

DECLARE INTERESTS. MANAGE CONFLICTS. PROTECT THE NHS.

**How well are conflicts of interest managed
in local NHS commissioning in England?**



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EXECUTIVE SUMMARY

This report looks at how changes to the NHS in England over the past decade have created greater risks of abuses of power, and how reforms to local commissioning are exacerbating them. Since 2012, membership organisations made up of General Practitioners (GPs), called Clinical Commissioning Groups (CCGs), have managed most of the NHS' budget in England. They are responsible for purchasing £78 billion of healthcare services on behalf of the NHS. At the same time, these same GPs are independent contractors to the NHS and are in receipt of around £8.5 billion of NHS funding each year.

Because CCG governing boards comprise commissioners and contractors of health services, obvious conflicts of interest can arise. If not managed properly, this can result in the misuse of public money for private benefit at the expense of patients and taxpayers. As with any public body, these organisations should have measures in place to protect against the risks of impropriety. Specifically, they should have:

- transparent and effective management of any potential conflicts of interest held by senior officials
- clear governance arrangements

These core protective measures aim to prevent abuses of power for private gain and to ensure that decisions about healthcare services are taken in the best interests of patients and taxpayers.

This report looks at the potential scale of conflicts of interest within local NHS commissioning organisations in England, and how these organisations protect against their abuse. It covers CCGs and their emerging successor bodies that are taking over the co-ordination of local NHS services – Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs).



FINDINGS AND RECOMMENDATIONS

FINDING 1

Local NHS Clinical Commissioning Groups, which control most of the NHS budget in England, have inherent conflicts of interest that would not be tolerated in any other part of the public sector.

Initially, because of the potential for conflicts of interest, CCGs were prevented from commissioning healthcare services from their own GP members. However, in 2015, the UK Government relaxed these rules and it is now the case that most CCGs have contracts for primary care with their own CCG members. When it introduced this policy, the Department of Health was aware that there was 'potential for significant conflicts of interest'.¹ We investigated the scale and nature of these conflicts of interest.

We reviewed the published accounts of 150 CCGs, and found that in 2018-19 alone, around £1.5 billion of public money was paid to companies partly or wholly owned by members of the CCGs' own board. We did not investigate whether any of these payments were inappropriate; however, they reveal the sheer scale of public money implicated in conflicted decision-making.

There are some protective measures in place to deal with this risk. The law requires CCGs to publish and monitor conflicts of interest, and statutory guidance requires them to have in place institutional arrangements to mitigate these risks. CCGs publish conflicts of interest registers regularly and there is no evidence to suggest that CCGs are not adhering to their various conflicts of interest policies. However, given the scale of the money involved in conflicted decision-making, with GPs effectively contracting with themselves, there are serious questions as to whether these existing governance arrangements are sufficient to prevent abuses of power.

RECOMMENDATION 1

Prohibit CCGs from purchasing healthcare services from their own board members.

Those responsible for spending public money on healthcare should not also be involved in providing those services. Whilst we recognise that this will require legislative change, the risks with the current institutional arrangements are so significant that they warrant a new legal architecture for the NHS.

FINDING 2

The new institutional arrangements for healthcare services at local and regional level lack basic governance arrangements.

Whilst CCGs remain the bodies with powers to commission healthcare services and contract with providers, since 2016, responsibility for arranging healthcare services for local populations has been moving to new organisations. These are called Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). Although they are not statutory bodies, STPs and ICSs have the important role of transforming healthcare in their areas.

Despite the importance of these new organisations, we found that in many cases, few have any formal governance arrangements in place. Our research in November 2020 found that out of the 44 STPs and ICSs, 18 (40 per cent) did not publish really basic information about their governance arrangements; for example the names of the members of their senior leadership team, a constitution setting out the terms of the partnership/care system, or a diagram outlining where responsibility and accountability lie. Twenty-eight (60 per cent) did not publish any minutes of board meetings over the last year, whilst only one (2 per cent) made registers of interests held by senior members of the STP/ICS readily available online. Even an official list of ICSs is not available from NHS England. When we contacted NHS England for this information, it said it had not yet identified them formally in its reference data.

Given that these new bodies will ultimately each have responsibility for populations of between 1 and 3 million people, and for managing collective financial resources running into billions of pounds a year, the lack of transparency, formal institutional arrangements and safeguards is a significant governance issue.

Despite the importance of these new organisations, we found that in many cases, few have any formal governance arrangements in place.

¹ National Audit Office, *Managing Conflicts of Interest in NHS Clinical Commissioning Groups*, London, National Audit Office (NAO), 2015, <https://www.nao.org.uk/wp-content/uploads/2015/09/Managing-conflicts-of-interest-in-NHS-clinical-commissioning-groups.pdf>, (accessed 2 October 2020).

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✓ RECOMMENDATION 2

Define new local NHS structures in law.

The new, informal institutional arrangements for the local NHS, which gives substantial powers to ICSs and STPs, should be put on a statutory footing so that the law provides clear and transparent governance arrangements.

These should include measures to reduce and prevent the abuse of conflicts of interest, and protect against undue influence. As with our recommendation for CCGs, there should be no possibility that those involved in commissioning services should also be involved in providing them.

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MILLION
PEOPLE



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BILLIONS OF POUNDS

a year, the lack of transparency, formal institutional arrangements and safeguards is a significant governance issue.

✓ RECOMMENDATION 3

Improve the quality of information about ICS and STP governance.

Whilst our proposals above require statutory change, there are measures that ICSs and STPs can introduce beforehand to improve transparency and accountability over their arrangements. As a minimum, they should provide key governance documents on their websites, including the details of:

- board members
- senior management
- board meetings and minutes
- potential conflicts of interest held by board members and senior management
- a constitution or terms of reference for the ICS/STP showing the organisations involved and the division of responsibilities and accountabilities within the ICS/STP

INTRODUCTION

All healthcare systems are at risk of fraud and corruption. The US healthcare system is the most frequently cited example, where an estimated \$272 billion is lost each year to fraud, and where financial incentives often drive decisions about patient care.²

Arguably, the risks faced by the NHS from abuse of this kind are much lower because, until recently, opportunities for private healthcare companies to benefit financially from providing services were limited in the UK. For most of the past 70 years, healthcare services in the UK have been funded out of taxation and delivered by state organisations and public-sector employees. The lack of opportunities to profit from healthcare over this period insulated the UK healthcare system from the types of corporate influence and abuses of power experienced in other jurisdictions.

