NHS
Worcestershire
Acute Hospitals
NHS Trust

Policy: Ethical clinical decision-making during COVID-19 pandemic

Department / Service:	Chief Medical Officer, Worcestershire Acute Hospitals NHS Trust
Originator:	Jane Ball
Accountable Director:	Mike Hallissey
Approved by:	Silver Meeting
Date of approval:	10th August 2020
First Revision Due:	31st December 2020 This is the most current document and should be used until a revised version is in place.
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All wards and clinical departments
Target staff categories	All clinical staff

Policy Overview:
This document describes the Trust's policy for making ethically balanced clinical decisions during the COVID 19 pandemic and has been drafted in alignment with the Ethical framework for the Hereford and Worcester Integrated Care Network

Latest Amendments to this policy:
Final draft; 13 April 2020 10th August 2020 – Document approved at Silver Meeting 8th January 2021 – updated

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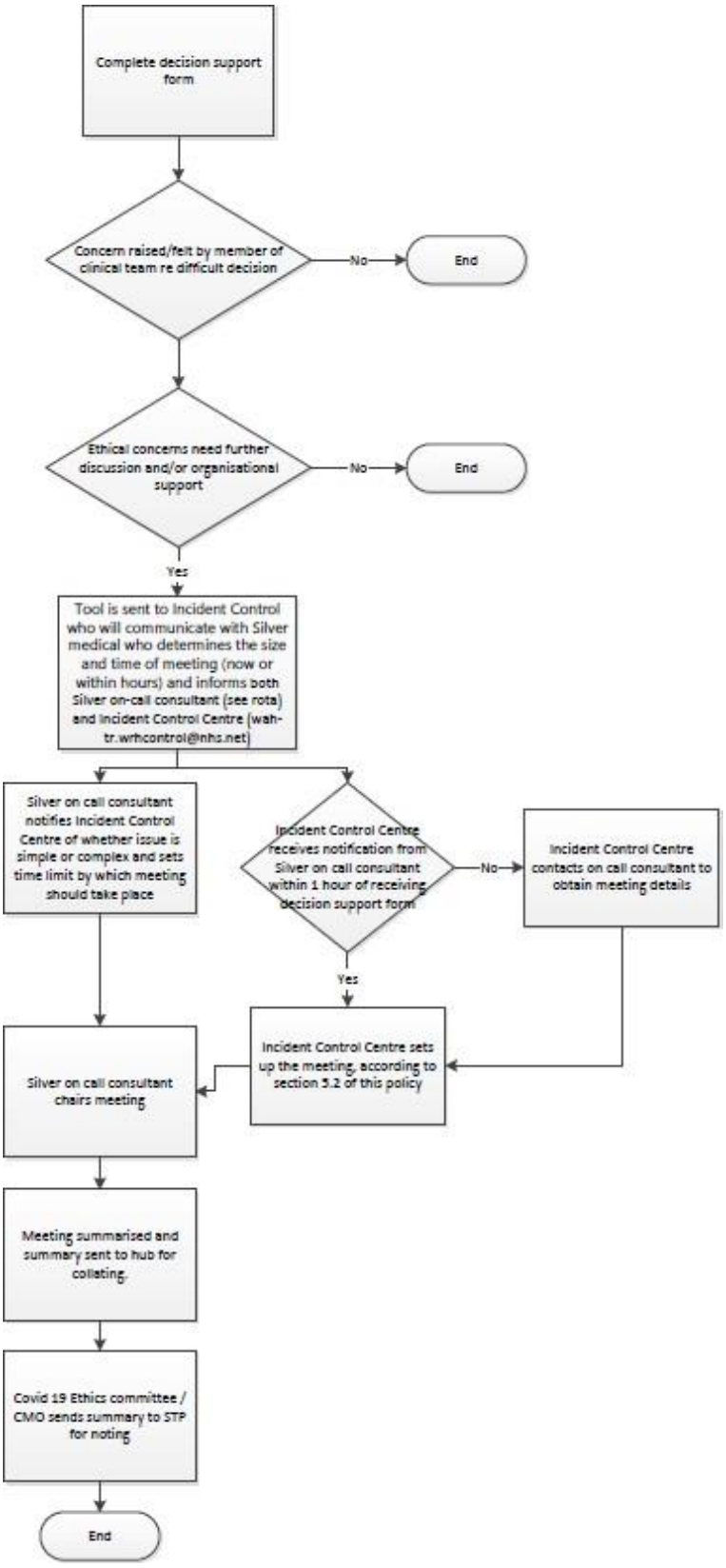


1 Introduction

The British Medical Association advises that doctors will face serious ethical challenges during the COVID 19 pandemic and has issued a guidance note[1] about what they might expect and how they should be supported, particularly whilst working in unfamiliar roles or settings. This policy describes the Trust's framework for supporting doctors and nurses to make difficult decisions and support ethical decisions during the pandemic and is in line with the Ethical Framework approved across the STP (Appendix 4).

