RCGP Centre for Commissioning

NHS CONFEDERATION

September 2011

Managing conflicts of interest in clinical commissioning groups

Key points

- If conflicts of interest are not managed effectively by clinical commissioning groups (CCGs), confidence in the probity of commissioning decisions and the integrity of the clinicians involved could be seriously undermined. However, with good planning and governance, CCGs should be able to avoid these risks.
- This paper examines the types of conflicts of interest that might face professionals involved in CCGs; highlights existing standards and policies that describe how conflicts of interest should be managed; sets out draft principles CCGs might adopt when developing local policies; and identifies outstanding policy questions requiring further debate.

The 2010 NHS white paper, *Equity and excellence: liberating the NHS* and the subsequent 2011 Health and Social Care Bill set out far-reaching proposals for reforming the healthcare system in England. As part of this reform programme, the Government intends to restructure the health service commissioning system in England and to replace primary care trusts (PCTs) – the existing statutory commissioning bodies – with clinical commissioning groups (CCGs) by April 2013.

Although these are no longer to be referred to as 'GP-led commissioning consortia', as in the original proposals, general practitioners (GPs) remain at the centre of the new system, with CCGs to be formed by groups of practices and based on their registered lists of patients. One of the issues that GPs will need to get to grips with as they form statutory commissioning bodies and take on financial and contractual responsibilities as commissioners, is how they will manage real and perceived conflicts of interest facing the individuals involved in their governance and decision making.

There has been growing concern about this issue among healthcare professionals, and it has been a prominent feature in public and political debate of the reforms.

If conflicts of interest are not managed effectively, and GPs and their colleagues are seen or believed to be abusing their new commissioning powers, the consequences will be serious, and could be particularly damaging to the general practice profession and community. It could undermine providers' and regulators' confidence in the probity and fairness of commissioners' decisions, weaken patients' confidence in the independence of healthcare professionals, and, ultimately, destabilise public confidence in the system as a whole.

However, the problem here is not new or unique. PCTs have had to manage the conflicts of interest facing local healthcare professionals who are members of their boards, professional executive committees and practice-based commissioning groups, for example, as well as the separation of their own provider and commissioning functions. Indeed,

Supported by Capsticks

all NHS bodies and independent sector healthcare providers have to identify and manage conflicts of interest facing their professionals and managers. Many of the standard mechanisms they already use to do this will be relevant and available for CCGs to adopt.

Nonetheless, it is possible that decisions on how best to handle conflicts of interest could become more complex under the new commissioning arrangements, and likely that they will be subject to significant scrutiny and challenge.

The NHS Confederation, the Royal College of General Practitioners (RCGP) Centre for Commissioning and Capsticks have been working together to explore these concerns and identify ways in which they can be addressed both by clinical commissioners themselves and by policy-makers.

In this paper we consider when, why and how conflicts of interest might arise for healthcare professionals involved in commissioning, and set out practical approaches to avoiding them and principles for managing them. We also highlight outstanding policy questions and implementation challenges that we believe require further analysis at a national or local level.

Establishing systems and processes for managing conflicts of interest is just one aspect of good governance, and CCGs will need to connect this to their wider strategies for ensuring they are transparent, accountable and objective in the way they conduct their work and take decisions. The RCGP is undertaking a broader piece of work to develop an ethical framework for commissioning groups, and the Department of Health or shadow NHS Commissioning Board will be providing guidance to commissioning groups on the standards of governance they will be required to meet in order to be authorised. The issues set out in this paper will need to be considered in this context.

What are conflicts of interest and why do they matter to clinical commissioners?

A conflict of interest can be defined as: "a set of conditions in which professional judgement concerning a primary interest (such as patients' welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)"[1] or a situation in which "one's ability to exercise judgement in one role is impaired by one's obligation in another"[2].

For a GP or other clinical commissioner, therefore, a conflict of interest may arise when their own judgment as an NHS commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a healthcare provider or as a member of a particular peer, professional or special interest group, or those of a close family member.

The fear that GP commissioners will face multiple conflicts of interest is therefore understandable. They will, by definition, have interests in their local health economy as both purchasers and providers, and their priorities and duties in those two roles may not always be aligned. Commissioning decisions that are in the overall best interests of taxpayers and the local population may not always be in the best interest of individual patients for whom GPs are required to advocate, or for the companies and partnerships which they own, manage or work for.

There is nothing inherently wrong in this situation in itself, and seeking to eliminate conflicts of interest completely is unlikely to be possible or desirable. It is obviously important for someone to have a strong interest in a subject or cause in order to understand, promote and take it seriously.