However, the relationship between the state, private companies and the provision of healthcare has changed significantly in England because of government policy from the early 2000s onwards, when Labour administrations opened up the provision of NHS-funded services to private companies.³ This trend towards greater private-sector involvement in the English NHS expanded under the Health and Social Care Act 2012 (the '2012 Act'), which explicitly sought to turn NHS healthcare provision into a regulated market and to provide greater opportunities for private companies to deliver state-funded services.

Because of this legislation, the total amount spent on private companies within the NHS has increased by 23 per cent (£5.6 billion) in the six years since the 2012 Act came into force, and private healthcare companies now provide a growing number of state-funded care services.⁴ For example, almost one in three NHS-funded hip replacement operations in the UK are now provided by the private sector, an arrangement that would not have occurred before the 2012 Act, when almost all of this type of healthcare would have been delivered in NHS hospitals.⁵

These new opportunities for private providers to generate significant amounts of revenue from the provision of state-funded healthcare services have increased risks to the integrity of the English NHS. Indeed, as documented by the Centre for Health and the Public Interest (CHPI), the creation of a new market in healthcare services has seen some of the same companies engaged in fraudulent activity in the US granted contracts to provide services in the NHS.⁶ There is also substantial evidence that private hospital companies in the UK are using financial incentives to win business from medical consultants, for example by offering share-ownership schemes and lucrative hospitality packages to influence NHS employees.⁷

² Donald M. Berwick and Andrew D. Hackbarth, 'Eliminating Waste in US Health Care', *Journal of the American Medical Association*, vol. 307, no. 14, 11 April 2012, <https://jamanetwork.com/journals/jama/article-abstract/1148376>, (accessed 2 October 2020).

³ Allyson M. Pollock, NHS PLC: *The Privatisation of Our Healthcare*, London and New York, Verso, 2004.

⁴ David Rowland, 'Flawed data? Why NHS spending on the independent sector may actually be much more than 7%', *LSE Policy and Politics Blog* [web blog], 1 October 2019, <https://blogs.lse.ac.uk/politicsandpolicy/nhs-spending-on-the-independent-sector>, (accessed 2 October 2020).

⁵ George Stoye, 'Recent trends in independent sector provision of NHS-funded elective hospital care in England', *Briefing note*, 22 November 2019, <https://www.ifs.org.uk/publications/14593>, (accessed 2 October 2020).

⁶ Mark Button and Colin Leys, *Healthcare Fraud in the New NHS Market: A Threat to Patient Care*, London, Centre for Health and the Public Interest (CHPI), 2013, <https://chpi.org.uk/wp-content/uploads/2012/06/CHPI-Healthcare-Fraud-a-threat-to-patient-care1.pdf>, (accessed 2 October 2020).

⁷ David Rowland, *Pounds for Patients? How Private Hospitals Use Financial Incentives to Win the Business of Medical Consultants*, London, CHPI, 2019, <https://chpi.org.uk/wp-content/uploads/2019/06/FINAL-REPORT-POUNDS-4-PATIENTS-070619.pdf>, (accessed 2 October 2020).

At the heart of these changes is a tension between the interests of patients and those of private companies, whose directors are obliged legally to promote their success.⁸ Patients desire good treatment and the best care they can secure, whilst private companies' primary motivation is the pursuit of profit. These interests are not always in harmony.

The supposed trade-off for introducing greater market forces into the NHS is increased efficiency. Yet this requires proper governance structures to impose limits to protect the public good. Without them, there arises the risk that those providing care put profit before patients. This report examines how the 2012 Act amplified these conflicts of interest, and how they are changing with the introduction of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs).

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Legislative and policy context

In England, there is no healthcare-specific legislative or regulatory framework for protecting against conflicts of interest and abuse of office in healthcare services. Instead, the NHS in England relies on laws and policies that apply across the public sector and wider society. For example, the Bribery Act 2010 criminalises giving, soliciting or accepting inducements to impropriety in public office.⁹ The Fraud Act 2006 criminalises a broad range of activity, including making false representations and abuse of office.¹⁰ And the contracting regulations require safeguards to protect the public purse from rigged procurement and misuse of public funds.¹¹

Government departments and public-sector bodies are also expected to uphold the seven principles of public life (the 'Nolan Principles') – the ethical standards for holders of public office developed by the Committee on Standards in Public Life (CSPL).¹² Although they are not legally enforceable, the Nolan Principles set expectations

as to what constitutes good governance within public bodies, such as ensuring that:

- conflicts of interest held by those in positions of power are declared and published
- decision-making is carried out openly and transparently
- appointments to public bodies are fair and transparent in order to protect against cronyism

Because many of the more common types of protective measure are voluntary and not legally enforceable, the extent to which they exist at different levels within the English NHS is unclear. This makes it difficult to assess how well the NHS is protected against potential risks to the integrity of its decision-making.

For the purposes of this report, we examined whether the following three core protective measures are in place in local NHS commissioning by examining the:

- nature and value of related party transactions between officials based in NHS bodies and private organisations
- existence of transparent governance arrangements relating to NHS bodies
- publication and availability of conflicts of interest registers

Whilst acknowledging that it is beyond the scope of this report to make any definitive assessment of the susceptibility of the NHS as a whole to undue influence, nor to identify any clear instances of corruption or fraud, we have sought to highlight where there is cause for concern.

Background

The 2012 Act established Clinical Commissioning Groups (CCGs). They have legal responsibility for purchasing healthcare services for their local populations from a market of different healthcare providers. Providers in this market include NHS trusts, private companies, charities and voluntary organisations. Under NHS procurement regulations, it is a legal requirement for CCGs to put services out to competitive tender¹³ unless only one provider delivers that service.¹⁴

⁸ Companies Act 2006, <https://www.legislation.gov.uk/ukpga/2006/46/section/172>, (accessed 21 October 2020).

⁹ Bribery Act 2010, <https://www.legislation.gov.uk/ukpga/2010/23/crossheading/general-bribery-offences>, (accessed 21 October 2020).

¹⁰ Fraud Act 2006, <https://www.legislation.gov.uk/ukpga/2006/35/contents>, (accessed 21 October 2020).

¹¹ The Public Contracts Regulations 2015, <http://www.legislation.gov.uk/uksi/2015/102/contents/made>, (accessed 2 October 2020).

¹² Committee on Standards in Public Life, *The Seven Principles of Public Life*, London, Committee on Standards in Public Life, 1995, <https://www.gov.uk/government/publications/the-7-principles-of-public-life>, (accessed 2 October 2020).