Teamwork and mutual support across the whole healthcare team are essential to making difficult decisions. Working together and consulting colleagues regularly, including MDTs where appropriate, recognises that everyone is working in very stressful situations, in different ways and may be exhausted.

In their paper[2], doctors and ethics researchers Dan Harvey & Dale Gardiner, Critical Care Consultants at Nottingham University Hospitals NHS Trust, note that one of the factors that leads to high levels of health professional burnout is moral distress. To quote directly,
Moral distress can occur when clinicians feel unable to do what they perceive to be the right thing, or when faced with ethical uncertainty. It is therefore of no surprise that moral distress occurs frequently in providing critical care.
This will be particularly true during the COVID 19 outbreak when wise clinical decisions in both critical and acute care, and consequent resource allocations, are to be made rapidly and in hitherto un-encountered clinical circumstances.

Making defensible, time-critical decisions is therefore a core requirement of critical care clinicians and those working in acute specialties[3]. Front-line clinicians should rely upon this policy both to provide confidence that ethical considerations have been made comprehensively and as a consistent way of presenting their dilemmas and decisions to colleagues to gain support and to reduce moral distress. The decision support provided and outcomes of related activities undertaken in accordance with the policy will have the support of the Trust Board.

1.1 Scope of this document

This policy presents a balancing tool for ethically difficult clinical decisions and describes a support framework within which the tool should be used. The tool and the framework are an adjunct to clinical decision-making. Together, they ensure that the inevitable impact of strained or over-whelmed resource availability, due to the COVID 19 outbreak, is given ethical consideration. Use of the tool balances the usual parameters of clinical efficiency and effectiveness with considerations caused by exceptional resource scarcity. When presented in accordance with this policy, the resulting analysis and consequent decision gains collaborative oversight and organisational support.

2 Definitions

"*Moral distress*" – a recognised result of the stress of:

- being unable to do the perceived "right thing" for patients and/or

[1] https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf
[2] https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf
[3] https://www.rcplondon.ac.uk/file/20726/download

- being tasked with balancing interests of staff, patients and others in an ethically sound way.

"*Resource availability*" - used in this policy in its broadest sense to refer to:

- workforce,
- skills,
- critical care and other acute beds,
- diagnostic facilities,
- equipment
- consumables, including PPE

"*Decision Support* tool" **-** This form can be used to guide and record the decision-making process regarding the level of support an ill patient should receive based on evaluation of interventions and benefit. It is designed to support best practice in decision-making.

Moral Balance tool" - a document completed for each ethically difficult decision in which moral distress is or could be a factor or for which organisational endorsement is needed

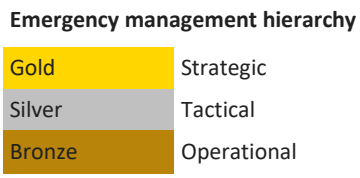
"*Framework*"- a process within which the result of balancing ethical considerations is reviewed and supported by senior colleagues and thereby organisationally endorsed

"*Simple*" case – requires an ethical decision in which, although clinicians may be confident in their clinical judgement, support is needed to balance the wishes of the patient and/or family members and/or others in the constrained circumstances and heightened emotions of the COVID 19 outbreak

"*Complex*" case –requires an ethical decision, perhaps incorporating clinical judgement, which is a fine balance, in favour of one patient over another or one group of patients over others.

"*Silver Medical*" on call consultant

The Silver on-call consultant is the Trust's link to other medical management within the emergency response system. He/she manages tactical implementation following the strategic direction given by Gold, making sets of actions that are completed by Bronze (i.e. consultant and specialty teams) A gold–silver–bronze command structure is a command hierarchy used for major operations by the emergency services of the UK.



