# NEWS


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Judge overturns New York's ban on supersize sweet drinks

## Antimicrobial resistance presents an "apocalyptic" threat, CMO warns

**Ingrid Torjesen** LONDON

Action is needed at both a national and international level to avert the "ticking time bomb" of antimicrobial resistance, which presents a threat as grave as climate change, the chief medical officer for England has warned.

In the second volume of her annual report for 2011, *Infections and the rise of antimicrobial resistance*,[1] Sally Davies spelt out the threat—overuse of existing antibiotics and increasing resistance to them, a "discovery void" of new antibiotics, a change in the types of organism presenting the greatest threat, and the need for better training of NHS staff in hygiene and infection control.

"If we don't get this right we will find ourselves in a health system not dissimilar to the early 19th century," where deaths from infections will be commonplace because of a lack of effective treatments, Davies told a press briefing at the Department of Health. The department would publish a five year strategy for action in the next couple of weeks, she said.

At the chief medical officer's recommendation, the Department of Health and the Department for Environment, Food, and Rural Affairs have added antimicrobial resistance to their strategic risk registers. Davies has also requested that it be added to the National Security Risk Assessment, alongside pandemic flu and terrorism, to ensure cross government action.

"Governments and organisations across the world, including the World Health Organization and G8, need to take this seriously," she said. This included finding some way of incentivising the pharmaceutical industry to develop new antibiotics. No new antibiotic classes have been discovered since 1987, and Davies said that no pharmaceutical companies had any new antibiotic classes in their pipeline, and that there were few new antibiotics of existing classes in development.

With the pipeline drying up, stewardship of antibiotics in health, fisheries, and farming had become increasingly important, she said. In health, that meant prescribing antibiotics only when appropriate and ensuring that the patient completed the course.

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## Financial strains must not risk work of volunteers in the NHS

**Zosia Kmietowicz** BMJ

Commissioners and service providers need to better plan the role of volunteers in both the health and social care sectors if they are to avoid alienating the swathes of people who provide their time for free and ease growing tensions with those in paid jobs, a report from a leading think tank has said.[1]

An estimated three million people in England volunteer in the NHS, health charities, and social care organisations—the same number in paid employment in the NHS and social care systems, says the report from the King's Fund. Volunteers play a vital role in delivering services such as assisting with mealtimes, providing support for bereaved families, and befriending older people in care homes.

The Institute for Volunteering Research has suggested that volunteers are worth around £700 000 a year to hospital trusts, £500 000 a year to mental health trusts, and £250 000 a year to a primary care trust.

The latest report was commissioned by the Department of Health to look at the effect of the current changes to health and social care sectors on volunteering. The government sees volunteering as helping to achieve its wider ambitions to decentralise power, reduce reliance on the state, and encourage people to take an active role in their communities.

However, the current economic climate means that some "tensions have already emerged," said the report. Some people are questioning the value of volunteers, and research has shown that staff are sometimes unclear about what volunteers do. Financial pressures also risk creating strains with paid employees who are concerned about their jobs.

It is for these reasons, the report said, that commissioners and service providers need to focus on how volunteers will help improve quality and bring benefits to organisations, patients, and communities.

To make the most of volunteers, commissioners and providers must acknowledge the value of volunteers, develop a clear vision of how volunteers can help organisations and patients, measure their input, and clarify the boundaries between professional and volunteer roles to allay concerns of job substitution.

The report said, "It is more important than ever to think strategically about the role of volunteering. The health and social care system will find it increasingly difficult to meet its objectives without doing so."

Chris Naylor, fellow at the King's Fund, said that volunteering should be used to improve quality and not to reduce short term costs.

Cite this as: *BMJ* 2013;346:f1595

LIFE IN VIEW/SPL

**Without volunteers the NHS will find it increasingly difficult to meet its objectives, said the King's Fund**

# IN BRIEF

**Services are failing people with dementia:** People with dementia who live in care homes in England are more likely than similar people without dementia to go to hospital with avoidable conditions such as urinary infections, the Care Quality Commission has said. Once admitted, people with dementia are more likely than those without dementia to stay in hospital longer, be readmitted, and die in hospital.

**Disclosure of pharma sponsorship made compulsory in Portugal:** A law that was enacted on 15 February requires doctors, scientific societies, and patient associations in Portugal to publicly disclose all sponsorship from the pharmaceutical industry to the national drug regulator (Infarmed). Failure to disclose conflicts of interests could result in fines of €2000 (£1740) to €45 000.