¹³ *The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*, Regulation 4, <https://www.legislation.gov.uk/uksi/2013/500/contents/made>, (accessed 2 October 2020).

¹⁴ *The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*, Regulation 5.

In 2019-20, a total of 192 CCGs were allocated £78.4 billion to purchase healthcare services, which is around 60 per cent of the total NHS budget in England.¹⁵ Whilst one might assume that CCGs purchase almost all of the healthcare services for their local populations from NHS hospitals and other NHS provider organisations, this is not the case. There are in fact a large number of private businesses and charities with a financial interest in the procurement decisions made by CCGs.

A review of the accounts of CCGs for the financial year 2018-19 shows that the average proportion of a CCG budget spent on non-NHS providers – excluding GP – was 15 per cent, which amounts to £12 billion in total. However, for some CCGs, expenditure on non-NHS providers is more substantial. In 30 of the 185 CCGs for which we were able to identify data, over 20 per cent of their annual expenditure was on healthcare from non-NHS providers (see Table 1).

This demonstrates that CCGs are operating within a complex market involving an array of different financial interests belonging to companies and charities that are seeking to win contracts from them to provide healthcare services. One review of the role of the contracts held by CCGs in 2014 found that these commissioning bodies in total held around 15,000 contracts with private-sector organisations.¹⁶ Because of the roles that CCGs have in purchasing healthcare services, they are required to demonstrate that the decisions they take are in line with the principles set out in the NHS procurement regulations, namely to act transparently and proportionately, and to treat providers equally and in a non-discriminatory way.¹⁷

CCGs are at risk of legal challenge to their decisions, sometimes from powerful players in the healthcare services market.

CCGs are at risk of legal challenge from these financial interests if they do not take decisions that are fair and proportionate. Consequently, when CCGs take a procurement decision to choose one organisation or company over another, they are at risk of legal action by the companies or organisations that lose out. For example, in 2017, Virgin Care took legal action against Guildford and Waverley CCG following the decision by the CCG and five other CCGs to award the contract to

a competitor. Basing its case on what it described as 'serious flaws in the procurement process', Virgin Care reportedly received an undisclosed sum in an out-of-court settlement.¹⁸ Similarly, in 2019, private healthcare company Circle sued Rushcliffe CCG, again on the basis of a flawed procurement process, in relation to a contract for the provision of non-emergency services at Nottingham Treatment Centre.¹⁹

Given the number and value of contracts managed by CCGs, and the risk of legal challenge, it is therefore critical that strong safeguards are in place to ensure that decisions are made in the best interests of patients, and that CCGs are free from conflicts of interest and undue influence.

Table 1: 10 CCGs with the highest level of expenditure on non-NHS services.²⁰

CCG from 2018-19 accounts	% of budget spent on non-NHS providers (excluding GPs)
NHS East Staffordshire CCG*	33
NHS Nottingham City CCG	27
NHS Bath and North East Somerset CCG	26
NHS Mid Essex CCG	26
NHS North East Lincolnshire CCG	24
NHS Rushcliffe CCG	23
NHS Northern, Eastern and Western Devon CCG ²¹	23
NHS Bristol, North Somerset and South Gloucestershire CCG	23
NHS Greater Huddersfield CCG	22
NHS Hull CCG	22

Source: Review of 185 CCG annual reports and accounts 2018/19
* data only available for financial year 2017-18

¹⁵ House of Commons Library, 'NHS Funding Allocations: Clinical Commissioning Groups', *Briefing paper*, no. 8836, 4 September 2019, <https://researchbriefings.files.parliament.uk/documents/CBP-8399/CBP-8399.pdf>, (accessed 2 October 2020).

¹⁶ CHPI, *The Contracting NHS: Can the NHS Handle the Outsourcing of Clinical Services?*, London, CHPI, <https://chpi.org.uk/wp-content/uploads/2015/04/CHPI-ContractingNHS-Mar-final.pdf>, (accessed 2 October 2020).

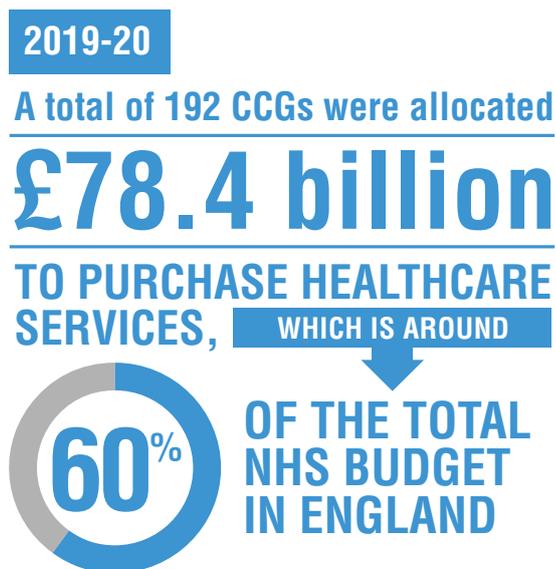
¹⁷ *The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*, Regulation 3.

¹⁸ Esther Oxford, 'Virgin Care starts legal proceedings against NHS', *Health Service Journal*, 13 March 2017, <https://www.hsj.co.uk/legal/virgin-care-starts-legal-proceedings-against-nhs/7016425.article>, (accessed 13 January 2021).

¹⁹ Nick Carding, 'CCG in legal battle with Circle over £320m contract', *Health Service Journal*, 1 May 2019, <https://www.hsj.co.uk/finance-and-efficiency/ccg-in-legal-battle-with-circle-over-320m-contract/7024975.article>, (accessed 13 January 2021).

²⁰ We reviewed the annual reports and accounts of all CCGs using the list published by NHS England for 2018-19. From this list, we were able to identify data in the accounts relating to expenditure on non-NHS services for 185 CCGs. In some cases, the data was not included in the accounts, or the accounts were not available at the time of our review.

²¹ This is now part of NHS Devon CCG, formed from NHS Northern, Eastern and Western Devon CCG and NHS South Devon and Torbay CCG.



Conflicts of interest are built into the institutional architecture of CCGs.

One of the acknowledged risks with these local purchasing arrangements is that conflicts of interest are inherent in the institutional framework of CCGs. Unlike other parts of the NHS or the public sector, decision-makers within CCGs are GPs who are themselves independent contractors to the NHS, and who provide healthcare services to their local populations. In short, the commissioners are also contractors, in some circumstances, with themselves.

