



South Sefton
Clinical Commissioning Group

Managing Conflicts of Interest and Gifts and Hospitality Policy September 2018

Title: Conflicts of Interest and Gifts and Hospitality Policy		Version: 7		
Next Revision Due: September 2020.	The policy shall be reviewed on an annual basis or as and when NHSE issues additional guidance	Author	Consultation and Communication	Approved by
Department responsible for this document:	Finance	CCG Governance Lead	COI Guardian Audit Committee	Audit Committee September 2018
DESIGNATION	NAME	SIGNATURE		DATE
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1. Introduction

- 1.1 The Governing Body of South Sefton CCG (“the CCG”) has ultimate responsibility for the actions carried out by staff and committees throughout the CCG’s activities. This responsibility includes the stewardship of significant public resources and the commissioning of healthcare services to benefit the local community.

This Conflicts of Interest and Gifts and Hospitality Policy respects the principles of good governance including

- The Seven Principles of Public Life (the Nolan Principles)¹
- The Good Governance Standards of Public Services²
- The Seven Key Principles of the NHS Constitution³
- The Equality Act 2010⁴

- 1.2 This policy should be read in conjunction with the CCGs Counter Fraud and Anti Bribery Policy

2. Statement of Intent

- 2.1 “If conflicts of interest are not managed effectively by CCGs, confidence in the probity of commissioning decisions and the integrity of clinicians involved could be seriously undermined. However, with good planning and governance, CCGs should be able to avoid these risks.” *RCGP and NHS Confederation’s briefing paper on managing conflicts of interest September 2011*⁵
- 2.2 South Sefton Clinical Commissioning Group (CCGs) manages conflicts of interest as part of its day-to-day activities. Effective handling of such conflicts is crucial for the maintenance of public trust in the commissioning system. Importantly, it also serves to give confidence to patients, providers, Parliament and tax payers that South Sefton CCG commissioning decisions are robust, fair, transparent and offer value for money.
- 2.3 This policy has been developed in accordance with guidance issued by NHS England in July 2017.⁶
- 2.4 The Policy sets out clear requirements for the CCG to make arrangements for managing conflicts of interest and potential conflicts of interest, to ensure they do not affect, or appear to affect, the integrity of the CCG’s decision making processes. These requirements are supplemented by procurement-specific requirements in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.
- 2.5 In respect of primary care Joint Commissioning activities with NHS England, the Audit Committee Chair and Accountable Officer will be required to provide direct formal attestation to NHS England that the CCG has complied with this policy. Subsequently, this attestation will form part of an annual certification. CCG approaches to management of conflicts of interest will also be considered on an ongoing basis as part of CCG assurance.

¹ Available at <https://www.gov.uk/government/publications/the-7-principles-of-public-life>

² Available at <https://www.jrf.org.uk/report/good-governance-standard-public-services>

³ Available at <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx>

⁴ Available at <http://www.legislation.gov.uk/ukpga/2010/15/contents>

⁵ *Managing conflicts of interest: revised statutory guidance for CCGs* available at <https://www.england.nhs.uk/commissioning/pc-co-comms/coi/>

⁶ <http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confli-int-guid-1214.pdf>

3. Aims of the Policy

3.1 The aims of this policy are to:

- enable the CCG and clinicians in commissioning roles to demonstrate that they are acting fairly and transparently and in the best interest of their patients and local populations;
- ensure that the CCG operates within the legal framework, but without being bound by over-prescriptive rules that risk stifling innovation;
- safeguard clinically led commissioning, whilst ensuring objective investment decisions;
- provide the public, providers, Parliament and regulators with confidence in the probity, integrity and fairness of commissioners' decisions; and
- uphold the confidence and trust between patients and GP, in the recognition that the CCG wants to behave ethically but may need support and training to understand when conflicts (whether actual or potential) may arise and how to manage them if they do.
- to define an interest
- to provide guidance on how and when to declare an interest and how to record that interest in an appropriate register
- provide guidance on declaring gifts, hospitality and commercial sponsorship
- provide guidance on how to report breaches of the policy

4. Scope of the Policy

4.1 This policy applies to;

- **All CCG employees**, including:
 - All full and part time staff;
 - Any staff on sessional or short term contracts;
 - Any students and trainees (including apprentices);
 - Agency staff; and Seconded staff
- In addition, any self-employed consultants or other individuals working for the CCG under a contract for services should make a declaration of interest in accordance with this guidance, as if they were CCG employees.
- Members of new care models joint provider /commissioner groups / committees
- **Members of the governing body:** All members of the CCG's committees, sub-committees/sub-groups, including:
 - Co-opted members;
 - Appointed deputies; and
 - Any members of committees/groups from other organisations (i.e. joint committees)
 - Where the CCG is participating in a joint committee alongside other CCGs, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating CCG.
 - All members of the CCG (i.e., each practice)
 - This includes each provider of primary medical services which is a member of the CCG under Section 14O (1) of the 2006 Act. Declarations should be made by the following groups:
 - GP partners (or where the practice is a company, each director);
 - Any individual directly involved with the business or decision-making of the CCG.

4.2 The policy will be subject to review, and if appropriate, amendment as and when required and no later than September 2018.

4.3 The Governing Body has a legal obligation to act in the best interests of the CCG and in accordance with the CCGs Constitution and terms of establishment created by NHS England, and to avoid situations where there may be a potential conflict of interest.

5. What are conflicts of interest?

5.1 A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. "For the purposes of Regulation 6 [*National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013*]⁷, a conflict will arise where an individual's ability to exercise judgement or act in their role in the **commissioning of services** is impaired.

5.2 As well as direct financial interests, conflicts can arise from an indirect financial interest (e.g. payment to a spouse) or a non-financial interest (e.g. reputation). Conflicts of loyalty may arise (e.g. in respect of an organisation of which the individual is a member or with which they have an affiliation). Conflicts can arise from personal or professional relationships with others, e.g. where the role or interest of a family member, friend or acquaintance may influence an individual's judgement or actions, or could be perceived to do so. Indirect interests may arise where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision. Depending upon the individual circumstances, these factors can all give rise to potential or actual conflicts of interest.

5.3 For a commissioner, a conflict of interest may therefore arise when their judgment as a commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a provider. In the case of a GP involved in commissioning, an obvious example is the award of a new contract to a provider in which the individual GP has a financial stake. However, the same considerations, and the approaches set out in this policy, apply when deciding whether to extend a contract.

5.4 NHS Clinical Commissioners has carried out a review of current guidance on conflicts of interest management and, together with the Royal College of General Practitioners and the British Medical Association, has developed a set of key principles that apply in this context. These principles are set out in **Annex 1**.

Principles to bear in mind:

- a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring;
- if in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it; and
- for a conflict of interest to exist, financial gain is not necessary.

⁷ <http://www.legislation.gov.uk/uksi/2013/257/contents/made>

5.5 Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out of hours commissioning and involvement with integrated care organisations and new care models, as CCG staff may here find themselves in a position of being both commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment from procurement exercises, to contract monitoring. References to 'new care models', in this policy refers specifically to referring to Multi-speciality Community Providers (MCP), Primary and Acute Care Systems (PACS) or other arrangements of a similar scale or scope.