**Regulator rules that advertisements on plain packs are misleading:** The Advertising Standards Authority has ruled that ads run by Japan Tobacco International—against the introduction of plain, standard packaging—are misleading and must not be published again. The ads, placed in the national press in 2012, stated that in 2008 the government had "rejected" plain packaging for tobacco because "there was no credible evidence" to support such a policy. The regulator concluded that the claim breached the advertising code of practice.

**Smoking to be banned from all Dutch cafes:** Dutch health minister Martin van Rijn has confirmed to MPs that he will bring forward changes to the law enforcing a smoking ban throughout the Netherlands' hospitality industry. Most MPs recently voted for a total ban. Currently some smaller cafés are exempt. Last year, smoking increased from 25% to 26% in adults.

**Partners agree to vaccinate 400 million children:** The Global Alliance for Vaccines and Immunisation (GAVI) and the Islamic Development Bank (IDB) have signed a memorandum of understanding to help save children's lives by accelerating the introduction of vaccines in IDB member countries. By 2020, GAVI plans to vaccinate more than 400 million children in at least 29 member countries with the aim of preventing 3.2 million deaths at an estimated cost of $7bn.

Cite this as: *BMJ* 2013;346:f1622

# Judge rules that decision to close three children's heart units was unfair

**Clare Dyer** BMJ

Campaigners fighting the decision to close the children's heart surgery unit in Leeds as part of an exercise to concentrate operations in fewer but larger centres have scored a comprehensive victory at the High Court in London.

Mrs Justice Nicola Davies ruled that the "Safe and Sustainable" consultation that recommended closing three units was flawed by procedural unfairness and a failure to take into account material considerations.

The success for the campaigning group, Save our Surgery Limited, on both grounds of its challenge is a significant setback for the plans to concentrate surgery at only seven sites: Bristol, Birmingham, Southampton, Liverpool, Newcastle, and two in London. Units in Leeds and Leicester and at London's Royal Brompton Hospital in London would be axed under the consultation recommendations.[1]

The judge ruled that the consultation process was unlawful in the first instance because the Joint Committee of Primary Care Trusts, which took the decision, had refused to disclose the sub-scores that an expert committee had given in a scoring exercise. Units were given only the overall scores.

SDS PHOTO/DEMOTIX/PA

**Campaigners to keep services in Leeds said the reform process had been "flawed and unjust"**

"I am satisfied that fairness did require disclosure of the sub-scores to enable Leeds to provide a properly focused and meaningful response," said the judge, who described the committee's refusal to hand over the sub-scores as "ill judged."

In addition, the joint committee also failed to take into account the sub-scores when carrying out the consultation, although the overall scores were acknowledged to be close, she said. The sub-

# New rules on competition are still a concern

**Zosia Kmietowicz** BMJ

The UK government has redrafted regulations on procurement, in an attempt to allay concerns raised by several medical bodies and MPs in the past few weeks that clinical commissioners would be forced to put out to competitive tender most of the services they wanted for their patients.

However, both the BMA and the Royal College of General Practitioners are still concerned that commissioners are not completely free to choose when to use competition and when not to.

The revised regulations, which were laid before parliament on 11 March, mean that the position on competition is unchanged from now, said the Department of Health—commissioners are able to offer contracts to a single provider where only that provider is capable of providing the services.

In explanatory notes, it said, "We have removed the words that inadvertently created the impression that there were only very narrow circumstances in which commissioners could award a contract without a competition."

The department said that the rewording makes it clear that Monitor, the economic regulator of the NHS, has no power to force the competitive tendering of services when the regulations come into force on 1 April, and that decisions about how and when to introduce competition are solely up to doctors and nurses in clinical commissioning groups. It added, "Competition should not trump integration—commissioners are free to commission an integrated service where it is in the interest of patients."

The UK Labour Party and the new National Health party criticised the original secondary legislation published in February.[1] More than 1000 doctors also urged MPs to force a debate on the regulations[2] and the Academy of Medical Royal Colleges expressed "considerable concern" at the regulations, which were published to supplement section 75 of the Health and Social Care Act.

