

Annex K: 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 models¹, 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

¹ Where we refer to 'new care models' in this note, we are referring to any Multi-speciality Community Provider (MCP), Primary and Acute Care Systems (PACS) or other arrangements of a similar scale or scope that (directly or indirectly) includes primary medical services.

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 non-clinical 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 provider 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 (see paragraph 97 onwards of the CCG guidance).
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 Paragraph 98 of this guidance. 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 (see below).

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.

Further support

26. If you have any queries about this advice, please contact: england.co-commissioning@nhs.net.