Initially, CCGs were not permitted to directly commission primary care services (the services that GPs provide). Instead, NHS England undertook this function as a central commissioning body. However, following a change of policy from NHS England in 2015, CCGs were permitted to commission all GP-led primary care services under what was known as ‘delegated commissioning’ arrangements.²² This change allowed GPs to arrange contracts with the practices and businesses where they worked or of which they were shareholders and partners. Because of these changes, a significant proportion of CCG annual expenditure now goes on purchasing

primary care services from the CCGs’ own membership (an estimated 10 per cent of their total budget, or around £8.5 billion overall).²³

Measures have been put in place to protect the integrity of local decision-making.

The National Audit Office (NAO) noted that under these new arrangements, ‘it is increasingly likely that sometimes all GPs on a decision-making body could have a material interest in a decision.’²⁴ Although the Department of Health has recognised that delegating primary care services to CCGs in this way ‘increased the potential for significant conflicts of interest’,²⁵ it felt that the expected benefits of clinically led commissioning outweighed the risks, and that CCGs could ‘manage the risks.’²⁶

As a result of these in-built institutional conflicts, a number of protective measures have been put in place by the government and NHS England to ensure the integrity of local commissioning arrangements. First, the 2012 Act imposes a legal duty on CCGs to manage conflicts of interest,²⁷ and under the regulations created by the 2012 Act they are required by law to publish on their websites details of procurement decisions, including how they manage conflicts of interest.²⁸ In addition, revised statutory guidance published by NHS England in 2017 requires that CCGs publish conflicts of interest registers for all decision-making staff; appoint a conflicts of interest guardian; and establish a dedicated primary care commissioning committee. Where CCGs undertake joint or delegated commissioning responsibilities for primary care services, the statutory guidance states that their audit committee chair and accountable officer must provide direct, formal attestation to NHS England that the CCG has complied with this guidance.²⁹

The NAO noted in its 2015 review of the conflicts of interest arrangements by CCGs that while almost all CCGs had published their conflicts of interest registers as required, there was little evidence that NHS England was monitoring the extent to which there had been breaches of the guidance or instances where conflicts of interests had caused problems.³⁰

²² NHS England, *Next Steps towards Primary Care Co-commissioning*, London, NHS England, 2014, <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf>, (accessed 2 October 2020).

²³ Department of Health and Social Care, *DHSC Annual Report and Accounts 2018 to 2019* (For the period ended 31 March 2019), HC2344, London, Department for Health and Social Care (DHSC), <https://www.gov.uk/government/publications/dhsc-annual-report-and-accounts-2018-to-2019>, (accessed 2 October 2020). The 10 per cent figure is based on an analysis of the expenditure by a random sample of 20 CCGs on primary care services as stated in their annual reports and accounts. Although the vast majority of CCGs are now commissioning primary care services under the delegated commissioning arrangements, this is not the case for all CCGs. As a result, not all of the £8.5 billion will be spent by CCGs on primary care services.

²⁴ *ibid.*

²⁵ National Audit Office, *Managing Conflicts of Interest in NHS Clinical Commissioning Groups*, London, National Audit Office (NAO), 2015, <https://www.nao.org.uk/wp-content/uploads/2015/09/Managing-conflicts-of-interest-in-NHS-clinical-commissioning-groups.pdf>, (accessed 2 October 2020).

²⁶ *ibid.*

²⁷ National Health Service Act 2006 (as amended), Section 140, <https://www.legislation.gov.uk/ukpga/2006/41/section/140>, (accessed 25 November 2020).

²⁸ *The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*, Regulation 9.

²⁹ NHS England, *Managing Conflicts of Interest: Revised Statutory Guidance for CCGs*, London, Strategy and Innovation Directorate, June 2017, <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf>, (accessed 2 October 2020).

³⁰ National Audit Office, *Managing Conflicts of Interest in NHS Clinical Commissioning Groups*, 2015.

QUANTIFYING THE FINANCIAL VALUE OF CONFLICTS OF INTEREST WITHIN CCGS

Above, we have seen how conflicts of interest are built into the way in which the NHS purchases services. This raises two questions:

- i is it practically possible for CCGs to manage these conflicts of interest effectively?
- ii is it desirable for CCGs to have to manage these risks, in addition to the challenges of commissioning healthcare services?

To help inform answers to these questions, we sought to quantify the value of these institutionalised conflicts of interest through examining the related party transactions set out in CCGs' annual reports and accounts.

A related party transaction refers to the transfer of resources, services or obligations between connected individuals or organisations, regardless of whether a price is charged.³¹ Related party transactions are included in annual accounts to ensure there is transparency about the relationship between organisations and any of their subsidiaries, including payments to organisations connected to their directors. This can help to identify and discourage insider fraud.

Public-sector bodies also include related party transactions in their accounts, in particular to highlight instances where members of the organisation or anyone related to them stand to benefit financially from any decision they make. Related party transactions carry inherent conflicts of interest that, if abused, could result in insider fraud.

The financial value of the conflicts of interest within CCGs is substantial.

We reviewed the accounts of 185 CCGs for the year 2018-19 and were able to identify 150 CCGs whose accounts included related party transactions involving the members of the governing body of the CCGs in question.³² We chose to focus on the governing body of CCGs rather than the CCG membership as a whole or any sub-committees. This is because the governing body is the ultimate decision-maker within the CCG. In total, across the 150 CCGs that we examined, we found £1.5 billion in related party transactions involving CCG governing body members. The average value of related party transactions for each CCG governing body was £11 million.

In total, across the 150 CCGs that we examined, we found £1.5 billion in related party transactions involving CCG governing body members.

The average number of declared conflicts of interest for each CCG is significant.

We also analysed a random sample of 20 CCG conflicts of interest registers to understand the number of these risks an average CCG may have to contend with. We found governing body members in these 20 CCGs had declared 819 conflicts of interest in total, an average of three conflicts of interest per governing body member and 40 per CCG.

Of these, 369 (45 per cent) of the conflicts declared were financial in nature, and 166 of these 369 (45 per cent) related to the member's role as a partner or employee in a GP practice that has a relationship with the CCG. Given the nature of the co-commissioning arrangements introduced in 2015, this is not surprising. Interestingly, the remaining (203) were for other types of conflicted financial interests, which included out-of-hours and community care contracts held by the CCG. We also found that numerous lay (public) board members were directors of health and care consultancy companies, presenting potential conflicts of interest.