Clare Gerada, chair of the Royal College of General Practitioners, said the revised regulations were "a step in the right direction but . . . do not go far enough in ensuring that commissioners are genuinely free to decide whether or not to expose services to competition."

Mark Porter, chair of the BMA Council, said, "It is vital that competition is not allowed to undermine integration, innovation, or clinical autonomy. There still needs to be a full parliamentary debate to provide absolute clarity that CCGs [clinical commissioning groups] will have the freedom to decide how best to secure high quality services for local populations," he said.

Cite this as: *BMJ* 2013;346:f1634

scores provided the basis for what was ultimately the difference of one point in the critical quality scoring between Leeds and Newcastle.

"In my view, and commensurate with their duty to properly scrutinise and assess all relevant evidence, the JCPCT [the joint committee] should have considered the sub-scores," she said.

At a further hearing on 27 March to decide what remedy should be granted, the Leeds campaigners are expected to argue that the decision on 4 July 2012 to concentrate children's heart surgery at the seven sites should be quashed. The joint committee is expected to seek an appeal.

The Royal Brompton initially succeeded in a High Court challenge to the plans but lost on appeal.[2]

If the decision is quashed, the Leeds campaigners would argue that surgery should continue at Leeds and Newcastle, the judge said.

Last October the health secretary, Jeremy Hunt, referred the decision to close the three units to the independent reconfiguration panel, which advises on contested changes to health services in England. The panel was expected to deliver its decision by the end of March.[3]

The units earmarked for closure have argued that the consultation, which began in 2008, has been working with outdated figures.

Cite this as: *BMJ* 2013;346:f1575

# Case against doctor from Stafford hospital set to start next week

**Clare Dyer** BMJ

A surgeon who worked at Stafford Hospital, where inquiries uncovered hundreds of excess deaths and "appalling" standards of care between 2005 and 2008, is to face a fitness to practise hearing at the Medical Practitioners Tribunal Service next week.

Roderic Hutchinson faces allegations of deficient professional performance at a 10 day hearing, which opens at the tribunal in Manchester on 18 March.

Three medically qualified managers at Mid Staffordshire NHS Foundation Trust are also set to appear before the tribunal, although no dates have yet been fixed. They have been named as John Gibson, medical director from 2003 to 2006; his successor, Valerie Suarez, who was appointed in September 2006 and stepped down in March 2009; and their deputy, David Durrans.

The hearings follow investigations by the General Medical Council (GMC) into 42 doctors who worked for Mid Staffs trust at the time.[1] Hutchinson's case is the first to be sent for a hearing.

A consultant general surgeon and colorectal surgeon, he underwent a GMC assessment of his professional performance in June 2011. The charges allege that his performance was "unacceptable in the area of working with colleagues, and a cause for concern in the areas of other good clinical care and relationships with patients."

The surgeon was allowed to continue working under conditions including supervision by a named consultant, but the conditions were lifted in October 2011. He left Mid Staffs in September 2012.

A review of the general surgery department at Stafford Hospital by the Royal College of Surgeons in 2009 concluded that the service provided was "inadequate, unsafe, and at times frankly dangerous."[2]

NHS managers who are not doctors are not subject to regulation, but GMC guidance makes it clear that those who are medically qualified may be held to account on how they fulfil their management roles.

Cite this as: *BMJ* 2013;346:f1632

# Britons are making healthier lifestyle choices than 40 years ago

**Ingrid Torjesen** LONDON

British adults are half as likely to smoke as they were four decades ago and are drinking less heavily and less frequently, show data from the Office for National Statistics (ONS) 2011 General Lifestyle Survey.

The survey's report, launched at a press conference in London on 7 March, also shows that despite the ageing population, the proportion of people in Great Britain living with a longstanding illness or disability has remained steady over the past 20 years at just under a third.[1]

The 2011 report marks 40 years of the survey. When the ONS survey first included questions about smoking in 1974, it found that 45% of adults smoked (51% of men, 41% of women). Since then, smoking has more than halved and the gap in prevalence of smoking between men and women has narrowed; in 2011, 20% of adults smoked (21% of men, 19% of women).

Although fewer people smoke now than in the 1970s, women who still do smoke consume similar numbers of cigarettes (12 per day in 2011 compared with 13 in 1974), and consumption has fallen only slightly in men—from 18 cigarettes per day in 1974 to 13 in 2011.