This is, in fact, part of the basic rationale for primary care-led commissioning, which is that primary healthcare providers who are embedded in their local health systems through often multiple roles in core general practice, enhanced primary care and out-of-hours provision, and who already play a central role in enabling patients to access and navigate NHS services, are ideally placed to assess their communities' healthcare needs and identify opportunities for improvement in local health services.

However, for commissioning purposes it is crucial that an interest and involvement in the local healthcare system does not also involve a vested interest in terms of financial or professional bias toward or against particular solutions or decisions. The fact that in their provider and gatekeeper roles GPs and their colleagues could potentially profit personally (financially or otherwise) from the decisions of a commissioning group of which they are also members, means that questions about their role in the governance of NHS commissioning bodies are legitimate. Failure to acknowledge, identify and address them could result in poor decision making, legal challenge and reputational damage.

However, the presence of a conflict of interest does not in itself suggest any actual impropriety, and it is generally accepted that it is the latter that must be protected against, not the existence of the conflict itself. The key is to ensure that conflicts are identified, declared and recorded, and that measures are taken to manage or diffuse them.

The potential problem with this is there are currently no strict definitions or criteria to determine what situations or circumstances might be viewed as creating significant conflicts of interest for GPs and other clinical commissioners. It is fairly obvious that a conflict might arise for an individual on the board of

a commissioning group who is a major shareholder in a company that has hopes of gaining a contract with that commissioning group, but there are different views on how a 'major' or 'significant' interest would be defined. Recent guidance on this matter, published by the General Practice Committee of the British Medical Association (BMA), suggests that directors of provider companies or those with holdings above 5 per cent should not be on CCG management boards if their company does, or is likely to do, business with the CCG (see page 7). However, there is no wider consensus on this issue across the clinical commissioning community.

Furthermore, as well as financial interests, there could also be less direct and tangible interests and concerns for GPs as practice partners, colleagues and peers of local specialists and as members of particular professional groups which, although less obvious, could also influence their judgements and decisions.

One simple check for identifying possible conflicts of interest could be described as "the Paxman test" – if you might be embarrassed if asked to explain a situation to an investigative journalist or reporter, a conflict of interest probably exists.

However, while applying professional judgement and standards is an important element in the management of conflicts of interest,

Scenario 1

Three GPs and a practice manager who are members of the governing body of a clinical commissioning group have recently bought a small number of shares in GP Provident – a company set up by an investor and 16 local GP practices to provide tier-2 community health services.

GP Provident has recently paid for two local GPs to be trained as GPs with a special interest (GPSIs) in gynaecology and has agreed to invest in the extension of a local surgery (where a commissioning group lead is a partner) and in purchasing ultrasound equipment so that a new GPSI service can be set up.

The CCG has recently published its strategic commissioning plan, which indicates that the group intends to see a shift of up to 30 per cent of outpatient gynaecology services from acute hospitals to community-based settings over the next three years, and that the CCG will be developing a specification for these community services to be delivered by Any Qualified Provider.

Discussion

Although the GPs and practice manager are not major shareholders in GP Provident, a conflict clearly exists as they have could made personal financial gain as a result of the CCG's commissioning strategy.

There is also a possibility that there could be a perception of actual wrongdoing. The CCG has to consider whether GP Provident has been given a competitive advantage over other providers or if these individuals have put themselves in a position to make a financial gain – due to access to insider knowledge about local commissioning intentions – and if it has put sufficient measures in place to avoid or remedy this.

The individuals concerned should have declared their interest in GP Provident when they bought the shares, and again at the point when the CCG began to discuss its commissioning strategy.

The CCG should have a policy that clearly identifies circumstances under which members of the governing body should not participate in certain activities. The governing body may have decided to exclude these members from certain decisions about the commissioning strategy in line with its policy, although in this case that would have removed four key decision-makers from a central part of the group's business. A decision to simply record the interest so that it is transparent might also be appropriate.

Even if not excluded from discussion of the strategy, these individuals may well be excluded by the group's policies from being involved in the development of the GPSI gynaecology service specifications (other than to the extent any other potential supplier might be involved in such service planning), or from any subsequent contract monitoring.

CCGs may wish to consider whether or not involvement with a provider company likely to develop services and bid for contracts in this way is compatible with being a CCG board member at all, as this scenario is likely to arise again. However, this situation should have been identified and dealt with at the point when individuals were being selected to join the CCG.

A decision should have been taken at that point on whether or not it would be appropriate for owners, directors or shareholders of local community service providers to be members of the governing body. If not, these individuals could not have been selected, or would be required to resign at the point when they decided to buy the shares.

it is also important to acknowledge that conflicts may not always be obvious to, or recognised by, the individuals concerned.