There is no suggestion that any of the individual CCG members have benefited illegitimately from their involvement in CCGs – indeed, the fact that the financial relationship between the CCG and the CCG board member is transparent is an important protective measure against abuse. Nevertheless, given the large value of the financial conflicts we identified involving governing body members and the overall total number of conflicts held by board members, the potential for abuse and the risk of challenge by other contractors are substantial. It is also difficult to think of any other public-sector body charged with purchasing services using taxpayer funds where such a large amount of money is paid in related party transactions to those involved in decision-making.

³¹ International Accounting Standards Board (IASB), IAS 24 Related Party Disclosures, 2009.

³² Not all CCGs report related party transactions in the same way – most listed the payments to governing body members, whereas others listed payments to all members of the CCG. We have only included here payments between the CCG and its governing body members.



NEW MODELS OF CARE, NEW RISKS

The powers granted to CCGs to purchase primary care services under delegated commissioning arrangements came at a time when NHS England had begun encouraging GPs and other healthcare providers to form new types of service delivery organisations. The thinking behind this move was that having contracts with a number of providers to deliver different types of healthcare to a population – primary care, secondary care and community care – was inefficient and also contributed to the fragmentation of care provision for patients. There was also a strong view that the model of the individual GP practice was becoming financially unsustainable, and that a shift towards a more corporate structure would enable GPs to pool resources, including facilities and shared back-office functions such as IT services.

As a result, NHS England and the Department of Health and Social Care have begun to create a new market for the delivery of healthcare that involves much greater corporatisation of service provision. CCGs are now being encouraged to purchase care services from new types of organisations and businesses that focus on delivering ‘integrated care systems’. GPs are involved in many of these new types of services.

These so-called ‘new models of care’ were trialled across the country from 2016. One model was for delivery by a ‘multispecialty community provider’ organisation, a description that includes GPs, secondary care providers, NHS trusts and community-based organisations.³³ Under this model, it is intended that there will be one contract between the local CCG (or group of CCGs) and a single provider organisation.

As a result, the relationship between CCGs as the commissioners of healthcare services and GP-led provider organisations is becoming more complex, potentially increasing the risks of greater conflicts of interest in the decision-making of these bodies.

This shift in policy has led to entrepreneurial GPs forming new types of companies and to the development of GP federations and super practices. All of these are expected to take on new roles, either as direct contractors or as sub-contractors to other organisations.

In 2018, it became NHS England policy that all GPs within a particular area be required to create primary care networks – formal partnerships between all the GPs in a CCG area that will be responsible for delivering services back to the CCG of which they are also members.³⁴ Many of the related party transactions contained within CCG accounts relate to GP federations or alliances in which local GPs have formed companies and joint ventures in advance of this shift towards primary care networks.

As a result, the relationship between CCGs as the commissioners of healthcare services and GP-led provider organisations is becoming more complex, potentially increasing the risks of greater conflicts of interest in the decision-making of these bodies.

³³ NHS England, *New care models: The multispecialty community provider (MCP) emerging care model and contract framework*, July 2016, <https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwk.pdf>, (accessed 1 January 2021).

³⁴ NHS England, *Primary Care Networks* [website], <https://www.england.nhs.uk/primary-care/primary-care-networks>, (accessed 2 October 2020).



CASE STUDY: MODALITY PARTNERSHIP

The Modality Partnership is an example of a GP-led company created in order to maximise the opportunities presented by the provision of these new models of care.

Modality was formed in 2009 in Sandwell and West Birmingham. Its objective was to ‘improve core services, garner economies of scale and broaden the range of services offered in primary care’.^{35, 36} Since its foundation, Modality has expanded from the West Midlands into Yorkshire, Buckinghamshire, Oxfordshire, Berkshire and East Surrey, comprising more than 100 GP partners to become by 2018 a ‘large-scale primary care provider’.³⁷

According to the King’s Fund:

Modality’s ambition is to use general practice as the foundation for a new community-based health and care system, with primary care providing a single point of access into a broader range of integrated community, mental health and social care services. Its projects focus on moving care into the community and reducing A&E attendance and unplanned hospital admissions.³⁸

To support this, Modality has developed a range of specialist services, including urology, dermatology, rheumatology and radiography. Over time, it plans to increase substantially the range of primary-care-sited outpatient services delivered by the partnership to include cardiology, gastroenterology, pain management, gynaecology, ear, nose and throat (ENT), orthopaedics and ophthalmology.

In 2016, Modality was selected by NHS England as one of 14 ‘vanguard sites’ to lead the roll-out of a ‘new model of care’ in the West Birmingham region. This involved working with a range of other health and social care providers through what was known as the ‘connected for care partnership’.³⁹

It is not clear whether a formal contract existed between the CCG area (Sandwell and West Birmingham) in which the pilot was being rolled out and Modality, whether the service was formally put out to competitive tender, and how Modality was selected. Modality claim that the selection process was open to all and the Vanguard sites were chosen by 269 groups of healthcare professionals.

The founder of Modality Partnership, Nick Harding, was Chair of Sandwell and West Birmingham CCG between 2012 and 2019. During this period, he was also a GP partner with Modality during the time of this new care pilot, and senior Clinical Advisor to NHS England for ICSs. In response to our enquiries, Nick Harding’s current employer, Operose Health, said that he had declared all relevant conflict of interests in line with NHS rules. They also said that he was not involved in any CCG or NHS England decision-making process where a conflict of interest was identified.

In the period between 2015-16 and 2018-19, the related party transactions in the accounts of Sandwell and Birmingham CCG show that Modality received £24.5 million.

The shift from CCGs to Integrated Care Systems is leading to a new accountability gap in the commissioning of local healthcare services.

The new models of care described above are part of a general shift in policy and institutional arrangements away from the purchaser–provider split, which was the idea that lay at the heart of the 2012 Act. Under the purchaser–provider split, the purchaser (the CCG) would use

contractual mechanisms to purchase healthcare services from a range of providers who would be entities distinct from the CCG. The CCG would then hold the provider to account for their performance.

As we have shown above, over time, the distinction between those purchasing services and those providing them has become much less clear, and this purchaser–provider split is being abolished gradually. This is part of

³⁵ *ibid.*

³⁶ NHS England, *NHS Five Year Forward View*, London, NHS England, CQC, Public Health England, et al., 2014, <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>, (accessed 2 October 2020).