Alongside smoking, the proportion of adults drinking heavily or frequently has also fallen. Among 16-24 year olds, the proportion of men drinking more than eight units (double the recommended maximum for men) in one day in the past week fell by almost a third in four years (from 32% in 2007 to 22% in 2011). The proportion of women drinking more than six units (double the recommended maximum for women) in any one day fell by a quarter over the same time period, from 24% to 18%.

The proportion of men drinking on five or more days in a week fell from 23% in 1998 to 16% in 2011, while the proportion of women drinking at least five times per week fell from 13% to 9%. However, the survey found that older people were far more likely than younger people to drink frequently. In 2011, men aged 45 years or more were more than twice as likely to drink five times or more per week as those aged 16-44 years.

**In 1974 the survey found that 41% of women smoked; in 2011 it was 19%**

While lifestyle has improved the population has aged. Between 1971 and 2011, the proportion of the population aged 65 years or over increased from 13.3% to 16.5%.[2] However, this ageing has not been reflected in the overall prevalence of longstanding illness or disability. In 1972, 21% of the population reported living with a longstanding illness or disability. This proportion rose to 32% in 1991 and has remained steady. The most common longstanding illnesses reported were musculoskeletal illnesses, followed by heart and circulatory conditions, respiratory illnesses, and endocrine and metabolic conditions. However, the proportion of people living with a longstanding illness or disability has increased from 15% in 1975 to 19% in 2011.

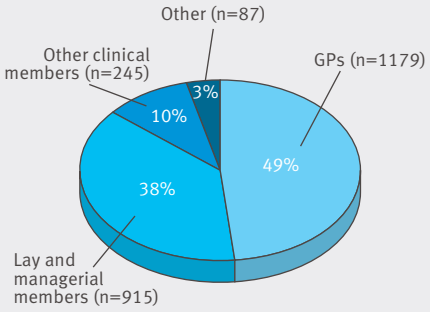
Cite this as: *BMJ* 2013;346:f1583

# More than a third of GPs on CCG boards have conflicts of interest

On the eve of one of the biggest upheavals in the history of the NHS, **Gareth Iacobucci** looks at the conflicts at the heart of clinical commissioning groups

**Membership of CCG governing bodies**

**Total number of board members in 176 CCGs analysed (n=2426)**




More than a third of GPs on the boards of the new clinical commissioning groups (CCGs) in England have a conflict of interest resulting from directorships or shares held in private companies, a new analysis by the *BMJ* has shown.

An examination of the registered interests of almost 2500 board members across 176 CCGs provides the clearest evidence to date of the conflicts that many doctors will have to manage from 1 April, when the GP led groups are handed statutory responsibility for commissioning around £60bn of NHS healthcare services.

Our investigation shows that conflicts of interest are rife on CCG governing bodies, with 426 (36%) of the 1179 GPs in executive positions having a financial interest in a for-profit private provider beyond their own general practice—a provider from which their CCG could potentially commission services.

The interests range from senior directorships in local for-profit firms set up to provide services such as diagnostics, minor surgery, out of hours GP services, and pharmacy to shareholdings in large private sector health firms that provide care in conjunction with local doctors, such as Harmoni and Circle Health.

In some cases most of the GPs on the CCG governing body have financial interests in the same private healthcare provider.

Some doctors have relinquished interests in private enterprises because of their new roles as commissioners. These include GPs linked to Richard Branson's Virgin Care, which announced in October 2012 that it planned to end its joint venture partnerships with over 300 GPs in England,[1] after admitting that many were becoming "increasingly worried about the perception of potential conflicts of interest."

### Calls for doctors with interests to step down

But our analysis found that, in total, 555 (23%) of 2426 clinical, lay, and managerial members of CCG governing bodies had a financial stake in a for-profit company.

Leading GPs, including a senior government adviser on commissioning, have called for doctors with conflicts that were "too great" to step down and have urged the NHS Commissioning Board to offer tougher guidance to those with multiple interests. Last week the BMA's UK consultants' conference passed a motion expressing concern at "the clear conflict of interest of GP commissioners who run their own private companies" and called on GP commissioners to "be barred from being involved in companies that they are giving contracts to."[2]

But others have said that conflicts are an inevitable by-product of allowing more clinicians into management positions and said that focusing too much on the issue may prevent commissioners redesigning services effectively.