In 2001, Richard Smith, then editor of the *British Medical Journal* (*BMJ*), concluded that while most authors who submit papers to medical journals were confident that their conflicts did not affect their judgment, the evidence showed otherwise[3]. Financial benefit made authors more likely to look favourably on the drug they were studying, for example. It also made doctors more likely to refer patients for tests, operations or hospital admission, or to ask that drugs be stocked by a hospital pharmacy.

As a remedy for this, the *BMJ* has a policy of full disclosure regarding competing interests, and this is likely to be a good rule of thumb for healthcare professionals as they exercise their new commissioning responsibilities – "If in doubt, disclose".

Scenario 2

The diabetes lead of a CCG has been working on a community diabetes project for two years and has a plan to reduce diabetes outpatients activity by 50 per cent and to reinvest in primary care education, patient education, more specialist nurses and community consultant sessions.

A cornerstone of this new service is a proposal to fund local practices for participating in GP and nurse education, and improving the prevention, identification and management of diabetes within primary care.

Discussion

Rather than benefiting a particular organisation, in this scenario all GP practices/primary care providers in the area could potentially benefit from the proposals being developed by primary care-based commissioners, at the expense of existing secondary care providers.

The CCG may have to deal with the perception and challenge that the GP commissioners were favouring their 'electorate'. However, there is nothing wrong with the proposal if it can demonstrate that it is possible and appropriate to reduce the number of people being referred to hospital for the management of diabetes and related complications, that it is likely to improve patient experience and outcomes overall, and that the service improvement required to achieve this relates specifically to general practices with registered lists of patients.

The CCG should have set out and communicated the case for change and the rationale for the proposed service model clearly and transparently before taking, or recommending, the final decision to proceed.

When developing the diabetes commissioning strategy, the group should have consulted on, and then been absolutely clear about, who would have the opportunity to provide the service model. This should have been consistent with an existing commissioning strategy and procurement framework and with the Joint Strategic Needs Assessment and health improvement plans of the relevant health and wellbeing board.

Other qualified providers should be given the opportunity to provide those elements of the new service model not specifically embedded in general practice, for example, specialist nursing and community-based consultant sessions.

However, it also seems clear that individual professionals should not be expected to take full responsibility for identifying and assessing their own conflicts. Not only is this unlikely to provide adequate assurances to potential critics and scrutineers, it also exposes individuals to unreasonable and unnecessary risk and exposure.

Policies, strategies and processes for managing conflicts of interest must be embedded in the structures of CCGs from the outset if the credibility and viability of this model of commissioning is to be sustained.

Types of conflicts of interest facing CCGs

There are a number of different types of conflicts of interest that individual professionals involved in the decision-making activities of commissioning groups might have, or be perceived to have, and that CCGs will need to find ways of dealing with.

As in any other business or organisational context, conflicts might occur due to the possibility of individuals having:

- a direct financial interest
- an indirect financial interest
- non-financial or personal interests
- conflicts of loyalty.

For clinical commissioners, there is also a specific sub-set of this last category – that of perceived conflicts between their professional duties or responsibilities when acting on behalf of a whole population as a commissioner, and of individual patients as a primary care provider.

Direct or indirect financial interests

A clear conflict of interest arises when an individual involved in taking or influencing the decisions of an organisation could receive a direct financial benefit as a result of the

decisions being taken. This may arise as a result of holding an office or shares in a private company or business, or a charity or voluntary organisation that may do business with the NHS.

Indirect financial interest arises when a close relative of a director or other key person benefits from a decision of the organisation.

As healthcare providers as well as commissioners, individual healthcare professionals sitting on the governing bodies of CCGs (and their family members or business partners) may have commercial interests in organisations that their commissioning group is already purchasing from or that could potentially bid/offer to provide services that the group might procure and fund.

The positions which might create real or perceived conflict due to financial interests include:

- partnership (for example, in a general practice which will benefit from a proposal) or employment in a professional partnership, for example, limited liability partnership
- directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)
- ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
- shareholdings in organisations likely or possibly seeking to do business with the NHS
- any connection with a voluntary or other organisation contracting to provide NHS services
- research funding/grants that may be received by an individual or their department/company.

Non-financial or personal conflicts

These occur where directors or other key persons receive no financial benefit, but are influenced by external factors such as gaining some other intangible benefit or kudos, for example, through awarding contracts to friends or personal business contacts.

Even if the individuals leading a CCG do not have commercial or other direct interests in particular services or providers, they are likely to have long-standing professional relationships with colleagues to whom they may have allegiances as peers, and with whom they have developed particular ways of working over a period of time. Personal conflicts could therefore exist when decisions are being taken that would affect such relationships in some way.