"*Incident Control Centre*" – (from 10th April) located in the conference room on the first floor of the Worcestershire Oncology Centre, manned 8am to 8pm, responsible for answering queries, supporting Silver command and organising and noting important meetings, including virtual meetings, related to management of the COVID 19 outbreak.

3 Responsibilities and Duties

- COVID 19 Ethics Committee – implements this policy
- Silver on call consultant – manages operation of this policy
- Incident Control Centre – supports operation of this policy
- Consultant staff and their teams – follow this policy
- Nursing, ward and department staff – follow this policy

4 Ethical decision-making during COVID- 19 outbreak

Ethically defensible, balanced decisions need to be made quickly and with clarity during the outbreak. This policy outlines two steps to be taken to achieve this aim.

4.1 Step 1: Apply the *Decision Support* tool.

Based on a recognised seminal work[4] regarding ethical decision making in medical settings, the tools are at appendix 1. Clinicians should follow and document the recommended four steps:

i Establish the facts of the decision in question.

ii Decide what is in scope and out of scope.

iii Specify the outcomes within four recognised principles of ethical decision making

iv Balance the principles to give them action-guiding capacity.

Used at the bedside, these tools facilitate a structured analysis of ethical issues, helping to:

- Expose bias within decisions,
- Suggest compromise or alternative resolutions
- Aid communication.
- Clarify disagreement, which may persist but will be clear and documented.

Where ethical issues are identified which need further support these can be identified to raise with the Ethics Group for exploration. When decisions are later challenged by patients, families or external authorities, this transparent process will have led to a defensible, documented conclusion.

4.2 Step 2: Obtain review and organisational endorsement of the ethically balanced decision

The majority of decisions on patient management can be made on routine criteria. Where there is likely to be *moral distress or there are unresolved ethical issues* arising from a decision, the COVID 19 Ethics group encourages consultant teams, in collaboration with the relevant department's senior nurse/ Matron on duty to obtain review and endorsement of both simple and complex ethical decisions before taking action. These decisions should be based on the values outlined below:

Value	*Description*
Accountability	Measures are needed to ensure that ethical decision-making is sustained throughout the crisis and aligned to STP Ethical framework
Inclusivity	Decisions should be taken with stakeholders and their views in mind
Transparency	Decisions should be publicly defensible
Reasonableness	Decisions should be based on evidence, principles and values that

[4] Principles of Biomedical Ethics. Beauchamp TL, Childress JF. Principles of biomedical ethics. 5th ed. Oxford: Oxford University Press; 2001

Value	*Description*
	stakeholders can agree are relevant to health needs, and these decisions should be made by credible and accountable members of staff
Responsiveness	Flexibility in a pandemic is key. There should be opportunities to revisit and revise decisions as new information emerges throughout the crisis, as well as mechanisms to address disputes and complaints

The process of review is as follows:
On request, the Silver on call consultant will assemble a panel of experienced colleagues to assist and endorse balanced decision making.

- **Simple cases**: Supported by the Incident Control Centre, the Silver consultant will convene a review panel of four clinicians, comprising him/herself, as chair of the panel, a hospital consultant, a Senior Nurse and a GP. This group will be supported by a member of the Chaplaincy service. In a virtual meeting of no more than 45 minutes duration, the panel will ask the clinical team to present their decision, using the Moral Balance tool as a presentation aid. Together, the panel and the clinical team will review and explore any areas of uncertainty, enabling the clinical team to define a course of action. The team will implement that agreed course.

- **Complex cases:** the process is as that for simple cases, above. Additional panel members, will be included, namely the CMO/deputy CMO or CNO/Deputy CNO and a Divisional Director.

The quick reference guide at the beginning of this policy contains the steps required to call for a review. The roles of Incident Control Centre and the Silver on call consultant within this policy can be found at appendix 3.

5 Implementation

5.1 Plan for implementation

The policy will be implemented once approved by the Executive team and will be a resource for cases in both secondary and primary care.

5.2 Dissemination

The policy will be circulated to all clinical staff within the trust and Health and Care trust. It will be made available to the Clinical Directors in the Worcester Primary Care Networks for their information.

5.3 Training and awareness

Due to constraints over meetings during the current conditions, training and awareness will be by regular communications from the central team.

6 Monitoring, compliance and risks associated with this policy

Compliance with this policy will be measured by:

- Collation of Decision Support forms for central review
- Triangulation with data from established incident and complaints management policies to identify when and if the Moral Balance tool has been used.