The *BMJ* analysed the registered interests of 176 of the 211 commissioning group boards, obtained through requests made under freedom of information legislation and from CCG websites. The remaining groups were not able to disclose their lists, though they must maintain and publish them from 1 April.[3]

Our analysis also showed that 4% of GPs on CCG boards were consultants to or advised private health or pharmaceutical companies, while 5% were employed by a private health company as well as working as a GP.

Some 12% of GPs declared links with not for profit voluntary or social enterprise providers that represented a conflict of interest with their commissioning role, while 9% of GPs declared a conflict of interest through a family member.

## COMMISSIONING—WHAT HAPPENED WHEN

### 2010

**May 2010**

Coalition government is elected. Andrew Lansley (right), who had served as the Conservatives' shadow health secretary for six and a half years, is appointed secretary of state for health. But it is understood that the Conservatives' policy chief, Oliver Letwin, and the Liberal Democrat MP Danny Alexander drew up the new government's health policy as part of their hastily devised "programme for government" (*BMJ* 2012;345:e4833).

**July 2010**

Government publishes its NHS white paper Equity and Excellence: Liberating the NHS. This proposes handing sweeping powers to GPs in a major shake-up of the NHS. The radical proposals include the abolition of primary care trusts and the establishment of new consortiums, led by GPs, to manage NHS commissioning budgets (*BMJ* 2010;341:c3796).

### 2011

**January 2011**

Department of Health publishes the Health and Social Care Bill, outlining its vision for healthcare. An accompanying impact assessment identifies potential conflicts of interest as a key risk associated with the proposed changes (*BMJ* 2011;342:d507).

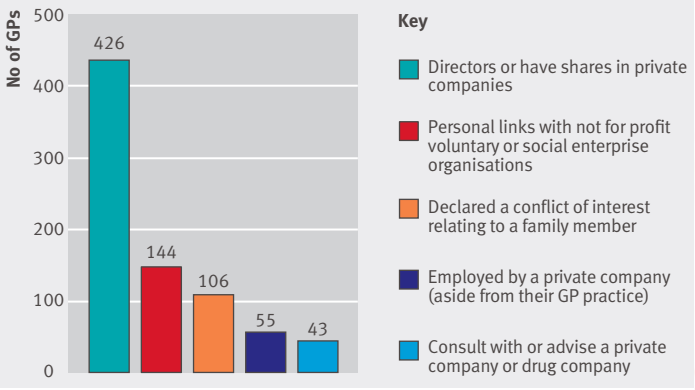
**April 2011**

Government announces "pause" in the passage of the Health and Social Care Bill, prompted by concerns from the Liberal Democrats, the Labour Party, and the medical profession. Steve Field, former RCGP chairman (below), is put in charge of the Future Forum set up to hear such concerns during the pause (*BMJ* 2011;342:d2216).

**June 2011**

After the listening exercise conducted during the "pause" the government announces that the GP consortiums will be renamed clinical commissioning groups (CCGs) to reflect the wider clinical involvement beyond GPs. It says that each CCG must have at least two other clinicians on its governing body, including at least one secondary care specialist doctor (*BMJ* 2011;342:d3777).

**Types of interests registered by GPs on CCG boards**





The NHS Commissioning Board has issued rules to CCGs stating that board members must remove themselves from decisions from which they could materially benefit.[4]

Some CCGs have responded to this by including a provision to co-opt additional members if doctors on the governing body have to remove themselves from decisions. Others have increased the number of lay members on boards to try to alleviate potential conflicts.

But doctors' leaders have expressed concern that clinical input into commissioning decisions might become diluted if too many doctors were forced to remove themselves from particular decisions.

### CCGs with notable conflicts

Governing bodies with notable conflicts include NHS Leicester City CCG, where seven GPs on the board have a financial interest in the LLR (Leicester, Leicestershire and Rutland) GP Provider Company; NHS Oldham CCG, where five of the eight GPs have an interest in the provider Primary Care Oldham LLP; and NHS Blackpool CCG, where six of the eight GPs have an interest in the local out of hours provider Fylde Coast Medical Services.

In NHS Chiltern CCG, in Buckinghamshire, two of the three GPs on the governing body hold shares in the for-profit provider Chiltern Health, while in NHS Aylesbury Vale CCG, also in Buckinghamshire, both GP voting members of the board have interests in the private provider Vale Health. In NHS Southwark CCG, in London, five of nine GPs on the governing body have a stake in various for-profit provider companies.