Perhaps most significantly, the leaders of CCGs will be elected by, and will have ongoing professional and peer relationships with, the constituent members of the commissioning groups whose working practices, and potentially income, will be affected by the decisions of the commissioning group. There is a risk that clinical commissioners will be suspected of taking decisions that favour the most vocal and influential members of this electorate.

Conflict of loyalties

Decision-makers may have competing loyalties between the organisation to which they owe a primary duty and some other person or entity. For healthcare professionals, this could include loyalties to a particular professional body, society or special interest group, and could involve an interest in a particular condition or treatment due to an individual's own experience or that of a family member.

Conflicts in professional duties and responsibilities

Some GPs (and their patients) may feel that their responsibilities as commissioners for prioritisation and resource management at a population level could conflict with their professional duty to advocate for and protect the interests of individual registered patients. Concerns have been expressed by the BMA and others, for example, that the central doctor-patient relationship that lies at the heart of general practice could be undermined if there is a perception that GPs might have financial incentives to under-treat or under-refer patients in the interests of their CCG.

There is a particular set of issues around the perceived conflicts of interest inherent in offering GPs incentives to address referral or treatment patterns or volumes. This could create the perception, or even the reality, that they are being paid to simply refer or treat patients less. It would clearly be unethical to accept payment for doing so. GPs must at all times exercise clinical judgement and refer appropriately.

However, it is not unacceptable to reduce referral or treatment rates if this is in line with evidence-based protocols and best practice, particularly if as a result resources are released for other priorities. It is good medical practice to critically review and reflect on practice and to recognise the opportunity costs of doing these things is acceptable. It takes time to do an audit, organise and hold a referral review meeting, or develop, discuss and disseminate clinical guidelines and take part in peer review. Payment must not be related to the outcome of decreasing referrals, but is arguably legitimate for taking part in such activities.

There are different views on this and, in particular, how the proposed quality premium for

rewarding effective commissioning should work. At the time of publication the details of this policy are still being developed.

While acknowledging that they are not unrelated, this paper therefore focuses on conflicts of interest that relate to commissioning, procurement and contracting decisions made by commissioning groups, rather than the implications for patient-professional relationships for creating and offering commissioning-related incentives to practices.

Professional codes, standards and guidance

The existence of and need to manage conflicts of interest is clearly not a new issue for the NHS and the healthcare professionals working in it, and there are various existing sets of guidance and policy on which CCGs will be able to draw as they establish their own procedures.

The rules of public accountability

The seven principles of public life, or 'Nolan Principles' (see box) were established in 1995 by the Committee for Standards in Public Life and set out the ways in which holders of public office should behave in discharging their duties. While these do not offer specific procedures or mechanisms for managing conflicts of interest, they provide a good description of the way in which clinical commissioners might be expected to conduct themselves when making decisions about the use of public resources, and give a clear steer regarding the need to declare and be honest about any potential conflicts.

The General Medical Council

Medical practitioners also have their own code of professional conduct and failure to comply with it could affect their registration.

There are sections on conflicts of interest in the GMC's Good Medical Practice guidance (see box).

The Nolan Principles of public life

Selflessness – holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness – holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership – holders of public office should promote and support these principles by leadership and example.

The GMC also has a section for doctors working as managers, which will apply to those doctors who take up leadership roles in CCGs. In this section, the GMC currently states that:

"You must declare any interest you have that could influence or be seen to influence your judgement in any financial or commercial dealings you are responsible for. In particular, you must not allow your interests to influence:

- the treatment of patients
- purchases from funds for which you are responsible
- the terms or awarding of contracts
- the conduct of research."[4]

The British Medical Association

The General Practice Committee of the BMA has produced guidance for GPs on how to ensure transparency and probity in the operation of clinical commissioning[5]. They see this as a matter of fundamental importance to the medical profession, due to the risk that doctors' probity might be brought into question. Their guidance is that:

- Directors of provider companies or those with holdings above 5 per cent should not be on a clinical commissioning management board if their company does business or is likely to do business with the CCG.
- CCGs must keep a register of the interests of anyone who might be able to influence a decision. This must be available to the public. It should also extend to the interests of family members and those closely connected to the member.
- Interests must be declared at the beginning of meetings even if it is included in the register. They should not be allowed to speak or

vote on the issue unless the group has decided that the interest is non-prejudicial.

- If the interest would be considered prejudicial by a reasonable person, the member should leave the room while the item is discussed.
- If the meeting is left non quorate because of this, an independent body should be appointed to verify any decisions made.
- When a CCG decides to commission enhanced services from its GP members, the issue should always be referred to the local overview and scrutiny committee for approval.