³⁷ Rebecca Thomas, ‘The Integrator: Integrated care providers, finally, make a breakthrough’, *Health Service Journal*, 2 August 2018, <https://www.hsj.co.uk/commissioning/the-integrator-integrated-care-providers-finally-make-a-breakthrough/7023066.article>, (accessed 13 January 2021).

³⁸ Ben Collins, *New care models: Emerging innovations in governance and organisational form*, London, King’s Fund, 2016, https://www.kingsfund.org.uk/sites/default/files/field/publication_file/New_care_models_Kings_Fund_Oct_2016.pdf, (accessed 2 October 2020).

³⁹ Judith Smith, Jo Ellins, Robin Miller, Laura Griffith, Hilary Brown, Rebecca Rosen and John Appleby, *An evaluation of new models of care in Sandwell and West Birmingham*, University of Birmingham, 2018, <https://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/research/projects/2017/an-evaluation-of-new-models-of-care-in-sandwell-and-west-birmingham.aspx>, (accessed 2 October 2020).

a trend to integrate care in different regions of England over the next few years through non-statutory ICSs. These organisations will make decisions about local healthcare services.

What has emerged from this policy shift is a highly complex and often difficult to comprehend set of institutional arrangements that lack a clear legal basis. This institutional complexity is itself a cause for concern, given the large amounts of public expenditure (£78 billion) on healthcare services at the local level. In addition, as we have shown above, the market for the provision of healthcare services at the local level is highly complex, with growing numbers of private and non-NHS providers seeking to win business and contracts to provide NHS services.

Following the political difficulties caused during the passage of the 2012 Act, successive governments have been reluctant to introduce new primary legislation that would lead to a further re-organisation of the health service. As a result, the UK Government has allowed the leadership of NHS England to re-organise substantially the NHS to bring about greater integration of care, but has provided no new legal framework to clarify roles and responsibilities.

ICSs began their lives as STPs, which were essentially forums for local authorities, CCGs and providers of services to 'plan services that are safer and more effective'.⁴⁰ STPs were intended to supplement rather than replace the accountability of other organisations, such as CCGs; however, it was acknowledged that all STPs needed a basic governance and implementation 'support chassis' to enable this type of effective working.⁴¹

ICSs will ultimately each have responsibility for system strategy and planning for a population of between one and three million people, and will also have responsibility for managing performance and 'collective financial resources'.⁴² In 2019, the NHS confirmed the aim that ICSs will cover every part of England by 2021.

Because STPs and ICSs are not legal entities created under statute, they do not have powers themselves to strike contracts with any other organisations or business.

Nor do they have any budget allocated to them to commission services. Instead, the legal basis on which these organisations will engage in a contract with a provider (or a number of providers) to deliver healthcare services will be through the powers vested in CCGs under the 2012 Act.

These arrangements significantly weaken the role of the individual CCG: power and decision-making regarding healthcare service delivery are shifting decisively to these new, non-statutory bodies. The number of CCGs was reduced from 191 to 135 in 2020, with the intention that there should eventually be one CCG for each ICS.^{43,44}

However, the procurement arrangements for ICSs will be substantially different from that seen in the original CCG model. Under ICSs, commissioners can award a single contract to a provider that is responsible for the integrated provision of general practice, wider NHS, and potentially local authority services.⁴⁵

If ICSs will oversee the procurement of significant amounts of NHS-funded healthcare services, it is important that, as for any public body, they comply with basic standards of transparency and openness. This is critical to help identify and mitigate any potential conflicts of interest held by those involved in making key decisions.

Sustainability and Transformation Partnerships and Integrated Care Systems opacity.

The CHPI has identified that the process for appointing chairs and chief executives for these new bodies does not comply with the standards expected of public appointments, as overseen by the Professional Standards Authority. There is no formal job description for the individuals undertaking these roles and there is no clear line of accountability in the event that they fail to perform in accordance with their duties.⁴⁶

We reviewed publicly available information to understand more about the governance arrangements for these organisations. In particular, we wanted to see whether they published at least:

- **A website** holding basic information about the STP/ICS, such as active contact details and their members.

⁴⁰ NHS England, *Next Steps on the NHS Five Year Forward View*, London, NHS England, 2017, <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>, (accessed 2 October 2020).

⁴¹ *ibid.*

⁴² NHS England, *Designing Integrated Care Systems (ICSs) in England*, London, NHS England, June 2019, <https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf>, (accessed 2 October 2020).

⁴³ Sharon Brennan, 'Revealed: The CCG map after new wave of mergers', *Health Service Journal*, February 2020, <https://www.hsj.co.uk/commissioning/revealed-the-ccg-map-after-new-wave-of-mergers/7026848.article>, (accessed 13 January 2021).

⁴⁴ NHS England, *Designing integrated care systems (ICSs) in England*, June 2019, <https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf>.

⁴⁵ NHS England, *Integrated Care Provider Contract* [website], <https://www.england.nhs.uk/integrated-care-provider-contract>, (accessed 2 October 2020).

⁴⁶ David Rowland, Freedom of Information Response: The Legal Status of Sustainability and Transformation Plans [sic] and the Appointments Process for the Leads and Chairs of STPs, London, CHPI, June 2019, <https://chpi.org.uk/resources/nhs-england-freedom-of-information-response-re-the-legal-status-of-sustainability-and-transformation-plans-and-the-appointments-process-for-the-leads-and-chairs-of-stps>, (accessed 2 October 2020).

- **Basic information about their governance structure**, such as the names of the members of the senior leadership team, a constitution setting out the terms of the partnership/care system, or a diagram outlining where responsibility and accountability lie.
- **Minutes of board meetings** from the last year, which show major decisions and issues under consideration by the bodies
- **Conflicts of interest registers** for senior leaders of the STP/ICS, to understand where private interests may clash with their public roles.

Initially, we tried contacting NHS England for an official list of STPs and ICSs. There is an official list of STPs, but NHS England has not yet differentiated between STPs and ICSs formally in its reference data. Instead, we used information on its website as of November 2020 to identify 44 STPs/ICSs. Table 2 provides the details of our findings.⁴⁷

Currently, only one STP/ICS does not have some form of working website (Somerset). However, many of the links provided on the NHS England website are now out of date and we used a search engine to find many of the STP/ICS websites. Ideally, members of the public should be able to navigate easily to a dedicated STP/ICS website, either via NHS England's website or a search engine.