All these CCGs told the *BMJ* that they had robust systems in place for managing potential conflicts, including publishing their policies on conflicts of interest and regularly updating members' declarations of interest.

Amanda Doyle, a GP and chief clinical officer at NHS Blackpool CCG, told the *BMJ* that her CCG had sought to tackle potential conflicts by opting to double the number of lay members on its governing body from the minimum set by the government, including a lay chairperson (box).

Doyle acknowledged that most of the GPs on the board would have to "step away" if the local out of hours service were to be retendered. But she warned that the benefits of having doctors leading commissioning might be lost if conflicts of interest gained too much attention.

Ian Wilkinson, a GP and chief clinical officer at NHS Oldham CCG, who does not have a financial stake in a private provider company, said that the CCG's board had also recruited additional lay and clinical members to ensure that decisions could be made if members needed to remove themselves. He added that so far no voting members had removed themselves from governing body or committee proceedings.

Richard Gibbs, a lay board member at NHS Southwark CCG, told the *BMJ* that his CCG had attempted to deal with conflicts by appointing him as a "guardian" who would judge when it might be appropriate for members to remove themselves from decisions (box).

A spokeswoman for Leicester City CCG said that a significant proportion of its local general practices were members of the LLR GP Provider Company and said that it would co-opt members from neighbouring CCGs if its governing body were conflicted. She said, "They have to remain neutral, so we would bring in members from our fellow CCGs—East Leicestershire and Rutland/West Leicestershire—or bring in a GP member from a neighbouring county such as Northamptonshire."

## 2012

**September 2011**

RCGP and NHS Confederation, the membership body for organisations that commission and provide NHS services, publish joint guidance on "managing conflicts of interest in clinical commissioning groups" (BMJ Careers, http://bit.ly/W7y9wK).

**February 2012**

House of Lords agrees amendments to the Health and Social Care Bill stating that CCGs would have to publish registers of board members' interests (http://bit.ly/ wqDqVP).

**June 2012**

NHS Commissioning Board Authority publishes a code of conduct. This states that members must remove themselves from decisions from which they could materially benefit

**October 2012**

The private sector company Virgin Care, owned by Richard Branson (top right), announces plans to dissolve its joint venture provider partnerships

with GPs, in response to concerns from GPs over conflicts of interest in the new commissioning landscape (*BMJ* 2012;345:e7227).

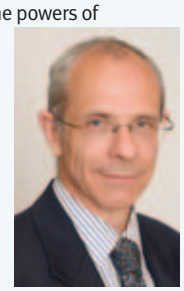
**November 2012**

NHS Commissioning Board rejects a call from GP commissioning leaders for conflicts of interest to be treated with leniency (*BMJ* 2012;345:e7967).

## 2013

**February 2013**

In its response to its consultation "Securing the Best Value for Patients," health department says that it will strengthen the powers of Monitor, headed by David Bennett (right), to act where conflicts "may affect the integrity of a commissioner's decision."



A spokesman for NHS Chiltern CCG said that the group had co-opted additional members to a decision making panel for the recent procurement of a GP led minor illness and injury unit where there was "potential for perceived conflict of interest," while NHS Aylesbury Vale CCG said that it had written the ability to co-opt members into its constitution.

### Declaring an interest "not enough"

However, despite the measures being taken, James Kingsland, the government's national clinical lead for NHS clinical commissioning and a GP on Merseyside, said that he believed some doctors on local commissioning boards should step down from one of their roles if they had a substantial stake in a local private healthcare company, because their conflicts were too acute.

He said, "If it is somebody who has got a major stake in some of the provider services which the CCG commissions, I don't think excluding [himself or herself] or declaring an interest is enough—not for the public. I think they have got to step down."

Kingsland said that his stance had been criticised by some doctors, who were concerned that forcing people to step down could lead to a shortage of clinicians willing to sit on CCG boards.

But he said, "That isn't an excuse to allow conflict to go. If they are enthusiasts as both senior provider and senior commissioner, my answer would be: make your choice and be accountable for that choice.

"If you can justify a marginal amount of conflict that can be declared and managed, then fine. If you can't marginalise a conflict, and you are excluding yourself from the board week in, week out because you've got an interest, ultimately it becomes unaccountable. Where you draw the line is difficult; if somebody is going to be the arbiter of that, it should be the public."