6. Arrangements for recording, managing and publishing interests

6.1 The CCG shall

- Maintain appropriate registers of interests;
- Maintain registers for declaring gifts, hospitality and commercial sponsorship
- Publish and make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified in section 4.1 and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts and potential conflicts of interest (e.g. developing appropriate policies and procedures); and
- Have regard to guidance published by NHS England in relation to conflicts of interest.
- Have systems in place to satisfy itself as a minimum on an *annual* basis that their registers of interest are accurate and up-to-date

In addition

- The CCG will not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract;
- The CCG will keep a record of how it managed any such conflict in relation to NHS commissioning contracts it enters into

6.2 An interest is defined for the purposes of regulation 6 as including an interest of the following:

- a member of the commissioner organisation;
- a member of the governing body of the commissioner;
- a member of its committees or sub-committees or committees or sub-committees of its governing body; or
- an employee.

6.3 Conflicts of interest will be managed by:

- Doing business appropriately and within lawful, appropriate, published decision making frameworks
- Ensuring that relevant stakeholders have been involved in decision making
- Being proactive, not reactive by ensuring that conflicts of interest are identified, declared and reported as the earliest possible stage in the commissioning and associated decision making cycle
- considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making bodies;
- Ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest.
- Prohibiting the award of a contract where the integrity of the award has been, or appears to have been, affected by a conflict;

7. Maintaining a register of interests and a register of decisions

7.1 All members and relevant members of staff must declare interests, this includes the interests of all relevant individuals within their own organisations (e.g. partners in a GP practice), who

have a relationship with the CCG and who would potentially be in a position to benefit from the CCG's decisions.

7.2 When entering an interest on its register of interests, the Corporate Support Officer will ensure that it includes sufficient information about the nature of the interest and the details of those holding the interest.

7.3 The Corporate Support Officer is responsible for ensuring that, as a matter of course, declarations of interest are made and regularly confirmed or updated. This includes the following circumstances:

- **On appointment:**
 - Applicants for any appointment to the CCG or its governing body will be required to declare any relevant interests. When an appointment is made, a formal declaration of interests will be made and recorded.
- **At meetings:**
 - All attendees will be asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. This is a standard agenda item for CCG meetings. Even when an interest is declared in the register of interests, it will also be declared again at meetings where matters relating to that interest are discussed. Declarations of interest will be recorded in minutes of meetings. A template is provided at Annex 7.
- **Quarterly:**
 - The Audit Committee will review the Register on a quarterly basis and submit to the Governing Body at a public meeting.
- **On changing role or responsibility:**
 - Where an individual changes role or responsibility within a CCG or its governing body, any change to the individual's interests must be declared.
- **On any other change of circumstances:**
 - Wherever an individual's circumstances change in a way that affects the individual's interests (e.g. where an individual takes on a new role outside the CCG or sets up a new business or relationship), a further declaration must be made to reflect the change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising.
 - When exiting the organisation

7.4 Individuals who have a conflict shall declare this as soon as they become aware of it, and in any event not later than 28 days after becoming aware.

7.5 Whenever interests are declared, they will be reported to the Corporate Support Officer who will then update the register accordingly.

7.6 Only the declarations from decision-making staff will included on the published register.

7.7 The "register" is available upon request for inspection at the South Sefton CCG Headquarters and in multiple forms upon request.

7.8 Register of procurement decisions

The CCG will put in place a register of procurement decision, the register includes information on

- the details of the decision;
- who was involved in making the decision (i.e. governing body or committee members and others with decision-making responsibility); and
- a summary of any conflicts of interest in relation to the decision and how this was managed by the CCG.

The “procurement decision” register will be updated whenever a procurement decision is taken.

Whenever interests are declared, they will be reported to the Corporate Support Officer who will then update the register accordingly.

The “procurement register” will be updated and made available on the website each time a new declaration is made.

The “procurement register” is available upon request for inspection at the South Sefton CCG Headquarters and in multiple forms upon request.

8. Raising concerns and reporting breaches

- 8.1 It is the duty of every CCG employee, governing body member, committee or sub-committee member and GP practice member to speak up about genuine concerns in relation to the administration of the CCG’s policy on conflicts of interest management, and to report these concerns. These individuals must not ignore their suspicions or investigate themselves, but rather speak to the Corporate Support Officer, the CCG’s governance lead or the Conflict of Interest Guardian (Lay Member for Governance).
- 8.2 Any non-compliance with this policy must be reported Corporate Support Officer, the CCG’s governance lead or the Conflict of Interest Guardian. This can be done in any manner, written, verbal or otherwise and in any way which the reporting individual feels appropriate. Such reports may also be anonymous. In all cases when a breach is reported, it shall be treated on a strictly confidential basis.
- 8.3 Anyone who wishes to report a suspected breach, who is not an employee or worker of the CCG should also ensure that they comply with own organisation’s whistleblowing policy.
- 8.4 The breach will be recorded in a “Register of Breaches”
- 8.5 The Corporate Support Officer, in conjunction with the Conflict of Interest Guardian shall arrange for an investigation of the breach, the outcome of which shall be reported to the Audit Committee.
- 8.6 The Corporate Support Officer, or any other senior officer identified by the Conflict of Interest Guardian will undertake an initial investigation of the breach and establish;
- If a breach has actually occurred
 - The nature of that breach

- The impact of the breach
 - The arrangements in place at that time that could have prevented a breach
 - The learning as a consequence
 - What remedial action is required
 - What other policies may need to be engaged to address the breach (e.g, but not limited to, HR or Whistleblowing)
- 8.7 The findings will be reported to the Conflict of Interest Guardian who will then submit the findings to the Audit Committee. The Audit Committee has responsibility for determining the most appropriate course of action.
- 8.8 In the event that the substantiated breach is caused by a primary care contractor (or their employee) the Audit Committee's view is that the breach is significant in nature as to cause reputational harm, financial detriment or compromise decision making, concerns will be notified to NHSE.
- 8.9 The Corporate Support Officer will publish all material and immaterial breaches on the website as part of an annual publication in April each year.

9.0 Gifts and hospitality

Gifts

- 9.1 The CCG has in place a gifts and hospitality register. All individuals listed in section 4.1 of this policy are required to decline gifts or hospitality or other benefits, which might reasonably be seen to compromise their professional judgement or integrity.
- 9.2 All the individuals listed in section 4.1 need to consider the risks associated with accepting offers of gifts, hospitality and entertainment when undertaking activities for or on behalf of the CCG or their GP practice. This is especially important during procurement exercises, as the acceptance of gifts could give rise to real or perceived conflicts of interests, or accusations of unfair influence, collusion or canvassing.
- 9.3 A 'gift' is defined as *“any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value”*
- 9.4 All gifts of any nature offered to CCG staff, governing body and committee members and individuals within GP member practices by suppliers or contractors linked (currently or prospectively) to the CCG's business above a value of £6 should be declined. The person to whom the gifts were offered must also declare the offer to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality so the offer which has been declined can be recorded on the register.
- 9.5 In line with the NHS-wide guidance, gifts of low value (up to £6), such as promotional items, can be accepted.
- 9.6 Gifts offered from other sources under £50 can be accepted from non-suppliers and non-contractors, and do not need to be declared; and gifts with a value of over £50 can now be accepted on behalf of an organisation, but not in a personal capacity.
- 9.7 Any **personal** gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the

CCG) must always be declined, whatever their value and whatever their source, and the offer which has been declined must be declared to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality and recorded on the register.