Eighteen STPs/ICSs (40 per cent) did not publish really basic information about their governance arrangements, for example the names of the members of their senior leadership team, a constitution setting out the terms of the partnership/care system, or a diagram outlining where responsibility and accountability lie. We set a very low bar when assessing available documents, which in some cases was little more than biographies for the partnership/care system's board members, or a short description of how the STP/ICS works.⁴⁸ Others provided much more detail, including Memoranda of Understanding (MoUs) between members of the STP/ICS.⁴⁹

CCGs, their predecessor bodies, are required to provide and maintain a constitution that outlines their governance arrangements.⁵⁰ A similar legal requirement should apply to CCG's successors.

Twenty-eight (60 per cent) STPs/ICSs did not publish any minutes of board meetings over the last year. It is not clear whether this is because there were no board meetings, or that these meetings were taking place in private. Given that members of these groups are delivering a critical part of the COVID-19 public health response, it is hard to imagine that they were having no meetings of senior leaders during the last year. Making this information publicly available should be a routine part of STP/ICS governance.

Only one (2 per cent) made registers of interests held by senior members of the STP/ICS readily available online.⁵¹ This register was last updated in December 2019. Seven (16 per cent) included declarations of interest at board meetings, although these were often scant on detail. The remaining 36 (80 per cent) provided no information about potential conflicts of interest held by senior personnel at all. Such opacity over the interests held at senior levels of STPs/ICSs is deeply problematic because:

As with CCGs, there are significant opportunities for conflicts of interest to arise as NHS services will be commissioned from providers whose owners or representatives are part of the ICS board.

They have little, if any, formal governance structures to prevent these being abused.

From this year, the NHS leadership will give ICSs powers to decide how to spend billions of pounds of public money.

As a minimum, STPs/ICSs should include conflicts of interest policies within their governing documents, and publish relevant interests held by their senior personnel regularly.

Given the central role that these new bodies will play in shaping local healthcare provision and determining which providers will deliver potentially billions of pounds of healthcare services for their local populations, the lack of formal governance arrangements is a significant risk to the integrity of the health service.

⁴⁷ We note that the number of ICSs is changing constantly, with another 11 added in December 2020; NHS England, *NHS chief confirms 11 new integrated care systems serving 14 million people* [website], <https://www.england.nhs.uk/2020/12/nhs-chief-confirms-11-new-integrated-care-systems-serving-14-million-people/>, (accessed 16 December 2020).

⁴⁸ BLMK ICS, *Governance* [website], <https://www.blmkpartnership.co.uk/about/governance/>, (accessed 16 December 2020).

⁴⁹ Joined Up Care Derbyshire, *Our Governance* [website], <https://joinedupcarederbyshire.co.uk/about/our-governance>, (accessed 16 December 2020).

⁵⁰ National Health Service Act 2006 (as amended), Chapter A2, <https://www.legislation.gov.uk/ukpga/2006/41/part/2/chapter/A2>

⁵¹ Joined Up Care Derbyshire, *Our Board* [website], <https://joinedupcarederbyshire.co.uk/about/our-board>, (accessed 16 December 2020).

CONCLUSIONS

Under the Health and Social Care Act 2012, the policy intention is for the procurement of healthcare services by local public bodies (CCGs) to take place within a competitive marketplace. In this system, public bodies tender for services from a range of different care providers across the primary, secondary and community care sectors.

Because CCGs are membership organisations made up of GPs – who are also independent contractors within this competitive marketplace – there are conflicts of interest hardwired into the current commissioning system. This risks procurement decisions being taken in the financial interests of those making them, rather than in the best interests of patients and taxpayers.

The UK Government has recognised this risk and has put in place a number of protective measures (conflicts of interest policies and transparency requirements) designed to prevent abuses occurring. According to an NAO review in 2015, in most cases, CCGs adhere to these requirements.⁵² However, the financial value of the related party transactions between CCGs and the members of their governing bodies is so substantial that it is unclear whether any type of protective measures can fully mitigate the risks of those entrusted with these powers abusing it for private gain.

A further set of risks emerge from the fact that GPs are being encouraged to develop new organisations and businesses that will deliver services outside their traditional role in primary care, and to form partnerships with other providers (multi-care provider organisations). In an attempt to bring about greater integration, this shift removes the distinction between those commissioning and procuring services and those delivering them. Consequently, it is possible that GPs, as CCG members, will increasingly strike contracts with large organisations of which they are a part (either directly or indirectly). This also raises questions as to who will hold the providers of services to account if both the commissioner and the provider are the same.

More problematically, the new organisations NHS England is creating to bring this about are not legal entities and so are not subject to the same protective and accountability measures that apply to CCGs. The fact that it is not possible to identify even basic governance documents relating to some of these new bodies raises significant questions as to how they will prevent conflicts of interest from influencing their decision-making and how they can be held to account for their decisions.

⁵² National Audit Office, *Managing Conflicts of Interest in NHS Clinical Commissioning Groups*, 2015.