### The "local newspaper test"

Michael Dixon, chairman of the NHS Alliance, which represents organisations and individual professionals in primary care, has previously called for "more leniency" in handling conflicts of interest in the new system.[5] He warned that placing too much emphasis on the issue might prevent clinical commissioners from bringing more care into community settings.

He said, "The priority is to move services out of hospital and into primary care. The reason this hasn't happened to date is because of blocks in the system. It's more important to remove those blocks than be preoccupied with conflicts of interest. Dixon said that he believed that "transparency is all you need" to handle conflicts and urged doctors to use "the local newspaper test" when assessing their own interests: "You have got to be happy for everything you do as a GP and a commissioner to appear on the front page."

Chaand Nagpaul, the BMA's lead GP negotiator on commissioning and a GP in Harrow, called for the NHS Commissioning Board to issue more robust guidance on handling conflicts.

"The Commissioning Board's guidance has not gone far enough. Their guidance is all about declaring and managing conflicts, rather than recognising that some conflicts of interest are too great," he said.

Nagpaul said that he supported the idea of CCGs co-opting additional members to help make decisions where conflicts existed, but he said that it was crucial that this extra help did not just focus on lay members, as it could "dilute" clinical commissioning.

"It would undermine the whole concept of clinically led commissioning to not have clinical input," he warned.

A spokeswoman for the NHS Commissioning Board said that it had already published "comprehensive guidance" on managing conflicts of interest, which "clearly sets out that the decision on whether an individual's conflicts of interest are likely to be so great as to preclude them from taking a role on the governing body should be made by the CCG."

But she said that the board was reviewing its existing guidance and would shortly be publishing "final, comprehensive guidance on managing conflict of interest."

### Strengthening the rules

The Department of Health acknowledged in its response to its consultation "Securing the Best Value for Patients" that concerns about conflicts needed to be answered, and it pledged to strengthen the power of the healthcare regulator Monitor to act where conflicts "may affect the integrity of a commissioner's decision."[6]

The department said that this would mean that "Monitor is able to take action where conflicts have not been managed appropriately in awarding a contract, and not only where Monitor is able to establish that the decision to award a contract was the result of an interest in the provider."

Niall Dickson, chief executive of the General Medical Council, said that there were "no new principles involved" as far as doctors' ethical conduct was concerned. He added, "The considerable additional responsibilities about to be undertaken by GPs does mean that some face conflicts of interests more often than in the past. We expect doctors to be open about any financial and commercial interests linked to their work."

Cite this as: *BMJ* 2013;346:f1569

## TACKLING THE ISSUE OF CONFLICTS OF INTEREST

### NHS Blackpool CCG

Amanda Doyle, chief clinical officer at NHS Blackpool CCG, who has declared an interest in the local provider of out of hours services, said that her CCG had sought to deal with potential conflicts by opting to have four lay members on its governing body—double the minimum set by the government—including a lay chairperson.

"We were very conscious of the need to demonstrate that we were not letting conflicts interfere with our decisions," she explained.

But Doyle added that it was important to strike a "balance" between managing conflicts appropriately and "ensuring that we get a full range of clinical input into service redesign and commissioning decisions."

She warned, "There is a risk of getting so tied up with worrying about conflicts of interest that you don't go ahead and reap the benefits of having clinicians leading commissioning."

Doyle acknowledged that most GPs on the board would have to step away if the local out of hours service were to be retendered. She said that it was "unlikely" that the board would co-opt additional clinicians onto the board in such a case but said that it may take "clinical input and advice" from outside the area if this was needed.

### NHS Southwark CCG

Richard Gibbs, lay member of the board of the NHS Southwark CCG, said that his group had tried to tackle potential conflicts by appointing him as a "guardian"—with the remit of exercising judgment on when it might be appropriate for members to remove themselves from decisions.

Gibbs, who has no financial interests in any private providers, said that the CCG had also set up a three person evaluation panel, comprising himself, the chief officer, and the director of public health, to arbitrate on commissioning decisions where two or more members have to remove themselves from decisions because of conflicts.

"We have convened the panel on three or four occasions," Gibbs said. "If we needed to get additional expertise then we would co-opt in someone who isn't conflicted, presumably from outside Southwark."