- 9.8 The CCGs form for declaring “Gifts and Hospitality” is provided at Annex 6 and available on the CCG’s intranet.

Hospitality

9.9 Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of ‘traditional’ working hours. As a result, CCG staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted, and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

9.10 Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events etc.

9.11 Overarching principles:

- CCG staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement;
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event;
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals should always obtain senior approval and declare these.

9.12 Meals and Refreshments:

- Under a value of £25 may be accepted and need not be declared;
- Of a value between £25 and £75⁸ may be accepted and must be declared;
- Over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation’s register(s) of interest as to why it was permissible to accept;

A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

⁸ The ABPI Code of Practice for the Pharmaceutical Industry:
<http://www.pmcpa.org.uk/the/code/Pages/default.aspx>

10 Commercial sponsorship

- 10.1 CCG staff, governing body and committee members, and GP member practices may be offered commercial sponsorship for courses, conferences, post/project funding, meetings and publications in connection with the activities which they carry out for or on behalf of the CCG or their GP practices. All such offers (whether accepted or declined) must be declared so that they can be included on the CCG's register of interests, and the team or individual designated by the CCG to provide advice, support, and guidance on how conflicts of interest should be managed should provide advice on whether or not it would be appropriate to accept any such offers. If such offers are reasonably justifiable then they may be accepted but prior approval must be sought from a member of the Senior Leadership Team or the Conflicts of Interest Guardian (Lay Member for Governance/Audit Committee Chair)
- 10.2 Notwithstanding the above, acceptance of commercial sponsorship should not in any way compromise commissioning decisions of the CCG or be dependent on the purchase or supply of goods or services. Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event. The CCG shall not endorse individual companies or their products and there must be no breach of patient or individual confidentiality or data protection legislation. Furthermore, no information should be supplied to a company for their commercial gain unless there is a clear benefit to the NHS. As a general rule, information which is not in the public domain should not normally be supplied.
- 10.3 All declarations made under this section must be made promptly and within no more than 10 working days of the date of the offer. A declaration form is at Annex 8.
- 10.4 Sponsored events: Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result there should be proper safeguards in place to prevent conflicts occurring.

When sponsorships are offered, the following principles must be adhered to:

- Sponsorship of CCG events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the CCG and the NHS;
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied;
- At the CCG's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event;
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency;
- CCGs should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event;
- Staff should declare involvement with arranging sponsored events to their CCG.

- 10.5 Other forms of sponsorship: Organisations external to the CCG or NHS may also sponsor posts or research. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage, or if sponsored posts cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition. There needs to be transparency and any conflicts of interest should be well managed. For further information, please see Managing Conflicts of Interest in the NHS: Guidance for staff and organisations.

11. Designing service requirements

- 11.1 The CCG will engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient need. Such engagement, done transparently and fairly, will ensure that CCG is acting in an entirely legal way. However, conflicts of interest can occur if the CCG engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid.
- 11.2 The CCG will seek, as far as possible, to specify the outcomes that they wish to see delivered through a new service or new model of care, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this will help to prevent bias towards particular providers in the specification of services.
- 11.3 Such engagement will follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. The CCG will;
- Ensure that the same information is given to all.
 - Advertise the fact that a service design/re-design exercise is taking place widely and invite comments from any potential providers and other interested parties (the CCG will keep a record of all interactions);
 - as the service design develops, the CCG will engage with a wide range of providers on an ongoing basis to seek comments on the proposed design, e.g. via the commissioner's website or via workshops with interested parties;
 - use engagement to help shape the requirement to meet patient need but take care not to gear the requirement in favour of any particular provider(s);
 - if appropriate, engage the advice of an independent clinical adviser on the design of the service;
 - be transparent about procedures;
 - ensure at all stages that potential providers are aware of how the service will be commissioned; and
 - maintain commercial confidentiality of information received from providers.
- 11.4 Details of all contracts, including the contract value, will be published on the CCGs website as soon as contracts are agreed. For services commissioned through Any Qualified Provider (AQP), the CCG will publish on their website the type of services they are commissioning and the agreed price for each service. Such details will also be set out in the annual report.

12. Governance and decision-making processes

- 12.1 The CCG will review, on an annual basis, its governance structures for managing conflicts of interest to ensure that the arrangements reflect current guidance and are appropriate, particularly in relation to any co-commissioning roles which the CCG proposes to undertake. This will include consideration of the following:
- the make-up of its governing body and committee structures (including, where relevant, the approach set out below for decision-making in delegated or joint commissioning of primary care);
 - whether there are sufficient management and internal controls to detect breaches of the CCG's conflicts of interest policy, including appropriate external oversight and adequate provision for whistleblowing;
 - how non-compliance with policies and procedures relating to conflicts of interest is being managed (including how this will be addressed when it relates to contracts already entered into). As well as actions to address non-compliance, CCGs will have procedures in place to review any lessons to be learned from such cases by the CCG's audit committee conducting an incident review;
 - reviewing and revising approaches to the CCG's registers of interest
 - whether any training or other programmes are required to assist with compliance, including participation in the training offered by NHS England.

13. Appointing governing body or committee members

- 13.1 The CCG will consider whether conflicts of interest should exclude individuals from being appointed to the governing body or to a committee or sub-committee of the CCG or governing body. These will be considered on a case-by-case basis and will be reflected in the CCGs Constitution.
- 13.2 The CCG will assess the materiality of the interest, in particular whether the individual (or a family member or business partner) could benefit from any decision the governing body might make. This will be particularly relevant for any profit sharing member of any organisation but should also be considered for all employees and especially those operating at senior or governing body level.
- 13.3 The CCG will also determine the extent of the interest. If it is related to an area of business significant enough that the individual would be unable to make a full and proper contribution to the governing body, that individual should not become a member of the governing body.
- 13.4 Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to the CCG (either as a provider of healthcare or commissioning support services) should not be a member of the governing body if the nature of their interest is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively operate as a governing body member..

14. Decision-making when a conflict of interest arises: general approaches

- 14.1 Where certain members of a decision-making body (be it the governing body, its committees or sub-committees, or a committee or sub-committee of the CCG) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (i.e., not have a vote).
- 14.2 The Chair of the meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the chair may wish to consult the member of the governing body who has responsibility for issues relating to conflicts of interest. All decisions, and details of how any conflict of interest issue has been managed, will be recorded in the minutes of the meeting and published in the registers.
- 14.3 Depending on the nature of the conflict, GPs or other practice representatives may be permitted to join in discussions by the governing body, or such other decision-making body as the CCG has created, about the proposed decision, but should not take part in any vote on the decision.
- 14.4 The CCG recognises that in some cases, all of the GPs or other practice representatives on a decision-making body could have a material interest in a decision, e.g., where the CCG is proposing to commission services on a direct award basis from all GP practices in the area, or where it is likely that all or most practices would wish to be qualified providers for a service under AQP. Where such a situation relates to primary medical services, the arrangements set out below shall apply.
- 14.5 For decision making where such a conflict arises and which are not covered by the primary medical care arrangements, the CCG will:
- where the initial responsibility for the decision does not rest with the governing body, refer the decision to the governing body and exclude all GPs or other practice representatives with an interest from the decision-making process, i.e., so that the decision is made only by the non-GP members of the governing body including the lay and executive members and the registered nurse and secondary care doctor;
 - where the decision rests with the governing body, consider
 - a) *co-opting individuals from a Health and Wellbeing Board or from another CCG onto it (although care should be taken to ensure, particularly if the other CCG is from a nearby locality, that their representatives do not also have a conflict of interest and are not excluded from governing body membership under the relevant regulations. It would also be necessary for the CCG's constitution to allow such an arrangement);*
or
 - b) *inviting the Health and Wellbeing Board or another CCG to review the proposal*
 - ensure that rules on quoracy (set out in the CCG's constitution) enable decisions to be made.