- Spot audits of a selection of notes of patients with COVID 19 and collection of anecdotal evidence to consider/establish the completeness of documentation and the frequency of use of:
    - the Decision Support tool
    - the number of Decision Support tool enabled decisions which were endorsed by a Silver panel

Number of referrals to the Ethics Group	
Number of decisions where ethical concern resolved or influenced	
Number of cases where resolution not achieved	
Number of complaints related to decisions	
Review of cases by the Medical Examiners	

The effectiveness of this policy will be shown by the number of cases where the ethical concerns of the clinical teams, patients and families are resolved by the panels. There will be an evaluation of responses to complaints or other challenges which rely on, or incorporate, evidence documented within the *Moral Balance* tool

The COVID 19 Ethics committee has agreed the following risk assessments with regard to this policy:

- Ethically balanced decisions are not documented – the tool's use reduces this risk
- Trust is accused of unethical decisions with regard to individual factors such as protected characteristics – use of the tool shows how these risks were balanced in the circumstances at the time the decision was made

6.1 System reporting

The COVID 19 Ethics Committee will summarise and report ethical decisions made according to this policy to the Herefordshire and Worcestershire COVID 19 Ethics Committee. The committee meets monthly. Reports should be made two days before the date of the meeting.

7 Policy Review

This policy is extant throughout the duration of the COVID 19 outbreak. The COVID 19 Ethics Committee will carry out an early review for practicality and amend, if necessary, by 31st May 2020. Thereafter, review will be 6 monthly for necessity and practicality.

8 References

References:	Code:
Other Trust policies	
Management of clinical incidents	
Management of patient complaints	
External references	
See footnotes	

9 Background

9.1 Equality requirements

See supporting document 1 (attached)

9.2 Financial risk assessment

See supporting document 2 (attached)

9.3 Consultation

The policy will be communicated to the ICS Ethics Forum

9.4 Contribution List

This key document has been circulated to the following individuals for consultation:

Designation
Trust Chair
Chief Executive Officer
Executive directors
Incident Control Centre lead – Lisa Peaty
DDs
Clinical Directors

This key document has been circulated to the chair(s) of the following committees/groups for comment:

Committee
Quality Governance Committee

9.5 Approval Process

The policy will be approved by Trust Management Executive the Trust Board.

9.6 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:
6th April 2020	First draft for comment	J Ball
7th April 2020	2nd draft for review • MH comments on 1st draft incorporated • Decision Support tool amended per MH review and new version inserted • *Moral balance* document inserted for use "as required"	J Ball
13 April 2020	Revised flow chart inserted	M Hallissey
8th January 2021	Revised appendix 1 (Decision Support form) inserted	J Ball
11th February 2021	Revised appendix 1 (Decision Support form v.2 inserted	J Ball

Affix Patient Label here or record:	Hospital admission date:
Name:	Date of assessment:
NHS No:	Time of assessment:
Hosp No:	Date for review:
D.O.B: D D / M M / Y Y Y Y Male ☐ Female ☐	

COVID-19 Patient Care: Decision - Support

This form can be used to guide and record the decision-making process regarding the level of support an ill patient should receive based on evaluation of interventions and benefit. It is designed to support best practice in decision-making.

Evidence: Clinical

Acute presentation:

Past Medical History:
There is a recognition that an increasing number of the listed co-morbidities, frailty and age will adversely impact on outcome and escalation will be associated with limited benefit. Factors which may be of significance include: Recent cardiac arrest in last 3 years, more than 3 admissions in last year or a prolonged hospital admission in last 12 months.

Chronic cardiac disease	The ISARIC risk calculator may provide useful information: **See page 4 of this form** The information in the table is required to complete the assessment plus age, sex, respiratory rate, saturations, GCS, urea and CRP. Calculated mortality risk: .....
Chronic respiratory disease (excluding asthma)	
Chronic renal disease (estimated glomerular filtration rate ≤30)	
Mild-to-severe liver disease	
Dementia	
Chronic neurological conditions	
Connective tissue disease	
Diabetes mellitus (diet, tablet or insulin-controlled)	
HIV/AIDS	
Malignancy	
Clinician-defined obesity	

Intensive care mortality (ICNARC 31/12/20) from COVID pneumonia ventilation strategy:

Requirement is CPAP only – 55% mortality, requires mechanical ventilation – 70% mortality

Rockwood Frailty score: Patients with CF > 5 account for only 10% of ICU admissions.

