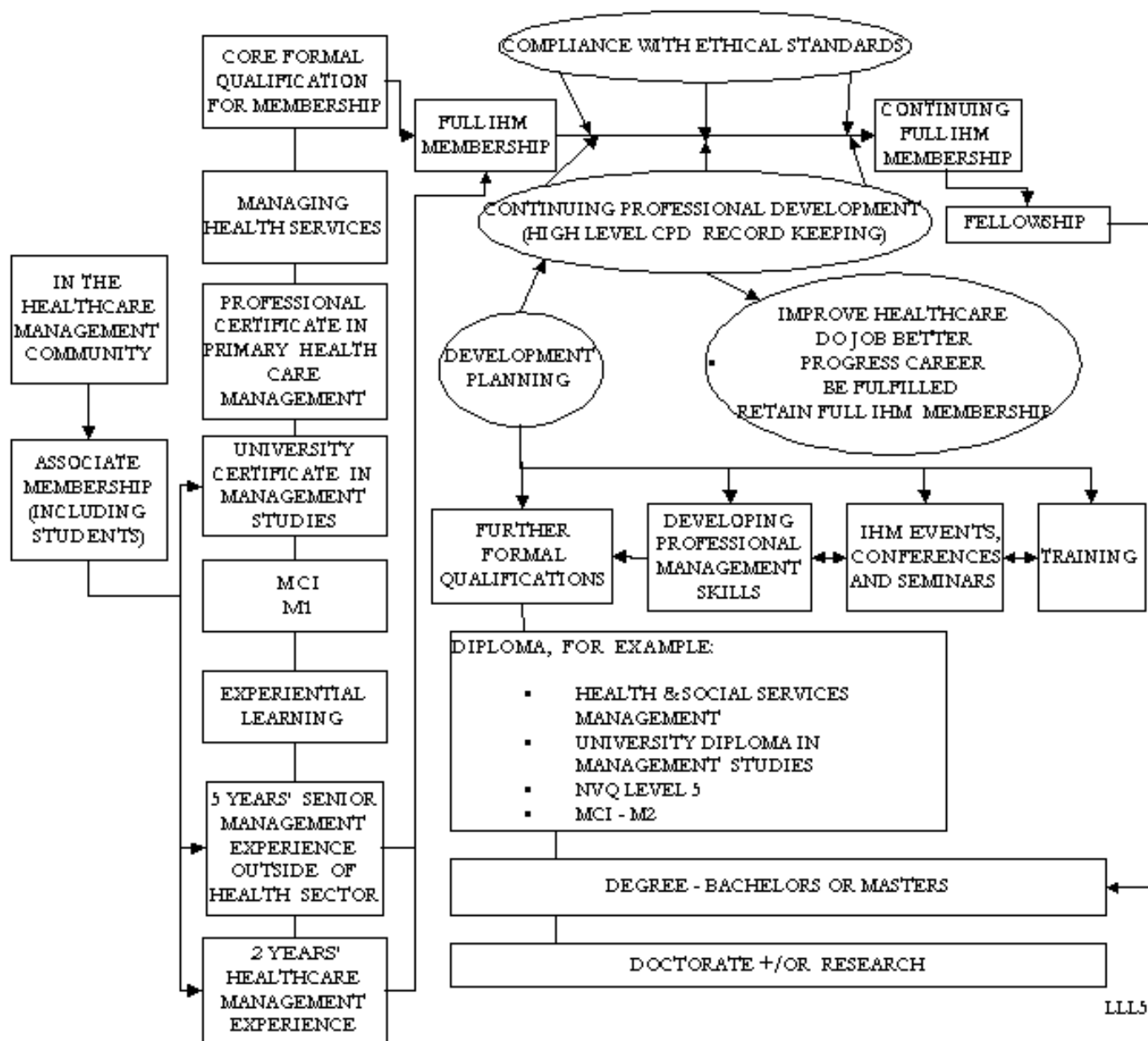
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Appendix A



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Appendix B

7. Keeping up to date, maintaining your performance

"You must keep your knowledge and skills up to date throughout your working life. In particular you should take part regularly in educational activities, which develop your competence and performance.... Another part of keeping up to date is ..with the law. Many areas of general practice are influenced by statute.... If you employ staff or provide public access to your premises, you have additional responsibilities to be aware of and respond to: Employment Law, Health and Safety Law and related matters, and regulations governing access to premises e.g. disabled people, both patients and employees).

The excellent GP

- Is up to date with developments in clinical practice and regularly reviews his or her knowledge and performance
- Uses these reviews to develop practice and personal developments plane
- Uses a range of methods to monitor different aspects of care and to meet his or her educational needs
- Has information available on laws related to general practice
- Has a named person in the practice who is responsible for employment matters and health and safety at work, and ensure compliance with them.

The unacceptable GP

- Has little knowledge of developments in clinical practice
- Is hostile to external audit or advice
- Has limited insight into the current state of his or her knowledge or performance
- Where employing staff, neither understands nor meets his or her responsibilities as an employer.

19: Financial and commercial dealings

Examples of unprofessional conduct

- Defrauding the NHS or any organisation you work for
- Exerting pressure on patients to enter a nursing home, which you own

The excellent GP

- Ensures that his or her financial affairs are capable of withstanding searching outside audit
- Never seeks inappropriate personal gain in the pursuit of practice

The unacceptable GP

- Carelessly attaches his or her name to documents or certificates
- Seeks personal financial gain from his or her patients other than the normal remuneration expected in his or her job [13]

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