15. Decision-making when a conflict of interest arises: primary medical care

- 15.1 Procurement decisions relating to the commissioning of primary medical services should be made by a committee of the CCG's governing body. This should:

- for joint commissioning take the form of a joint committee established between the CCG (or CCGs) and NHS England; and
 - in the case of delegated commissioning, be a committee established by the CCG.
- 15.2 In either case, the membership of the committee will be constituted so as to ensure that the majority is held by lay and executive members. In addition to existing CCG lay members, members may be drawn from the CCG's executive members, except where these members may themselves have a conflict of interest (e.g. if they are GPs or have other conflicts of interest). Provision will be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of conflicts of interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCG's secondary care specialist and/or governing body nurse lead).
- 15.3 Any conflicts of interest issues will be considered on an individual basis.
- 15.4 A standing invitation will be made to the CCG's local Healthwatch and Health and Wellbeing Board to appoint representatives to attend joint commissioning committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives will not form part of the membership of the committee.
- 15.5 As a general rule, meetings of these committees, including the decision-making and the deliberations leading up to the decision, should be held in public (unless the CCG has concluded it is appropriate to exclude the public)
- 15.6 In joint commissioning arrangements, the joint role of NHS England in decision-making will provide an additional safeguard in managing conflicts of interest.
- 15.7 The CCG, from time to time, may wish to include decisions on other commissioning issues within the remit of the committee. The CCG also may wish to designate an existing committee to incorporate the above responsibilities within their remit. In this event the CCG will ensure that the membership and chairing arrangements are compliant with the above requirements, or that, when dealing with primary care procurement issues, the participating membership and chairing arrangements are adjusted to meet these requirements. Where an existing committee is so designated, the above requirements on Healthwatch and Health and Wellbeing Board participation and on meeting in public would apply for co-commissioning decisions.
- 15.8 The arrangements for primary medical care decision making will not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest. They apply to decision-making on procurement issues and the deliberations leading up to the decision.

16. Role of commissioning support

- 16.1 The CCG will ensure that any services they commission from CSSs, or that they secure through in-house provision, include this type of support. When using a CSS, the CCG will assure itself that a CSS' business processes are robust and enable the CCG to meet

its duties in relation to procurement (including those relating to the management of conflicts of interest) by engaging the support of Internal and External auditors.

- 16.2 The CSS will be asked to prepare and present information on bids, including an assessment of whether providers meet pre-qualifying criteria and an assessment of which provider provides best value for money.
- 16.3 The CCG acknowledges that it is prohibited from delegating commissioning decisions to an external provider of commissioning support. Although CSSs are likely to play a key role in helping to develop specifications, preparing tender documentation, inviting expressions of interest and inviting tenders, the CCG itself will:
- determine and sign off the specification and evaluation criteria;
 - decide and sign off decisions on which providers to invite to tender; and
 - make final decisions on the selection of the provider.

17. Transparency of GP earnings

- 17.1 In accordance with commitments on transparency of GP earnings, there will be a new contractual requirement for GP practices to publish on their practice website by 31 March 2016, the mean net earnings of GPs in their practice (to include contractor and salaried GPs) relating to 2014/15 financial year. Alongside the mean figure, practices must publish the number of full and part time GPs associated with the published figure. The figure will include earnings from NHS England, CCGs and local authorities for the provision of GP services that relate to the contract and which would have previously been commissioned by PCTs. Costs relating to premises will not be included.

18. Statement of conduct expected of individuals in the CCG

- 18.1 The CCG expects members of the governing body, members of committees and employees, adhere to the expectations set out in the *Standards for Members of NHS Boards and Clinical Commissioning Groups*⁹

19. Fraud and Bribery

- 19.1 Any suspicions or concerns of acts of fraud or bribery can be reported online via <https://www.reportnhsfraud.nhs.uk/> or via the NHS Fraud and Corruption Reporting Line on 0800 0284060. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.
- 19.2 Any suspicions or concerns of acts of fraud or bribery can also be reported to the CCG's Anti Fraud Specialist Michelle Moss
Telephone: **0151 285 4547**

⁹ <http://www.professionalstandards.org.uk/docs/psa-library/november-2012---standards-for-board-members.pdf?sfvrsn=0>

Mobile: **07825858685**

michelle.moss@miaa.nhs.uk or michelle.moss1@nhs.net

Annexes

Annex 1: NHS Clinical Commissioners, Royal College of General Practitioners and British Medical Association principles on conflicts of interest

Annex 2: Declaration of conflict of interests for bidders/contractors template

Annex 3: Declaration of interests for members/employees template

Annex 4: Procurement template

Annex 5: 10 key questions for commissioners

Annex 6: Declaration of gifts and hospitality form

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Annex 8: Declaration of commercial sponsorship form

Annex 1: NHS Clinical Commissioners, Royal College of General Practitioners and British Medical Association - Shared principles on conflicts of interest when CCGs are commissioning from member practices

December 2014

1. Introduction

The ability for CCGs to become involved in co-commissioning General Practice and primary care services has the potential to bring many benefits but it also brings with it the potential for perceived and actual conflicts of interest.

NHS Clinical Commissioners (NHSCC), the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) have decided to collectively outline their high level starting principles in managing conflicts of interest when CCGs commission from member practices. In large part this has brought together principles articulated in previous lines/guidance/steer from the above organisations and NHS England.

Our principles are applicable to each of the three primary care commissioning models open to CCGs and should not be seen as being directive or be interpreted to mean that we prefer one model over another. These decisions need to remain a local, professionally led, decision

In developing these shared principles we would like them to sit alongside NHS England's updated guidance on Managing Conflicts of Interest (December 2014). We are on a journey regarding the co-commissioning of primary care and we will review these principles when needed and as CCGs work through the guidance.

It should be noted that this paper is not designed to address the issue of perceived or actual conflicts of interest in CCGs holding and performance managing GP contracts under co-commissioning arrangements.

2. Our headline shared principles around conflicts of interest

We collectively agree the following in relation to managing conflicts of interest when CCGs commission from member practices:

- If CCGs are doing business properly (needs assessments, consultation mechanisms, commissioning strategies and procurement procedures), then the rationale for what and how they are commissioning is clearer and easier to withstand scrutiny. Decisions regarding resource allocation should be evidence-based, and there should be robust mechanisms to ensure open and transparent decision making.
- CCGs must have robust governance plans in place to maintain confidence in the probity of their own commissioning, and maintain confidence in the integrity of clinicians.
- CCGs should assume that those making commissioning decisions will behave ethically, but individuals may not realise that they are conflicted, or lack awareness of rules and procedures. To mitigate against this, CCGs should ensure that formal prompts, training and checks are implemented to make sure people are complying with the rules. As a rule of thumb, 'if in doubt, disclose'
- CCGs should anticipate many possible conflicts when electing/selecting individuals to commissioning roles, and where necessary provide commissioners with training to ensure individuals understand and agree in advance how different scenarios will be dealt with.