Rockwood Frailty score:

Evidence of discussion with patient and next-of-kin with appropriate support

Ensure a RESPECT form is completed see COVID Guidance

Worcestershire Acute Hospitals NHS Trust

Affix Patient Label here or record:	
Name:	
NHS No:	
Hosp No:	
D.O.B: D D / M M / Y Y Y Y	Male ☐ Female ☐

Making ReSPECT COVID-19 Recommendations – Guidance

Assess for the presence of significant LTCs and frailty Decide on what treatment is recommended

↓

Ask where the patient places themselves on the spectrum / line between prioritising sustaining life (at all cost) and focusing on symptom control (with no attempt to sustain life)

↓

Record this position in section 3 of the ReSPECT plan

↓

Stress the positive components of supportive care and treatment that you are recommending as below. Explain treatment on offer which is a supportive treatment

↓

- Oxygen therapy and antibiotics if clinically appropriate
- Oxygen therapy and antibiotics if appropriate followed by consideration of escalation to non-invasive ventilation
- Oxygen therapy, antibiotics if appropriate, non-invasive ventilation and consideration of escalation to critical care ventilation / interventions

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Worcestershire Acute Hospitals NHS Trust

Affix Patient Label here or record:

Name: .....

NHS No:

Hosp No:

D.O.B: D D / M M / Y Y Y Y Male ☐ Female ☐

Balancing burdens and benefits of escalating treatment

Do the burdens of attempting CPAP outweigh the benefits for this patient? ☐ Yes ☐ No

Explanation:

Do the burdens of intensive care escalation or continuation outweigh the benefits for this patient?

☐ Yes ☐ No

Explanation:

Have ethical concerns been identified which require support: Yes ☐ **No** ☐

If yes list below:

1.

2.

3.

Contact Control hub if you wish discussion of Ethical concerns with copy of this form

Recommended treatment

- ☐ **For active treatment and admission to the intensive care unit**
- ☐ **For active treatment on the ward, with escalation to ICU if deteriorates.**
- ☐ **For active treatment with ceiling of ward-based care including CPAP. Start AMBER Care Bundle. DNACPR. If deteriorates for end-of-life care.**
- ☐ **For active treatment with ceiling of ward-based care but not CPAP. Start AMBER Care Bundle. DNACPR. If deteriorates for end-of-life care.**
- ☐ **For active symptomatic treatment. Start AMBER Care Bundle. DNACPR. If deteriorates for end-of-life care. Not a candidate for further escalation of treatment in ITU.**
- ☐ **For withdrawal of IMV/CPAP due to treatment failure and commencement of active symptomatic treatment. Start AMBER Care Bundle. DNACPR. If deteriorates for end-of-life care.**

Individuals Contributing to decision

Consultant

Name and GMC no: .....

Signature: .....

Senior Clinical Decision Maker 2 if necessary (including telephone discussion)

Name: .....

Signature (if available): .....

Grade: .....

Senior Clinical Decision Maker 3 if necessary (including telephone discussion)

Name: .....

Signature (if available): .....

Grade: .....

Review in : days or review not required:

Affix Patient Label here or record:

Name: . . . . . .

NHS No:

Hosp No:

D.O.B: D D / M M / Y Y Y Y Male ☐ Female ☐

Mortality Risk scoring tool

Indicator	Parameter	Score	Date	Date	Date	Date
Age	Less than 50	0				
	50 - 59	2				
	60 - 69	4				
	70 - 79	6				
	80 or over	8				
Sex @ Birth	Female	0				
	Male	1				
Number of co-morbidities	0	0				
	1	1				
	2 or more	2				
Resp rate (breaths per min)	Less than20	0				
	20 -29	1				
	30 or greater	2				
Oxygen saturations on room air	92% or higher	0				
	91% or lower	2				
Glasgow coma score	15	0				
	14 or less	2				
Urea (mmol/L)	6.9 or less	0				
	7 to 14	1				
	14.1 or above	3				
C-reactive protein (mg/L)	49 or less	0				
	50 to 99	1				
	100 or more	2				
Overall patient score						