The BMA also gives guidance to GPs in relation to how their new responsibilities might affect consultations with patients, but this is outside the scope of this paper.

Managing conflicts of interest

Existing NHS policies and procedures

The key provisions for the management of conflicts of interest are reflected in the model standing orders for NHS organisations issued by the Department of Health,[6] and also in the conflict provisions and protocols of other organisations. These usually include the following key steps:

Identification of relevant and material conflicts – Most conflict policies start by identifying those conflicts that are relevant and material.

Declaration of interests – Typically, the next stage in the policy or protocol is a requirement for staff to declare relevant and material interests to the organisation. They generally do this on appointment, and then on each subsequent occasion that a relevant interest arises. Interests are usually recorded in a register of interests, and this information is often made public. For example, the model standing orders for NHS trusts provide that relevant interests of directors will be published in the trust's annual report.

Conflict policies will often identify an officer of the organisation, such as the chair or company secretary, as the source of advice on the relevance of any interests, and whether they should be declared.

Exclusion of individuals on account of relevant interest – Where individuals have a relevant and material interest in a matter to be considered by their organisation, conflict policies will often provide for them to be excluded from the consideration and/or decision-making process. In the NHS model standing orders, exclusion only applies where there is a pecuniary interest in a contract or other matter being considered by the organisation. This includes indirect pecuniary interests such as where the individual or their nominee is a member of a company or other body with which the contract is made; or where he/she is a partner, associate or employee of any person with whom the contract is made. However, the requirement for exclusion will not apply where the potential value of the interest is minimal (for example, no more than 1 per cent of the total issued share capital of a company).

Managing the conflict of interest once a decision has been taken – There may be scope for the conflict to continue to be relevant, for example, in respect of the ongoing monitoring of a contract. In these circumstances, the organisation should put in place appropriate arrangements to ensure that the conflict continues to be properly managed. These may include ensuring that the individual concerned is not involved in the ongoing monitoring.

Possible limitations to the applicability of these standard approaches to commissioning groups

Many of the conflict scenarios that professionals and managers in CCGs will face are similar in nature to those that arise for other NHS bodies, and will therefore have similar remedies.

It seems clear, for example, that a CCG 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 authorisation framework

The GMC's Good Medical Practice guidance[7]

You must act in your patients' best interests when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues. (para. 1.74)

If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients. (para. 2.75)

If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser. (para. 3.76)

Scenario 3

Dr X is the chair of a local commissioning group. He is married to Dr Y. Dr Y is the clinical director for Health R Us, a company which has developed risk stratification software designed to enable primary care providers to identify vulnerable patients at risk of going into hospital and help them to put measures in place to address this.

Health R Us has offered to supply the software to Dr X's CCG free of charge for one year to help develop it. It will then be offered at a discounted price because of the work that the group would have done in developing it and acting as a demonstration site.

Discussion

There is no immediate financial gain to Drs X and Y from the decision to accept the software free of charge for a year. However, there is potential future gain to Dr Y (and therefore to her husband) as the clinical director of a company that could profit from a product that her husband's CCG has helped to develop, and from a preferential position as an incumbent supplier to that group.

Dr X should declare an interest and he should exclude himself from any decision-making about this project.

Any decision subsequently taken by the rest of the group should depend on whether or not the product on offer would help them to achieve an existing, stated commissioning objective (that is to say they should not accept it just because it is on offer), and whether or not the deal being offered was in line with the group's existing policies for partnership working/joint ventures/sponsorship, etc.

If the CCG had a clear, prioritised commissioning strategy and policies for working with other organisations, from the outset, this decision should be fairly straightforward.

However, there is a question as to whether or not the group should accept this offer at all. Although it may meet an explicit commissioning objective, it may not be appropriate even then to simply accept the offer without, at least, some kind of analysis of whether other companies might be willing or able to offer the same or better. The concern is not necessarily about the personal relationships involved, but more generally about whether this is an acceptable way for a public body to do business.

- make sure that all individuals involved in decision-making are required to declare their interests when joining the board or committee
- maintain a register of these interests which is updated regularly
- ensure that specific conflicts relevant to the agenda of a particular meeting are disclosed again at the beginning of that meeting and recorded, and that decisions are taken transparently and according to a clear policy as to whether conditional participation, partial exclusion or total exclusion from the decision-making is required
- ensure their procurement and contracting procedures comply with the law and good practice.

However, there are some practical and conceptual questions about the management of conflicts of interest for commissioning groups that may require further consideration. For example:

- How can situations where there are insufficient decision makers available after exclusion of those with relevant interests to enable effective decision making or management action, be avoided or managed?
- Will standard approaches to managing conflicts of interest be sufficient to address the potential indirect interest in developing a 'constituency' of supporters within a commissioning group?
- Would they deal with other indirect interests such as longstanding professional and organisational allegiances?

Principles for managing conflicts of interest

Guidance on the constitution and governance of CCGs will be developed by the Department of Health and Shadow NHS Commissioning Board. This is likely to give indications on how CCGs are expected to manage conflicts of interest, but may not fully address the type of questions highlighted above. In reality, the answers to such questions may only emerge as the commissioning system itself develops. In the meantime, even with some guidance and rules set out, CCGs will still need to understand, interpret and apply them to their particular local circumstances.

In preparing this paper, the RCGP, NHS Confederation and Capsticks hosted a seminar involving representatives from a number of professional bodies, commissioners and provider organisations to explore the issues involved. At this event, some basic principles emerged that might be used by CCGs as they develop, test and refine their local policies and procedures, in order to avoid and manage conflicts (see box).

Remaining policy issues

While the primary responsibility for ensuring conflicts of interest are identified and managed appropriately will lie with CCGs themselves, a number of other factors will impact on their ability to do this effectively.

In this final section, we set out some of the outstanding questions that we believe policy-makers need to address to enable CCGs to proceed with establishing their governance arrangements.

Who will monitor, assure and assess CCGs on how they are managing conflicts of interest, and how will they do this?

The infrastructure surrounding CCGs, and the roles of the various organisations that may have responsibility for reviewing and assuring their approaches to managing conflicts of interest, is still not completely clear. It will be crucial to ensure that the system as a whole works to support commissioners in managing conflicts of interest, and does not undermine them by placing contradictory, or overly onerous requirements on commissioning groups.

It will also be important to be clear what the sanctions should be for a CCG or an individual who fails to declare relevant conflicts of interest. Under what circumstances should this result in suspension from a commissioning role, for example, or even referral to the GMC?

How should members of the governing body of a commissioning group be selected?

How people get elected/selected to be members of CCGs will be critical to what conflicts of interest might exist and how they should be managed. There must be transparency throughout the whole process, as well as fairness.

There are different views on who and how many people should have voting rights in the election of CCG leaders and members. Some argue that because the individual commissioning 'unit' is a practice, voting rights should be confined to

Principles for managing conflicts of interest

Doing business properly
If commissioning groups get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid or deal with, because the rationale for all decision-making will be transparent and clear and should withstand scrutiny.

Being proactive not reactive
Those responsible for establishing CCGs should seek to identify and minimise the risk of conflicts of interest at the earliest possible stage in the process, by considering the actual or possible existence of conflicts of interest when electing or selecting individuals to join the governing body, and excluding individuals from this if these conflicts are too great. One way of doing this would be to require candidates for roles within CCGs to include a 'conflicts of interest statement' in their manifesto/application prior to election or selection. CCGs will also need to ensure that members of their governing bodies, and others with influence over decision making, are properly inducted into their roles and understand their obligations to declare conflicts of interest. They should also establish and maintain registers of interests, and agree in advance how a range of different situations and scenarios will be handled, rather than waiting until they arise.

Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest
Most individuals involved in commissioning will seek to do the right thing for the right reasons, but they may not always do it the right way due to lack of awareness of rules and procedures, insufficient information about a particular situation, or lack of insight into the nature of a conflict. Rules should assume people will volunteer information about conflicts and will exclude themselves from decision making where they exist, but there should also be prompts and checks to reinforce this.

Being balanced and proportionate
Rules should be clear and robust but not overly prescriptive or restrictive. Their intention should be to identify and manage conflicts of interest (not eliminate them) and their effect should be to protect and empower people by ensuring decision making is efficient as well as transparent and fair. Rules should not constrain people by making decision making overly complex or slow.

practice partners, and that most of the seats on a commissioning board should be reserved for partners too. Others would emphasise, however, that as each individual GP makes micro-commissioning decisions (about referrals, prescribing and treatment options), it is crucial that all parts of the profession, including salaried doctors as well as partners, are fully engaged in the local commissioning agenda and represented appropriately on CCGs.

We would agree that all GPs have a role and stake in the success of their local CCG and should therefore have a say in the membership of the governing body, and suggest this is another area where consensus across the general practice community would be helpful.

The fact that there must now be a nurse, two lay members (one of them a chair or deputy chair) and a secondary care doctor (from a different health economy) on the governing body of a CCG creates another set of issues and possible conflicts of interest that also need to be managed, and due thought will have to go into their selection process and what their role is expected to be.

Scenario 4

Dr A is a member of a CCG with a longstanding interest in and commitment to improving health and social care services for older people. She has worked closely with local geriatrician, Dr B, for many years, including working as her clinical assistant in the past. They have developed a number of service improvement initiatives together during this time and consider themselves to be good personal friends.

Recently, they have been working on a scheme to reduce unscheduled admissions to hospital from nursing homes. It involves Dr B visiting nursing homes and doing regular ward rounds together with community staff. It has been trialled and has had a measure of success which has been independently verified by a service evaluation. They would now like to extend the pilot, and the foundation trust that employs Dr B has suggested that a local tariff should be negotiated with the commissioning group for this 'out-reach' service.

However, the CCG has decided instead to run a tender for an integrated community support and admission avoidance scheme, with the specification to be informed by the outcomes of the pilot.

Discussion

Due to her own involvement in the original pilot, association with the incumbent provider and allegiance to her friend and colleague, Dr A may be considered to have a conflict of interest when it comes to making decisions about the specification of this service and the award of the contract.

She should probably not be involved in developing the tender, designing the criteria for selecting providers or in the final decision making, even though she is a local expert. If the CCG has clear prompts and guidelines for its members, this should be obvious to Dr A, who should decide to exempt herself, but may feel frustrated by this.

If the CCG was clear at the outset about its commissioning priorities and strategy and its procurement framework (setting out what kind of services would be tendered under what circumstances), its decision to tender for the service should not have come as a surprise to the trust, or to the individuals involved.

CCGs will need to ensure that they do not discourage providers, or their own members, from being innovative and entrepreneurial by being inconsistent or opaque in their commissioning decisions and activities.

How can commissioning incentives be designed in a way that avoids the creation of further conflicts of interest?

CCGs will need clarity on the rules regarding how clinicians can be incentivised financially to engage with the process and objectives of local commissioning, or reimbursed for the time that is spent engaged with commissioning activities. CCGs will also need guidance on how they might use resources freed up through effective commissioning. There are many good reasons for improving the facilities and equipment available to patients in primary care, but partners must not be seen to profit (directly or indirectly) as a result of public money being redeployed in this way.

Is it appropriate for individuals to be members of a CCG governing body if they have financial interests and/or management involvement in a (non-GMS/PMS) provider?

The BMA's guidance clearly says that individuals should not be involved in the governing bodies of CCGs if they have any significant financial interests (holdings over 5 per cent) in a provider organisation. Some GPs may find this clarity very helpful, and perhaps GPs should be expected to have to make choices about whether (outside the delivery of the core contract) their main interest is in providing or commissioning.

It may be that rules on this are not even necessary because

GPs who want to get actively involved in commissioning will recognise the need to take this decision for practical reasons and due to time constraints.

Some certainly consider that overly prescriptive rules could unhelpfully limit the pool of potential candidates for membership of commissioning bodies, and that most conflicts could be managed on a case-by-case basis, with members with provider interests being excluded from particular decisions where necessary, rather than prevented from participating altogether. In fact, some of the factors that will make individual GPs conflicted in relation to certain decisions are the same things that make them collectively well placed to lead commissioning organisations (that is, their involvement in, understanding of, and connectivity to the local healthcare system) and perhaps we should guard against rules that would undermine this.

We would welcome further discussion of and guidance on this issue so that individual groups have a common framework or standard to guide their decision-making.

Whatever the rules on membership should be, it is critically important to get the right people selected onto commissioning groups in the first place, so that individuals with multiple or extensive potential conflicts are not placed on them, and that the group as a whole does not have particular biases or sectional interests.

How will the Any Qualified Provider policy operate?

The introduction of Any Qualified Provider (AQP) will impact on clinical commissioners' procurement activities and referral options, and therefore on the extent of their conflicts of interest. However, there are different views regarding whether the extension of AQP will exacerbate or reduce the risk of conflicts of interest arising. Understanding exactly how this policy will be rolled out is therefore highly relevant to the governance arrangements required to manage conflicts of interest effectively.

Scenario 5

Dr S is a partner in a company that has recently taken over a number of single-handed practices and dramatically improved their performance in a short period of time. The company has a clear expansion strategy, and ambitions to operate nationally. Dr S is also a member of the governing body of a CCG.

The CCG has had two practices allocated to it that do not wish to engage with its commissioning strategy. Their patients use the local hospital more than comparable practices, their quality outcome measures are poor, and local community healthcare professionals have raised concerns about patient safety. Poor management of the secondary care and prescribing budget in these practices is having a detrimental effect on the financial situation of the whole commissioning group. The CCG is meeting to decide whether or not to refer their concerns about the quality of primary care being delivered by these practices to the NHS Commissioning Board.

Discussion

Dr S is an expert in primary care improvement and turnaround, and her input to this decision would be valuable to the group. However, if she was instrumental in a decision which led to the NHS Commissioning Board withdrawing the primary care contract from these practices, she could be in a difficult position if her company then bid to take over the running of these practices.

She could be accused by competitors as working with insider knowledge, or by the existing partners of the practices of taking a particularly hard-line approach to their performance management and referral in order to create opportunities for her own company.

The group would have to decide the level of involvement that Dr S should have in these discussions and whether or not she should be excluded from any decision making.

As Dr S's company has a clear intention to expand its business and may be considered likely to bid for these contracts, Dr S should probably not be involved in the decision as to whether to refer the practices to the NHS Commissioning Board.

However, it is also possible that other GPs on the CCG might also have a potential conflict of interest here, because they could be equally interested in taking over a failing practice, albeit not as part of a larger corporate enterprise.

This highlights the importance of not making assumptions about who will have conflicts and why, but of having formal prompts and procedures that ensure everyone has to consider this.

Conclusions

The fact that an individual involved in commissioning has conflicts of interest does not in itself mean they will take inappropriate or personally advantageous decisions or actions, or undermine the credibility and independence of their CCG's governing body.

Rarely will a conflict be so great that it will make it impossible for the individual to be seen to function effectively as an impartial commissioner. When this is the case, that person should obviously be excluded from commissioning decisions. More usually, it will be possible to handle the conflicts with integrity, by ensuring it is identified, declared and managed in an open and transparent way.

Concerns about this issue are understandable, however, and the risks of getting it wrong are great for individual healthcare professionals and CCGs, and for the new commissioning model as a whole.

This paper is intended to provide those involved in setting up these new arrangements with both food for thought and practical ideas on how to proceed, as well as highlighting to policy-makers some of the outstanding issues that need to be addressed.

For more information, or to share your views about the issues set out in this paper, please contact:

Elizabeth Wade, Senior Policy Manager (Commissioning), NHS Confederation, at elizabeth.wade@nhsconfed.org

Dr Dennis Cox, RCGP council member and clinical commissioning champion, at dennis.cox@rcgp.org.uk

RCGP Centre for Commissioning, at commissioning@rcgp.org.uk

For a summarised version of this document, see

Managing conflicts of interest in clinical commissioning groups – executive summary. RCGP Centre for Commissioning and NHS Confederation.
Available at **http://commissioning.rcgp.org.uk/resources/** or **www.nhsconfed.org/publications**

References

1 Thompson, D F (1993) 'Understanding financial conflict of interest'. *New England Journal of Medicine*, 329, pp. 573–576
2 *Roll Back Malaria Partnership. Conflict of interest policy and procedure*. World Health Organization, p.4. www.rbm.who.int/docs/constituencies/RBMcoiPolicy.pdf
3 Smith, R (2001) "Conflicts of interest: journals, guidelines and specialist societies". Presentation for lecture. Available at http://resources.bmj.com/bmj/interactive/talks
4 General Medical Council (2006) *Management for doctors*, para 55. Available at www.gmc-uk.org/guidance/ethical_guidance/management_for_doctors.asp
5 British Medical Association General Practitioners Committee (2011) *Ensuring transparency and probity: GPC guidance to ensure the honest and transparent operation of clinically-led commissioning consortia*. Available at www.bma.org.uk
6 *NHS trust model standing orders, reservation and delegation of powers and standing financial instructions – March 2006*. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4132059
7 General Medical Council (2009) *Good medical practice*. Available at www.gmc-uk.org/guidance/good_medical_practice.asp

Further copies or alternative formats can be requested from:
Tel 0870 444 5841
Email **publications@nhsconfed.org** or visit **www.nhsconfed.org/publications** or **http://commissioning.rcgp.org.uk/resources**

INF28201

The NHS Confederation
29 Bressenden Place London SW1E 5DD
Tel 020 7074 3200 Fax 0844 774 4319
Email enquiries@nhsconfed.org
www.nhsconfed.org

RCGP Centre for Commissioning
1 Bow Churchyard London EC4M 9DQ
Tel 020 3188 7400 Fax 020 3188 7401
Email: commissioning@rcgp.org.uk
www.rcgp.org.uk/commissioning

The NHS Confederation is a registered Charity no: 1090329. The RCGP Centre for Commissioning is a brand of the Royal College of General Practitioners. The RCGP is a Registered Charity no: 223106