- It is important to be balanced and proportionate – the purpose of these tools is not to constrain decision-making to be complex or slow.

3. Addressing perceived as well as actual conflicts of interest

Conflicts of interest in the NHS are not new and they are not always avoidable. The documents we reviewed to produce this paper were all clear that the existence of a conflict is not the same as impropriety and focus on how to avoid potential or perceived wrongdoing. Most importantly all acknowledge that perceived wrongdoing can be as detrimental as actual wrongdoing, and risks losing confidence in the probity of CCGs and the integrity of wider clinicians such as GPs in networks/federations, individual practices and partners.

The RCGP/NHS Confederation also notes evidence from the BMJ that people think they aren't biased by potential conflicts but often are so the common theme is - *if in any doubt it's important to disclose*.

The RCGP/NHS Confederation and NHS England Guidance identify four types of potential conflict of interest:

- direct financial;
- indirect financial (for example a spouse has a financial interest in a provider);
- non-financial (i.e. reputation) and;
- loyalty (i.e., to professional bodies).

The BMA recognises that for CCGs there will be situations where the best decision for the population and taxpayers is not in the best interest of individual patients (for whom GPs are required to advocate) and that this can create a perceived conflict. The RCGP/NHS Confederation paper acknowledges this but in terms of the governance when commissioning services.

4. Planning for populations

CCGs must always demonstrate that their commissioned services meet the needs of their local populations, as such CCGs will need to work with their Health and Wellbeing Board's or other local strategic bodies to ensure there is alignment to local strategic plans.

What is clear from all the existing guidance is that CCGs will need to identify the situations where they are involving their governing body clinicians to strategically plan for their population, and situations where their governing body clinicians need to be separated from procurement, planning and decision-making processes. In the former it is critically important to secure clinical expertise. In the latter, the CCG will need to manage risks around perceived and actual conflicts in relation to the tendering of services.

The BMA outlines that decisions regarding resource allocation should be evidence based, and there should be robust mechanisms to ensure open and transparent decision making. As such, GP involvement must be agreed at each stage of the commissioning and procurement process so that potential risks of conflicts are appropriately defined and mitigated early on.

5. Good practice – for CCGs

All the guidance suggests CCGs must have robust governance plans in place to maintain confidence in the probity of their own commissioning, and maintain confidence in the integrity of clinicians.

The RCGP/NHS Confederation suggests using existing NHS guidance as a starting point:

- Identify potential conflicts
- Declare interests in a register

Exclude individuals from discussion or decision making if financial interest exceeds 1% equity in the provider organisation - depending on the nature of the discussion (we would also add that includes considering the share of the contract value to make sure there are no loopholes, this might also apply to practices with profit sharing arrangements).

- Continue to manage conflicts post-decision i.e. contract managing (carefully separating overall strategy development for populations from individual procurement processes. The former will be important for CCG lay involvement will be important and include secondary care clinicians and non-executive board nurses, the latter can be managed by managers).

NHS England guidance also says that an individual with a 'material interest' in an organisation which provides or is likely to provide significant business should not be member of CCG governing body. The BMA suggests anything above 5% equity is a material interest. The RCGP/NHS Confederation reference this threshold but also say that something lower than a 1% stake could also be a material interest (if the size of the bid is significant).

Clearly these thresholds need to be considered in relation to individual practices and GP partners once co-commissioning is in place. The perceived risks must be recognised early on and we feel some worked case study examples would be helpful for CCGs as they work through the updated guidance. NHSCC, the RCGP and the BMA are planning to work with NHS England and Monitor to identify these examples.

NHSCC believe that CCG lay members, secondary care doctors and nurses on governing bodies play a vital role in both the design, implementation, leadership and monitoring of conflicts of interest systems and processes. They can provide robust challenge and ultimately a protection for GPs working in both the commissioning and provision of health care. Enabling them to carry out their roles in this regard is vital.

CCGs should also be proactive in their approach when considering conflicts when electing/selecting people, doing a proper induction (i.e. include continuous training and review at both Governing Body and membership (assembly level) and ensuring understanding from individuals, and agree in advance how different scenarios will be dealt with. The CCG should ensure individuals are prompted to declare an interest but not absolved from their responsibility to declare as well. Again, CCG lay members, secondary care doctors and nurse members of the governing body have a critical role in this process, as an independent arbiter and as those providing appropriate scrutiny and oversight.

NHS England's *Code of Conduct* guidance specifically explores when CCGs are commissioning services from their own GP member practices. When CCGs are commissioning from federations of practices, the same guidance should apply.

As practical support NHS England have also produced an updated code of conduct template for use when drawing up local plans (see their updated guidance). The template asks a series of questions to provide assurance to Health and Wellbeing Boards that the service meets local

needs, and to the Audit Committee or external auditors that robust process was used to commission the service, select the appropriate procurement route and address potential conflicts of interest.

6. Good practice - for individuals

The current guidance suggests that individuals making decisions in CCGs do so with the Nolan principles of public life in mind: selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

They also refer to the guidance the General Medical Council (GMC) has produced for doctors including:

- You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.
- If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest informally, and you should be prepared to exclude yourself from decision making.
- You must not try to influence patients' choice of healthcare services to benefit you, someone close to you, or your employer. If you plan to refer a patient for investigation, treatment or care at an organization in.

NHS England guidance indicates that individuals must declare an interest as soon as they come aware of it, and within 28 days. More informally, the RCGP/NHS Confederation also suggested the simple 'Paxman test' - whether explaining the situation to an investigative reporter/journalist like Jeremy Paxman would cause embarrassment. We think it would be helpful to develop this type of text into a tool for CCGs to use locally.

- NHS England guidance indicates that individuals must declare an interest as soon as they come aware of it, and within 28 days.
- Finally, the BMA suggested that commissioner doctors:
- Declare all interests, even if they are potential conflicts or the individual is unsure whether it counts as a conflict, as soon as possible.
- Update a register of interests every three months.
- Doctors must be familiar with their organisation's formal guidance.
- If individual doctors have any questions, they should seek advice from colleagues, err on the side of being open about conflicts of interest, or seek external advice from professional or regulatory bodies.

In addition to the above, the RCGP suggests there should also be a requirement to update the register of interests if a material difference arises in the circumstances of an individual at any point.

7. Procurement processes – CCGs and member practices

According to the BMA guidance, when CCGs are procuring community level services, these contracts are often below threshold requiring a competitive tender process. There are a number of procurement options for CCGs in this situation – for example a few may include:

1. Competitive tender where GP practices are likely to bid
2. AQP where GP providers are likely to be among the qualified providers

3. Single tender from GP practices

From the guidance that exists different questions arise around conflicts of interest when the above procurement processes are used. For example:

- Identifying whether approaches such as AQP are being used with the safeguards to ensure that patients are aware of the choices available to them.
- If single tender is the route used, CCGs will need to demonstrate a few things – depending on the nature of the procurement. For example that there are no other capable providers, why the successful bid was preferred to the others and the impact of disproportionate tendering costs. (Monitor's procurement guidance provides many useful steers on what CCGs will need to demonstrate)
- For primary care co-commissioning, NHSCC believes one of the elements to include on procurement processes are the issues around standing financial orders and schemes of delegation which should not allow CCGs to divide primary care budgets into smaller budgets to circumvent the procurement process. NHSCC's lay member network will have examples/steer on the correct wording to use from previous local experiences.