Risk of death calculator

Score	Risk of dying (%)
0 - 2	0.5
3	1.2
4	2.4
5 - 6	4.5
7 - 8	7.7
9	10.0
10	39.3
11 - 12	44.5
13 - 14	52.1
15 - 16	61.5
17 - 18	72.3
19 or above	80.1

Role descriptions for those operating this policy –

- Presenting team
  - Identify the ethical concerns that their decision presents to them

- Silver consultant on call
  - The meeting chair

- Incident Control Centre
  - Co-ordinates the requests and establishes the meeting

- COVID 19 Ethics Group
  - Contribute to the ethical discussion to help the clinical team resolve any ethical dilemmas

Herefordshire and Worcestershire STP Ethics Committee
Ethical Framework to support decision making in response to Corona Virus

3rd April 2020

This document sets out the ethical framework within which Herefordshire and Worcestershire STP (H and W STP) will develop and deliver its response to the Corona Virus pandemic.

The framework sets out the values and principles that underpin our system response, ensuring it is based upon the four principles of medical ethics:

1. **Autonomy** – ensuring that people have the right to control their own bodies, and refuse or accept treatments according to their wishes
2. **Beneficence** – ensuring that the health and care system strives to improve both population and individual patients health and wellbeing, in each and every situation
3. **Nonmaleficence** – 'first do no harm'; ensuring that decisions and actions cause no unintentional harm
4. **Justice** - being as 'fair' as possible in offering treatments and allocating medical resources

In doing so this ethical framework recognises our legal duties as public bodies, ensuring that our decisions and actions:

- Meet our statutory duties and are 'legal'
- Are reasonable and proportionate
- Are conducted with procedural propriety
- Promote equality and are non-discriminatory
- Are clear and open to scrutiny

The framework recognises that as health and care bodies our purpose and intent is to optimise the health and wellbeing of our patients and populations, through our individual and collective response to COVID-19. To achieve this our ethical framework requires that all decisions relating to our Corona Virus response will be made with regard to the following key principles:

Principle 1: Rational

Making rational decisions, acting fairly to balance completing claims on resources between different patient groups and between individual patients:

- Taking into account the relevant legal and policy context
- Ensuring that decisions are made based on evidence of clinical effectiveness
- Being logical in reasoning towards a decision - weighing up all the relevant factors and making a realistic appraisal of the likely benefits to patients
- Recognising that outcome measures need to be considered in terms of their importance to patients, including but not limited to terminal illness/palliative care
- Ensuring individuals involved in decision making are appropriately trained

Principle 2: Inclusive

Ensuring equal opportunity in access to healthcare, whilst balancing the rights of the individual with those of the wider community to achieve equitable resource allocation between patients and between groups:

- Ensuring there has been an active attempt to engage patients and carers in the decision-making process
- Ensuring there is no discrimination on the basis of 'protected characteristics' or other factors – factors such as age and cognitive/ physical function are considered only when this is clinically relevant

Principle 3: Clarity, Consistency and Transparency

Ensuring decision-making would stand up to public scrutiny:

- These principles and their underpinning values must be evident at all levels of decision making – strategic, tactical, operational and clinical
- Wherever possible decision making will be supported by objective frameworks, which identify the key issues and the key information required for effective decision making in accordance with this ethical framework
- The process and outcomes of decision making must be clearly documented, and communicated in an

effective and unambiguous manner

Principle 4: Resource Constraints

Recognising that we operate within finite resources; investing in one area of healthcare and/or patients diverts resources away from another. Decision making must take into account:

- The use of resources alongside the evidence of clinical effectiveness i.e. to what extent the use of resources will improve outcomes for individual patients/population groups
- The trade-offs between utilising resources for one patient/service area meaning that they are not available to be used for another
- Investment in treatments and services that are not of proven cost-effectiveness should only take place within well-designed and properly conducted clinical trials

Principle 5: Good Governance

Ensuring decision making is undertaken within robust and effective governance process's: and

- Is undertaken by competent individuals within the limits of their accountability/competencies
- With due regard to the governance frameworks of their professional bodies and employing organisations
- Takes place within an effective quality/clinical governance/audit framework

Meeting	**Herefordshire and Worcestershire Ethics Forum (COVID-19)**
Date Agreed	**3rd April 2020 by Martin Lee, Chair of H&W Clinical Leadership forum**
Chair	Professer Tamar Thompson – H&W CCG Lay member
Purpose	A H&W system ethics forum operating during the COVID-19 response, to review and consider the ethical implications of **national guidance** regarding the response to COVID 19, and to ensure local implementation: • Provides an objective review of decision-making frameworks for clinicians, that optimises the clinical effectiveness of our available resources, to optimise individual and population outcomes • Is undertaken with full understanding of ethical considerations – recognising provider ethics committees' establishment for effective decision making • Is undertaken with an understanding of associated risks, with clear recommendations on how the system, organisations and individual practitioners can mitigate those risks *The provider Trusts have their own ethical committees specifically related to COVID-19 to make time critical patient decisions around treatment*.