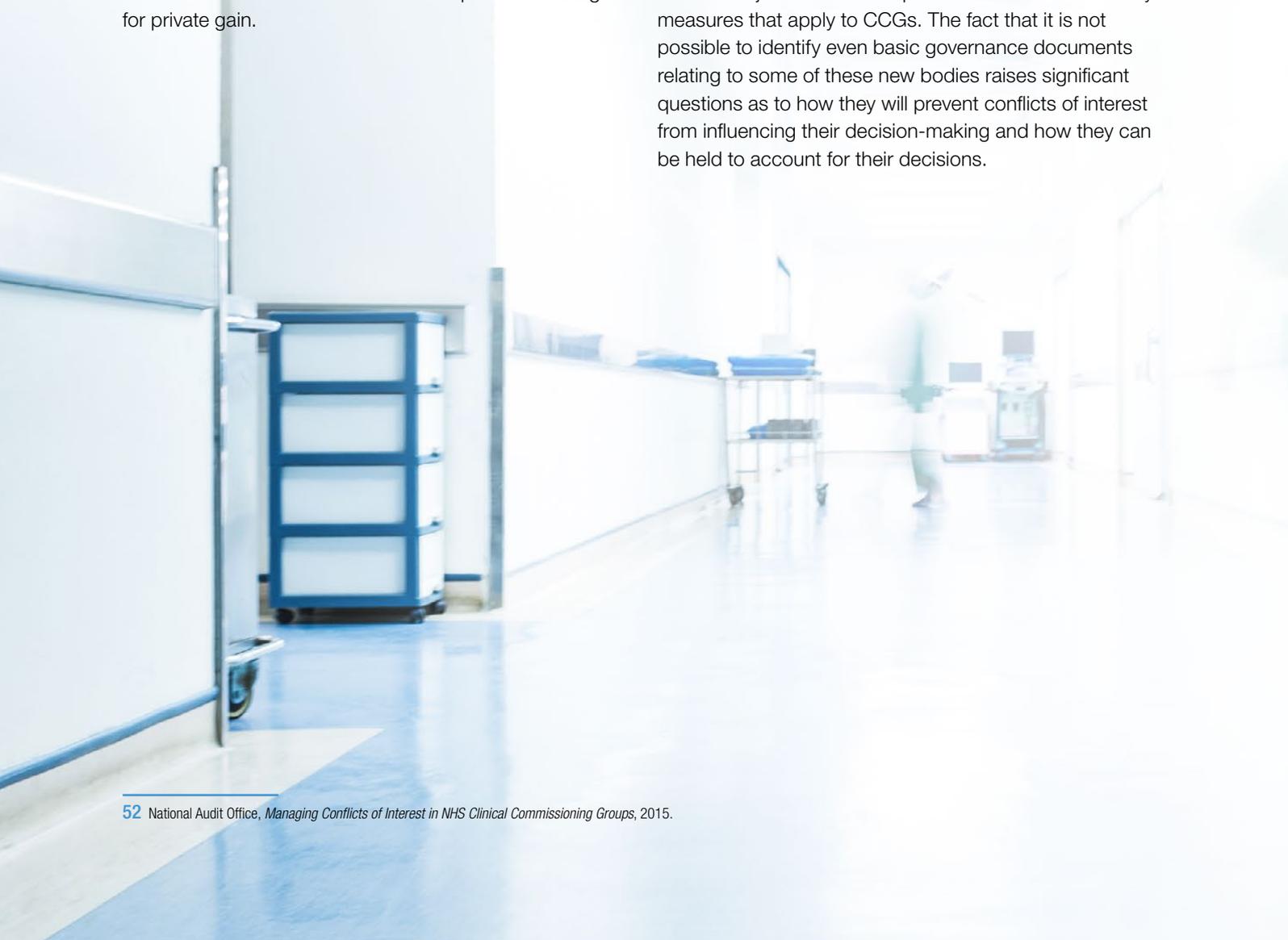


Table 2: Publicly available governance documents for Sustainability Transformation Partnerships / Integrated Care Systems.

No.	STP listed on NHS England website	Status ⁵³	ICS name	Website	Publication of governance arrangements	Publication of board meetings	Conflicts of interest register
1	Bath and North East Somerset, Swindon and Wiltshire			Yes	No	No ⁵⁴	No
2	Bedfordshire, Luton and Milton Keynes	ICS	Bedfordshire, Luton and Milton Keynes	Yes	Yes	Yes	No
3	Birmingham and Solihull			Yes	No	No	No
4	Bristol, North Somerset and South Gloucestershire			Yes	Yes	No	No
5	Buckinghamshire, Oxfordshire and Berkshire West	ICS	Buckinghamshire, Oxfordshire and Berkshire West	Yes	Yes	No	No
6	Cambridgeshire and Peterborough			Yes	No	Yes	No
7	Cheshire and Merseyside			Yes	Yes	No	No
8	Cornwall and the Isles of Scilly			Yes	Yes	Yes	No
9	Coventry and Warwickshire			Yes	No	Yes	No
10	Derbyshire			Yes	Yes	Yes	Yes
11	Devon			Yes	No	No	No
12	Dorset	ICS	Dorset	Yes	No	No	No
13	Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby	ICS	The North East and North Cumbria	Yes	Yes	Yes	No
14	East London			Yes	Yes	No	No
15	Frimley Health and Care	ICS	Frimley Health and Care	Yes	Yes	No	No
16	Gloucestershire	ICS	Gloucestershire	Yes	No	No	No
17	Greater Manchester	ICS	Greater Manchester (devolution deal)	Yes	Yes	Yes	No
18	Hampshire and the Isle of Wight			Yes	Yes	No	No
19	Herefordshire and Worcestershire			Yes	No	No	No
20	Hertfordshire and West Essex	ICS	Hertfordshire and West Essex	Yes	No	Yes	No
21	Humber, Coast and Vale	ICS	Humber, Coast and Vale	Yes	Yes	No	No
22	Kent and Medway			Yes	Yes	Yes	No

53 As of November 2020

54 Last board meeting minutes from over a year ago

16 Declare interests. Manage conflicts. Protect the NHS: How well are conflicts of interest managed in local NHS commissioning in England?

No.	STP listed on NHS England website	Status ⁵³	ICS name	Website	Publication of governance arrangements	Publication of board meetings	Conflicts of interest register
23	Lancashire and South Cumbria	ICS	Lancashire and South Cumbria	Yes	Yes	Yes	No
24	Leicester, Leicestershire and Rutland			Yes	Yes	No ⁵⁵	No
25	Lincolnshire			Yes	No	No	No
26	Mid and South Essex			Yes	No	No	No
27	Norfolk and Waveney			Yes	No	No	No
28	North Cumbria	ICS	The North East and North Cumbria				
29	North London			Yes	Yes	No	No
30	North West London			Yes	No	No	No
31	Northamptonshire			Yes	Yes	No	No
32	Northumberland, Tyne and Wear and North Durham	ICS	The North East and North Cumbria				
33	Nottinghamshire	ICS	Nottinghamshire	Yes	Yes	Yes	No
34	Shropshire, Telford & Wrekin			Yes	Yes	No	No
35	Somerset			No	No	No	No
36	South East London	ICS	South East London	Yes	Yes	Yes	No
37	South West London	ICS		Yes	No	No	No
38	South Yorkshire and Bassetlaw	ICS		Yes	No	No	No
39	Staffordshire and Stoke on Trent	ICS		Yes	Yes	No	No
40	Suffolk and North East Essex	ICS	Suffolk and North East Essex	Yes	No	No	No
41	Surrey Heartlands Health and Care Partnership	ICS	Surrey Heartlands (devolution deal)	Yes	Yes	No	No
42	Sussex and East Surrey	ICS	Sussex	Yes	No	No	No
43	The Black Country			Yes	No	No	No
44	West Yorkshire and Harrogate		West Yorkshire and Harrogate	Yes	Yes	Yes	No

⁵⁵ Last board meeting minutes from over a year ago

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