Regardless of what the local application is the most important part of this process is transparency. NHS England says to set out the details, including the value of all contracts on the CCG website. If they are using AQP, the types and prices of services they are commissioning should be on the website. All of this information should also be in the CCG's annual report.

When making procurement decisions, the current guidance suggests that anyone with a perceived or material conflict should be excluded from decision making, either both excluded from voting or from discussion and voting. What is not clear in the guidance is how far back this rule goes – i.e. to the planning stage or just the development of the specification and procurement. CCGs will need to agree that line locally.

According to the reviewed guidance if all GPs and practice representatives due to make a decision are conflicted, then the CCG should be:

- Referring decisions to the governing body, so that lay members / the nurse / the secondary care doctor can make the final decision. However this may weaken GP clinical input into decision making.
- Co-opting individuals from the HWB or another CCG onto the governing body, or invite the HWB / another CCG to review proposal to provide additional scrutiny (these individuals would only be able to participate in decision making if this was set out in the CCG constitution)
- Ensure that quoracy rules enable decisions to be made in this circumstance
- Plan ahead to ensure that agreed processes are followed.
- Use an appropriately constituted arms-length external scrutiny committee to ensure probity (recommended by the BMA)

CCGs can use commissioning support services (CSS) to reduce potential conflicts, for example a CSS can help select the best procurement route and prepare bids etc. However, this cannot completely eliminate the conflict as CCGs are responsible for signing off specification and evaluation criteria, signing off which providers to invite to tender, and making the final decision on the selection of the provider. The CCG is responsible for ensuring that their CSS or other third parties are compliant with regulations in the same way that the CCG must be.

NHS England also suggest any questions about the service going beyond the scope of the GP contract should be discussed with NHS England area teams, clearly that would need review in light of new delegated co-commissioning arrangements.

Networks and Federations

We note that the increasing number of GP networks and federations could potentially present an added complication to local procurement processes. If most or all CCG member practices are part of the local federation, then this could mean that a practice not part of the federation/excluded from a federation may not have the opportunity to win contracts through competitive tender – because the process is more suited to federated organisations. One way to mitigate this would be for the CCG to always design and procure service specifications according to best practice (with openness and transparency), thereby supporting all practices to bid. One area to be careful about is when all the GPs on a governing body have a declared interest in local federations – this makes decision making and accountability complex and the CCG will need to work that through carefully with the input of its lay members and wider clinicians on the governing body. Again, an external scrutiny committee with non-conflicted clinicians such as from a neighbouring CCG may be helpful.

8. Local engagement

Separately, the BMA suggests that LMCs should be involved in CCGs either by formal consultation, a non-voting seat on governing body, or as an observer on governing body. They indicate that a non-voting governing body seat would be the best option. Neither of the other two papers we reviewed address this.

9. Other conflicts of interest issues for consideration

Personal conflict

The RCGP/NHS Confederation highlight that in CCG governing bodies a personal conflict can arise because CCG leaders are elected by their constituent GP members. There could be a perception that CCG governing bodies are favouring the most vocal or influential of their GP practice members. Related to this is the potential indirect interest for elected GPs to build a constituency of supporters within their CCG.

The CCG is responsible for ensuring that their CSS or other third parties are compliant with regulations in the same way that the CCG must be.

NHS England guidance suggests that in the case of every GP governing body member being conflicted, the lay members, registered nurse and secondary care doctor make the decision (and that the constitution is written so that this is quorate).

This could however mean that decisions would be taken without a GP perspective.

Alternatively, CCGs may bring in members of the Health and Wellbeing Board or another CCG to provide oversight, or as the BMA suggests use an external scrutiny committee to make decisions.

Use of primary care incentive schemes

In its guidance, the BMA highlights its concerns about the professional and ethical implications of CCGs applying incentive schemes to reduce referral or prescribing activity. The BMA urges any doctor, whether commissioner or provider, to consider the schemes carefully and ensure that scheme is based on clinical evidence. NHSCC suggests that one solution is to ensure the expertise of secondary care clinicians and nurses on governing bodies plays an important part in providing clinical input and lay members can scrutinize commercial/ financial and performance data.

The RCGP acknowledge that it is not ethical to under-treat or under-refer for financial gain, but is not unethical to 'review and reflect' on variations in referral/prescribing rates and try to reduce referrals in line with evidence or best practice.

Note to the reader:

This paper has been developed from a review of three guidance documents and brings together previous lines/guidance from NHSCC, NHS England, the RCGP and the BMA.

- BMA 'Conflicts of interest in the new commissioning system: Doctors in commissioning roles' April 2013
- RCGP/NHS Confederation 'Managing conflicts of interest in clinical commissioning groups' September 2011
- NHS England 'Managing conflicts of interest: guidance for clinical commissioning groups.' March 2013 (includes Commissioning Board Document that precedes it). We have also read across the paper to the new version of this document published December 2014.
- NHSCC have also supplemented the principles raised in this paper with some points for steer that have been raised by members of its lay member network.

Annex 2: Declaration of conflict of interests for bidders/contractors template

NHS South Sefton Clinical Commissioning Group Bidders/potential contractors/service providers declaration form: financial and other interests

This form is required to be completed in accordance with the CCG's Constitution, and s140 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013 and related guidance

Notes:

- All potential bidders/contractors/service providers, including sub-contractors, members of a consortium, advisers or other associated parties (Relevant Organisation) are required to identify any potential conflicts of interest that could arise if the Relevant Organisation were to take part in any procurement process and/or provide services under, or otherwise enter into any contract with, the CCG, or with NHS England in circumstances where the CCG is jointly commissioning the service with, or acting under a delegation from, NHS England.
- Any changes to interests declared either during the procurement process or during the term of any contract subsequently entered into by the Relevant Organisation and the CCG must notified to the CCG by completing a new declaration form
- Relevant Organisations completing this declaration form must provide sufficient detail of each interest so that the CCG, NHS England and also a member of the public would be able to understand clearly the sort of financial or other interest the person concerned has and the circumstances in which a conflict of interest with the business or running of the CCG or NHS England (including the award of a contract) might arise.
- If in doubt as to whether a conflict of interests could arise, a declaration of the interest should be made.

Interests that must be declared (whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person), include the following:

- the Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing services or other work for the CCG or NHS England;
- Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;
- the Relevant Organisation or any Relevant Person has any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgements, decisions or actions.

Name of organisation		
Detail of interests held		
Type of Interest	Details	
Provision of services or other work for the CCG		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		
Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employee's judgements decisions or actions.		

Name of relevant person		
Detail of interests held		
Type of Interest	Details	Personal interest or that of a family member, close friend or other acquaintance?
Provision of services or other work for the CCG		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		
Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employee's judgements decisions or actions.		

To the best of my knowledge and belief, the above information is complete and correct. Undertake to update as necessary the information,

Signed: _____ on behalf of _____ Date: _____

Annex 3–: Declarations of Interest form

To be completed in all circumstances by the individuals listed below upon joining the CCG and thereafter at the request of the CCGs Governance Lead or Conflict of Interest Guardian.

- **All CCG employees**, including:
 - All full and part time staff;
 - Any staff on sessional or short term contracts;
 - Any students and trainees (including apprentices);
 - Agency staff; and
 - Seconded staff
- self-employed consultants or other individuals working for the CCG under a contract
- **Members of the governing body**
- All members of the CCG's committees, joint committees, sub-committees/sub-groups, including:
 - Co-opted members;
 - Appointed deputies; and
 - Any members of committees/groups from other organisations.

This includes each provider of primary medical services which is a member of the CCG under Section 14O (1) of the 2006 Act. Declarations should be made by the following groups:

- GP partners (or where the practice is a company, each director);
- Any individual directly involved with the business or decision-making of the CCG.

Name:	
Position within, or relationship with, the CCG (or NHS England in the event of joint committees):	
Please confirm you have read and understand the Conflicts of Interest Policy	

Detail of interests held (complete all that are applicable):				
Type of Interest* <small>*See supplementary advice</small>	Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)	Date interest relates From & To		Actions to be taken to mitigate risk (to be agreed with line manager or a senior CCG manager)

Detail of interests held (complete all that are applicable):				
Type of Interest* *See supplementary advice	Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)	Date interest relates From & To		Actions to be taken to mitigate risk (to be agreed with line manager or a senior CCG manager)

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that the CCG holds. If consent is NOT given please give reasons:

Signed:

Date:

Signed:

Position:

Date:

(Line Manager or Senior CCG Manager)

Please return to southsefton.ccg@nhs.net

Types of interest

Type of Interest	Description
Financial Interests	<p>This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:</p> <ul style="list-style-type: none"> • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment (In receipt of secondary income from a provider); • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	<p>This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:</p> <ul style="list-style-type: none"> • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE); • A medical researcher.
Non-Financial Personal Interests	<p>This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:</p> <ul style="list-style-type: none"> • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded treatment; • A member of a lobby or pressure groups with an interest in health.
Indirect Interests	<p>This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include:</p> <ul style="list-style-type: none"> • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend; • Business partner.

Annex 4: Procurement Template

[To be used when commissioning services from GP practices, including provider consortia, or organisations in which GPs have a financial interest]

NHS South Sefton Clinical Commissioning Group Service:

Question

How does the proposal deliver good or improved outcomes and value for money, what are the estimated costs and the estimated benefits?

How does it reflect the CCG's proposed commissioning priorities? How does it comply with the CCG's commissioning obligations?

How have you involved the public in the decision to commission this service?

What range of health professionals have been involved in designing the proposed service?

What range of potential providers have been involved in considering the proposals?

How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?

What are the proposals for monitoring the quality of the service?

What systems will there be to monitor and publish data on referral patterns?

Annex 5: 10 key questions

These questions are provided as a prompt to the CCG when considering key issues when reviewing their current arrangements for managing conflicts of interest.

1. Do you have a process to identify, manage and record potential (real or perceived) conflicts of interest that could affect, or appear to affect, the integrity of an award of a contract, including those that could arise in relation to co-commissioning of primary care?
2. How will the CCG make its final commissioning decisions in ways that preserve the integrity of the decision-making process?
3. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers, including an explanation of how the conflict has been managed?
4. Have you made arrangements to make registers of interest accessible to the public?
5. Have you set out how you will ensure fair, open and transparent decisions about:
 - priorities for investment in new services
 - the specification of services and outcomes
 - the choice of procurement route?
6. How will you involve patients, and the public, and work with your partners on the Health and Wellbeing Boards and providers (old and new) in informing these decisions?
7. What process will you use to resolve disputes with potential providers?
8. Have you summarised your intended approach in your constitution, and thought through how your governing body will be empowered to oversee these systems and processes – both how they will be put in place and how they will be implemented?
9. What systems will there be to monitor the patterns of decision making and how any conflicts of interest were managed?
10. Has your decision making body identified and documented in the constitution the process for remaining quorate where multiple members are conflicted?

Annex 6 - Declarations of gifts and hospitality form

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Details of Gift / Hospitality	Estimated Value	Supplier / Offeror Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier	Details of the officer reviewing and approving the declaration made and date	Declined or Accepted?	Reason for Accepting or Declining	Other Comments

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 5 working days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I **do / do not (delete as applicable)** give my consent for this information to published on registers that the CCG holds. If consent is NOT given please give reasons:

Signed:

Date:

Signed:

Position:

Date:

(Line Manager or a Senior CCG Manager)

Annex 7 – Template for recording minutes

Item	Agenda item	Actions
1	Chairs' welcome	
2	Apologies for absence	
3	<p>Declarations of interest</p> <p><i>SK reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of XXX clinical commissioning group. Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests. The Register is available either via the secretary to the governing body or the CCG website at the following link:</i></p> <p>Declarations of interest from sub committees None declared</p> <p>Declarations from today's meeting <i>The following update was received at the meeting: With reference to business to be discussed at this meeting, MS declared that he is a shareholder in XXX Care Ltd.</i></p> <p><i>SK declared that the meeting is quorate and that MS would not be included in any discussions on agenda item X due to a direct conflict of interest which could potentially lead to financial gain for MS. SK and MS discussed the conflict of interest, which is recorded on the register of interest, before the meeting and MS agreed to remove himself from the table and not be involved in the discussion around agenda item X.</i></p>	

Annex 8 - Declarations of commercial sponsorship

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Details of sponsorship	Estimated Value	Supplier / Offeror Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier	Details of the officer reviewing and approving the declaration made and date	Declined or Accepted?	Reason for Accepting or Declining	Other Comments

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 5 working days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I **do / do not (delete as applicable)** give my consent for this information to published on registers that the CCG holds. If consent is NOT given please give reasons:

Signed:

Date:

Signed:

Position:

Date:

(Line Manager or a Senior CCG Manager)

Annex 9:

Summary of key aspects of the guidance on managing conflicts of interest relating to commissioning of new care models

Introduction

1. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring. They arise in many situations, environments and forms of commissioning.
2. Where CCGs are commissioning new care models particularly those that include primary medical services, it is likely that there will be some individuals with roles in the CCG (whether clinical or non-clinical), that also have roles within a potential provider, or may be affected by decisions relating to new care models. Any conflicts of interest must be identified and appropriately managed, in accordance with this statutory guidance.
3. This annex is intended to provide further advice and support to help CCGs to manage conflicts of interest in the commissioning of new care models. It summarises key aspects of the statutory guidance which are of particular relevance to commissioning new care models rather than setting out new requirements. Whilst this annex highlights some of the key aspects of the statutory guidance, CCGs should always refer to, and comply with, the full statutory guidance.

Identifying and managing conflicts of interest

4. The statutory guidance for CCGs is clear that any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to a CCG (whether as a provider of healthcare or provider of commissioning support services, or otherwise) should recognise the inherent conflict of interest risk that may arise and should not be a member of the governing body or of a committee or sub-committee of the CCG.
5. In the case of new care models, it is perhaps likely that there will be individuals with roles in both the CCG and new care model provider/potential provider. These conflicts of interest should be identified as soon as possible, and appropriately managed locally. The position should also be reviewed whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests. For example where an individual takes on a new role outside the CCG, or enters into a new business or relationship, these new interests should be promptly declared and appropriately managed in accordance with the statutory guidance.
6. There will be occasions where the conflict of interest is profound and acute. In such scenarios (such as where an individual has a direct financial interest which gives rise to a conflict, e.g., secondary employment or involvement with an organisation which benefits financially from contracts for the supply of goods and services to a CCG or aspires to be a new care model provider), it is likely that CCGs will want to consider whether, practically, such an interest is manageable at all. CCGs should note that this can arise in relation to both clinical and nonclinical members/roles. If an interest is not manageable, the

appropriate course of action may be to refuse to allow the circumstances which gave rise to the conflict to persist. This may require an individual to step down from a particular role and/or move to another role within the CCG and may require the CCG to take action to terminate an appointment if the individual refuses to step down. CCGs should ensure that their contracts of employment and letters of appointment, HR policies, governing body and committee terms of reference and standing orders are reviewed to ensure that they enable the CCG to take appropriate action to manage conflicts of interest robustly and effectively in such circumstances.

7. Where a member of CCG staff participating in a meeting has dual roles, for example a role with the CCG and a role with a new care model provide organisation, but it is not considered necessary to exclude them from the whole or any part of a CCG meeting, he or she should ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the meeting minutes, but where it is appropriate for them to participate in decisions they must only do so if they are acting in their CCG role.
8. CCGs should take all reasonable steps to ensure that employees, committee members, contractors and others engaged under contract with them are aware of the requirement to inform the CCG if they are employed or engaged in, or wish to be employed or engaged in, any employment or consultancy work in addition to their work with the CCG (for example, in relation to new care model arrangements).
9. CCGs should identify as soon as possible where staff might be affected by the outcome of a procurement exercise, e.g., they may transfer to a provider (or their role may materially change) following the award of a contract. This should be treated as a relevant interest, and CCGs should ensure they manage the potential conflict. This conflict of interest arises as soon as individuals are able to identify that their role may be personally affected.
10. Similarly, CCGs should identify and manage potential conflicts of interest where staff are involved in both the contract management of existing contracts, and involved in procurement of related new contracts.

Governance arrangements

11. Appropriate governance arrangements must be put in place that ensure that conflicts of interest are identified and managed appropriately, in accordance with this statutory guidance, without compromising the CCG's ability to make robust commissioning decisions.
12. We know that some CCGs are adapting existing governance arrangements and others developing new ones to manage the risks that can arise when commissioning new care models. We are therefore, not recommending a "one size fits" all governance approach, but have included some examples of governance models which CCGs may want to consider.
13. The principles set out in the general statutory guidance on managing conflicts of interest (paragraph 19-23), including the Nolan Principles and the Good Governance Standards for Public Services (2004), should underpin all governance arrangements.

14. CCGs should consider whether it is appropriate for the Governing Body to take decisions on new care models or (if there are too many conflicted members to make this possible) whether it would be appropriate to refer decisions to a CCG committee.

Primary Care Commissioning Committee

15. Where a CCG has full delegation for primary medical services, CCGs could consider delegating the commissioning and contract management of the entire new care model to its Primary Care Commissioning Committee. This Committee is constituted with a lay and executive majority, and includes a requirement to invite a Local Authority and Healthwatch representative to attend
16. Should this approach be adopted, the CCG may also want to increase the representation of other relevant clinicians on the Primary Care Commissioning Committee when new care models are being considered, as mentioned in. The use of the Primary Care Commissioning Committee may assist with the management of conflicts/quorum issues at governing body level without the creation of a new forum/committee within the CCG.
17. If the CCG does not have a Primary Care Commissioning Committee, the CCG might want to consider whether it would be appropriate/advantageous to establish either:
 - a) A **new care model commissioning committee** (with membership including relevant non-conflicted clinicians, and formal decision making powers similar to a Primary Care Commissioning Committee (“NCM Commissioning Committee”)); or
 - b) A separate **clinical advisory committee**, to act as an advisory body to provide clinical input to the Governing Body in connection with a new care model project, with representation from all providers involved or potentially involved in the new care model but with formal decision making powers remaining reserved to the governing body (“NCM Clinical Advisory Committee”).

NCM Commissioning Committee

18. The establishment of a NCM Commissioning Committee could help to provide an alternative forum for decisions where it is not possible/appropriate for decisions to be made by the Governing Body due to the existence of multiple conflicts of interest amongst members of the Governing Body. The NCM Commissioning Committee should be established as a sub-committee of the Governing Body.
19. The CCG could make the NCM Commissioning Committee responsible for oversight of the procurement process and provide assurance that appropriate governance is in place, managing conflicts of interest and making decisions in relation to new care models on behalf of the CCG. CCGs may need to amend their constitution if it does not currently contain a power to set up such a

committee either with formal delegated decision making powers or containing the proposed categories of individuals

20. The NCM Commissioning Committee should be chaired by a lay member and include non-conflicted GPs and CCG members, and relevant non-conflicted secondary care clinicians.

NCM Clinical Advisory Committee

21. This advisory committee would need to include appropriate clinical representation from all potential providers, but have no decision making powers. With conflicts of interest declared and managed appropriately, the NCM Clinical Advisory Committee could formally advise the CCG Governing Body on clinical matters relating to the new care model, in accordance with a scope and remit specified by the Governing Body.
22. This would provide assurance that there is appropriate clinical input into Governing Body decisions, whilst creating a clear distinction between the clinical/provider side input and the commissioner decision-making powers (retained by the Governing Body, with any conflicts on the Governing Body managed in accordance with this statutory guidance and constitution of the CCG).
23. From a procurement perspective the Public Contracts Regulations 2015 encourage early market engagement and input into procurement processes. However, this must be managed very carefully and done in an open, transparent and fair way. Advice should therefore be taken as to how best to constitute the NCM Clinical Advisory Committee to ensure all potential participants have the same opportunity. Furthermore it would also be important to ensure that the advice provided to the CCG by this committee is considered proportionately alongside all other relevant information. Ultimately it will be the responsibility of the CCG to run an award process in accordance with the relevant procurement rules and this should be a process which does not unfairly favour any one particular provider or group of providers.
24. When considering what approach to adopt (whether adopting an NCM Commissioning Committee, NCM Clinical Advisory committee or otherwise) each CCG will need to consider the best approach for their particular circumstances whilst ensuring robust governance arrangements are put in place. Depending on the circumstances, either of the approaches in paragraph 17 above may help to give the CCG assurance that there was appropriate clinical input into decisions, whilst supporting the management of conflicts. When considering its options the CCG will, in particular, need to bear in mind any joint / delegated commissioning arrangements that it already has in place either with NHS England, other CCGs or local authorities and how those arrangements impact on its options.

Provider engagement

25. It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. This may include providers from the acute, primary, community, and mental health

sectors, and may include NHS, third sector and private sector providers. Such engagement, done transparently and fairly, is entirely legal. However, conflicts of interest, as well as challenges to the fairness of the procurement process, can arise if a commissioner engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid. CCGs should be particularly mindful of these issues when engaging with existing / potential providers in relation to the development of new care models and CCGs must ensure they comply with their statutory obligations including, but not limited to, their obligations under the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 and the Public Contracts Regulations 2015.