Key responsibilities	The key responsibilities of the ethics forum are: • To ensure H and W STP commissioning policies, clinical policies and practices relating to the COVID-19 response: 1. Are undertaken within an appropriate ethical framework 2. Optimise the population benefit from available resources 3. Ensure equity and fairness in access to care and services • To ensure that these policies and practices support organisations and individual clinicians with appropriate and objective decision-making frameworks at population and patient level • To collate and scrutinise decisions and underlying rationale ensuring this fits with the ethical framework • To act as an efficient and effective mechanism to share learning and implementation of best practice across the H&W system
Decision making	• All members are senior officers of health and care partners in H&W and with this bring the authority to provide a clear view from and commit to taking action on behalf of their organisation. Forum members will work collaborateively to reach consensus where a decision is required
Membership	All members have equal standing and are required to attend each meeting. In their absence they are to nominate a constant deputy with appropriate authority. Additional attendance is invited for specific clinical topics. H&W CCG • Lay chair • Director of integration and STP Programme Director (SRO) • Interim medical director (Quality and assurance) • Secondary care clinician • Chief nursing officer H&W Providers • Medical Director – Wye Valley NHS Trust • Medical director – Worcestershire Acute Hospitals NHS Trust • Medical Director – Worcestershire Health and Care NHS Trust • GP Provider Board representative • Non-executive director - Deputy Chair WAHT • Non-executive director - Chair of ethics forum System partners • Faith Leader/Chaplain – On behalf of H&W provider chaplains • Public health • Hospices / End of life representative Contribution as required • Medical consultants with Ethics MA – Worcestershire Acute Hospitals NHS Trust

	Quoracy • Executive level clinical representation from H&W CCG and all H&W Providers 2 lay or non-executive members
Relationships with other comittees & reporting	**Relationships with other forums** • There will be a direct relationship with the provider ethics / clinical comittees • There will be a timely link into regional and national structures as required
	Reporting • Into Clinical Leadership forum through to ICS Executive forum The minutes and actions log will be shared with the H&W CCG Clinical comissioning and executive committee
Frequency and structure	**Frequency and structure:** • Meetings will be held at a required frequency from the 1st of April 2020 • Meetings will be held via video or teleconference using Microsoft Teams Papers will be circulated atleast 2 working days before the meeting
Review of ToR	• The authority to approve and amend the ToR sits with the H&W clinical leadership forum ToR to be formally reviewed every 3 months

Version Control:

Version Number/Date produced	Date	Brief Summary of Changes	Circulated to
0.1	31.03.2020	Drafted from initial discussions held	Chair and SRO's
0.2	31.03.2020	Updated with amendments from ATS	H&W Ethics forum
0.3	03.04.2020	Updates from HW IC 01.04.2020: • Single SRO for committee – ATS • NED for WVT added to membership • Medics with ethic MA added as contributors • Link to regional and national work • Frequency flexible • Review of ToR to be 3 monthly	ML, ATS, TT, CM
1.0	03.04.2020	Final ToR approved by TT and ML on behalf of the CLF	H&W Ethics forum members
2.0	06.04.2020	Renamed from committee to forum due joint CCG and provider membership	H&W Ethics forum members

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	Pt choice may be a factor in treatment decisions
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	Older patients may not be good clinical candidates for treatment
2.	**Is there any evidence that some groups are affected differently?**	Yes	Early clinical evidence re COVID 19 suggests those with existing co-morbidities may not be candidates for treatment escalation
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	Yes	Yes, all decisions justifiable according to this policy
4.	**Is the impact of the Policy/guidance likely to be negative?**	Yes	See risk section of policy
5.	**If so can the impact be avoided?**	No	Yes, by implementing this policy for ethical decision making
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**		None
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	None

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval