Optical Confederation
The voice of UK optics

LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

Managing Conflicts of Interest in the NHS: A Consultation – questions

Response from the Optical Confederation and the Local Optical Committees Support Unit (LOCSU)

The Optical Confederation represents the community eye health sector, including the 13,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Optical Confederation also represents manufacturers, distributors and importers. As a Confederation we work with others to improve eye health for the public good.

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to Local and Regional Optical Committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

Q1: Do you agree with our definition of conflict of interest? Yes / No

No.

We fully support the intent of the proposed guidance: to ensure appropriate use of taxpayers' money and the responsibility of those providing care to NHS patients to justify the use of public funds. We welcome the recognition that greater partnership working between public, private and voluntary sector bodies will be essential in the future, but that for all three there are risks of conflicts of interest that must be managed. We agree that consistency and transparency are key.

With regard to the definition of a conflict of interest, we support the definition of an actual or potential conflict of interest. However caution needs to be exercised with the concept of a perceived conflict of interest. Actual and potential conflicts of interest are a matter of fact and can be clearly defined. However a perceived conflict of interest is a matter of perception or interpretation and cannot be easily or clearly defined – one person's perception will differ from another, and what one considers reasonable another may not. We therefore suggest that the definition of conflict of interest should be actual or potential. This should then be supported with guidance on perceived conflicts of interest, advising what questions someone should ask themselves and what they should do if they consider that there is a risk that others might perceive a conflict of interest.

We do however have some wider concerns about the draft proposals, which we set out below and subsequently in response to the other questions, where we believe that in some cases it is not clear what issue the guidance is seeking to address, or that as drafted the guidance may not address the particular problem it is directed at.

It is essential that the guidance is proportionate and, crucially, that it applies to all of those **but only those** who are actually in a position to make decisions or influence decisions about the design, commissioning or procurement of goods or services.

For example, in the case of optical practices and optical practitioners there is virtually no scope for conflict of interest in their normal activity as a provider of NHS funded services. Although part of

primary care, optical practitioners do not sit on or advise Clinical Commissioning Groups and have no role in procuring goods or services with public funds.

Optical practitioners primarily deliver sight tests under the General Optical Service (GOS) contract. These contracts are available on an any qualified provider basis, and patients entitled to NHS treatment are completely free to choose which provider they use. The only decisions with cost implications for the NHS that an optometrist can make are to refer a patient to hospital for further treatment (usually via their GP) or to prescribe spectacles, for which some people will be entitled to an NHS voucher to help meet that cost: optometrists do not procure spectacle frames or lenses on behalf of the NHS. These are clinical decisions

Some optical practitioners (and a growing number) also deliver a number of other primary eye care services, commissioned by CCGs under the Standard Contract. Here again the scope for conflicts of interest in the delivery of these services is very limited. Furthermore these contracts are negotiated and managed at a local level by Local Optical Committees (LOCs) and the Optical Confederation and LOCSU have provided guidance for LOC company providers when talking to commissioners.

Individual practitioners – optometrists and dispensing opticians – are regulated by the General Optical Council (GOC), as are registered optical businesses. GOC Standards draw attention to the need to manage any conflicts of interest, and make very clear that the clinician must always act according to clinical need and in the best interests of the patient. As private businesses optical practices are also governed by company law, and by the Bribery Act.

It would be excessive – and in some cases inappropriate – to expect private businesses and private employees to comply with these proposals where they are simply delivering a service under contract to an NHS body and with no financial decision making powers or influence. We do however agree that where a member of the optical professions – which may be an optometrist, dispensing optician, optical contractor or owner or director of an optical business - has any role in providing advice on or in deciding the design, planning or commissioning of services or goods, then they should of course be covered by these provisions.

We would therefore hope that the final guidance will make clear that these proposals only apply to optical practices, optical practitioners and their staff in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups) but not to their normal contractual service delivery role. Our answers to subsequent questions are predicated on the assumption that this will be the case.

Q2: Do you agree with our sub-classifications of interests? Yes / No

No.

We do not believe that the sub-classifications go far enough – we identify those items missing in response to question 3.

We also have the same concerns about the phrase “or appears to be an opportunity” as outlined in response to Q1 about perceived risk. We fully agree that these sub-classifications should apply where there is, or is potential for gain (or loss), which is a matter of fact, however whether or not

there appears to be a gain (or loss) is of course a matter of interpretation and individual perception, and therefore as discussed before would be better covered in guidance.

Q3: Are the circumstances we have identified sufficient to capture all instances? Yes / No

No.

These sub-classifications should also include the words "or avoid a financial loss" –since conflicts of interest will arise where an organisation seeks to avoid losing a contract or a service being transferred to another part of the NHS or another provider.

Outside interests need to be defined more broadly than simply employment. This could include roles with charities or on advisory boards. These are included under loyalty interests, but as non-financial interests. In fact many of these relationships will have actual or potential direct or indirect financial conflicts of interest.

Non-financial interests should also explicitly include academic or clinical experts whose professional reputation or career expectations may also be a factor when giving advice.

Q4: Do you agree with the proposed definition of senior staff? Yes / No

No.

As explained in detail in Q1and Q26, we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

We do not support the inclusion of all NHS contractor professions, such as optometrists, in the definition of senior staff. There appears to us to be some confusion here between NHS contractors, and contractor professions. In short, many of those in the contractor professions will be employees of a contractor. The assumption that an optometrist is automatically a senior employee is also incorrect: their role will be purely clinical and their decision making limited to clinical matters specific to a patient. Indeed, were they to be working within a hospital setting they would not fall within any of the definitions of senior staff.

In fact we would argue that defining senior staff is not helpful because what matters is not a person's role or seniority in their employing organisation, but any wider role that they may take on where they can influence or make decisions regarding public funding. So in short, an optometrist providing clinical advice to a CCG on which services should be contracted out to primary care should be subject to NHS England guidance on managing conflicts of interest; an optometrist who works in (or owns) an optical business providing services under a GOS contract should not.

Q5: Do you agree with our proposals regarding gifts? Yes / No

Yes.

Subject to the caveat, as explained in detail in Q1and Q26, that we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

As an aside we would note that the current General Optical Services (GOS) Contract Regulations (2008) allow for gifts of up to £100.

Q6: Do you agree with our proposals regarding hospitality? Yes / No

Yes.

Subject to the caveat, as explained in detail in Q1and Q26, that we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

Again, as an aside, we are not clear why the limit for gifts is £50 but for hospitality only £25.

Q7: Do you agree with our proposals regarding outside employment? Yes /No

No.

As explained in detail in Q1 and Q26, that we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

However we suggest that these proposals as drafted are unclear. They appear to be concerned with NHS employees who have outside employment and it is difficult to see how or why they would be relevant to contractor professions and organisations who are by definition outside the NHS, are not employed specifically to deliver NHS services and therefore their employment status is irrelevant.

We suggest that the concerns that this proposal appears to be seeking to address might be better addressed by ensuring that all of those who are members of NHS advisory groups and boards, or who provide clinical or commercial advice to the NHS, must declare to that board or advisory group all conflicts of interest.

Q8: Do you agree with our proposals regarding private practice? Yes / No

No.

The consultation states (paragraph 49) that this is for "medical practice" - i.e. a NHS doctor that undertakes private work in addition to their NHS employed position. However, wording later suggests this might apply to private work undertaken by any clinician.

If this applies to all private clinical practice, then it is effectively discriminating against anyone who works in the private sector (by assuming that this automatically creates a conflict of interest whereas employment in the NHS does not).

While we do not consider that these provisions apply to optometrists when delivering normal contractual services, we suggest that the penultimate bullet point (not initiating conversations about private work during an NHS session) also demonstrates that these provisions have only been drafted with NHS medical doctors in mind: following an NHS sight test it is perfectly normal to initiate a conversation about the private/commercial side of the business, if the patient needs spectacles but is not entitled to an NHS spectacle voucher; similarly it is normal for a dentist, following an NHS routine check-up, to give the patient the option, if any further treatment is needed, of using either NHS or private services, since the treatments available may differ (eg many people may choose to pay privately for a more cosmetically attractive filling).

We strongly suggest that these provisions are redrafted. There needs to be greater clarity about what issue it is they are seeking to address, and to ensure that in so doing they do not inadvertently sweep in those from other sectors to whom these provisions should not apply

Q9: In particular, do you agree with the proposal regarding declarations of information about private practice, including information about earnings? Yes / No

No.

We believe this to be excessive.

As explained in detail in Q1 and Q26, we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

We fully agree that an optometrist, or the director of an optical practice, when taking on a wider role such as membership of an advisory group, should declare any interests – ie that they are an optometrist delivering primary eye care services. However the level of detail suggested is unreasonable and intrusive for private businesses: identifying sessions can only relate to private medical practice, not contractor professions; and earnings from private practice have no bearing on the NHS and are commercial matters and should not be disclosed.

Q10: Do you agree with our proposals regarding general sponsorship? Yes / No

No.

As explained in detail in Q1 and Q26, we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

We fully agree that an optometrist, or the director of an optical practice, when taking on a wider role such as membership of an advisory group should declare interests such as sponsorship, and that they should not provide information to the sponsoring organisation about NHS services or NHS patients (unless agreed with the NHS). However, beyond that, for private sector organisations, how a sponsorship is approved and why it is entered in to are matters purely for directors of that organisation.

Q11: Do you agree with our proposals regarding sponsored events? Yes / No

Yes.

Subject to the caveat, as explained in detail in Q1 and Q26, that we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

Q12: Do you agree with our proposals regarding sponsored research? Yes / No

No.

We presume that this relates purely to NHS research and has no bearing on commercial research, or university based research, which is subject to full ethics committee requirements.

However, it only captures medicines and not medical devices, IT equipment and/or other. Change, “The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine” to “The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service model”.

Q13: Do you agree with our proposals regarding sponsored posts? Yes / No

Yes.

However we suggest that conflicts can arise in relation to decisions about service design, not just purchasing and the promotion of specific products.

Q14: Do you agree with our proposals regarding shareholdings? Yes / No

Yes.

Subject to the caveat, as explained in detail in Q1 and Q26, that we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

As an aside, the fourth bullet appears to be a sub-point of the third bullet and it would therefore be clearer if that were corrected.

Q15: Do you agree with our proposals regarding patents? Yes / No

No.

It should apply to any patents, regardless of the seniority of the staff that holds the patent.

Q16: Do you agree with our proposals regarding donations? Yes / No

No.

It is not clear what the guidance here is trying to achieve. Is the concern that charities may give donations, to NHS services, while also looking to influence service design or contracts? Or is it third parties offering a donation to a person or organisation's charity of choice rather than a direct gift? The third bullet is a matter of charity law, and is a matter for the charity to whom a donation is made, and therefore we are not clear why it is included.

Q17: Do you agree with our proposals regarding loyalty interests? Yes / No

No.

As explained in detail in Q1 and Q26, that we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

We believe that these provisions should apply to anyone (regardless of their role or seniority in their own organisation) who provides professional or clinical advice to an NHS body which may influence decisions on service design, commissioning or procurement. We would also suggest that the first bullet should include membership and professional bodies, which may well have fixed positions or vested interests in how services are provided.

Q18: Do you agree with the proposals regarding identification of interests?

No.

As explained in detail in Q1 and Q26, we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

The approach appears to us to be the wrong way round – possibly because it has been drafted from the presumption that the person/staff are NHS employees, without thinking through fully how this would apply to private sector organisations whose staff may serve on NHS advisory groups.

Where a person has a wider NHS role, then in our view they must declare those interests to the body on which they are serving, or to which they are providing advice. We cannot see what benefit there is for the NHS or for the general public for declarations to be recorded (and audited) by their employing, private sector organisation. Organisational records and returns are maintained where a person's role creates the potential for a conflict of interest for their employer, not for the NHS.

Q19: Do you agree with the proposals regarding Boards and sub-committees, advisory committees and procurement? Yes / No

No.

As the consultation document highlights, the public have a legitimate right to expect to be able to access information about interests of staff and organisations that take decisions which lead to the spending of public money (p.37). We support this.

Indeed this is precisely the reason that we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of boards or advisory groups).

As in our answer to Q18, where a person has a wider NHS role, then in our view they must declare those interests to the body on which they are serving, or to which they are providing advice.

With regard to procurement, we suggest the proposals should be strengthened as follows:

- '*Panel chairs should review member's interest prior to commencement of the tender exercise and take appropriate action (which might involve exclusion from the panel)*'. Change should to must.
- '*Expert advisors can be engaged at the discretion of the panel chair - but efforts should be made to ensure that they do not have a conflict of interest*'. This needs to state explicitly that expert

advisors complete a conflicts of interest declaration and this should be reviewed and kept on record as part of good governance.

Q20: Do you agree that information on interests held by senior staff described above should be published? Yes / No

No.

Paragraph 70 of the consultation document makes clear that this proposal is intended to enable the public to have access to information about the staff and organisations that make decisions which lead to the spending of public money and that the NHS should be more pro-active in publishing information it holds. We agree with these principles.

This is why, as explained in detail in Q1 and Q26, we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

We are concerned at the proposal in paragraph 72 that argues for publication of the interests of senior staff by their employing organisation. As we have outlined in response to several previous questions, this approach seems to us muddled, possibly because the drafter started from the assumption that all those to whom this guidance would apply are NHS employees.

Where a person has a wider NHS role, then in our view they must declare those interests to the body on which they are serving, or to which they are providing advice. We cannot see what benefit there is for the NHS or for the general public for declarations to be recorded (and audited) by their employing, private sector organisation. Organisational records and returns are maintained where a person's role creates the potential for a conflict of interest for their employer, not for the NHS.

We also refer back to our comments in response to Q4 about the definition of senior staff. In short, we do not support the inclusion of all NHS contractor professions, such as optometrists, in the definition of senior staff. Many of those in the contractor professions will be employees of a contractor and it is not correct to assume that they will automatically be a senior employee. Indeed, were they to be working within a hospital setting they would not fall within any of the definitions of senior staff.

In fact we would argue that defining senior staff is not helpful because what matters is not a person's role or seniority in their employing organisation, but any wider role that they may take on where they can influence or make decisions regarding public funding.

Q21: Do you agree that information on interests should be published in a consistent way across organisations, using the format described above? Yes /No

No.

We support the publication of information in the interests of transparency. However we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. In relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups), in our view they must declare those interests to the body on which they are serving, or to which they are providing advice and it should be for that organisation to publish information. We cannot see what benefit there is for the NHS or for the general public for declarations to be recorded and published by their employing, private sector organisation, indeed it would clearly make it much harder to find that information than if it were all published on the website pertaining to the board or advisory group.

Q22: Do agree that information on interests should be published (at least annually) by organisations? Yes / No

No.

Declarations of conflicts of interest should be made as soon as they arise. Given that we propose that boards and advisory groups should publish this information, it should be published as soon as possible. If this were not to happen transparency could well occur after decisions have been made rather than before.

Q23: Do you think that further consideration should be given to aggregating returns on MyNHS, or another suitable web portal? Yes / No

Yes.

Subject to the caveat, as explained in detail in Q1 and Q26, that we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role. Our response therefore relates purely to this proposal in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

Q24: Do you believe that we should pursue the approaches described above to ensure greater compliance with the Disclosure UK initiative? Yes / No

We are unclear what is being proposed and would wish to see more detail.

Q25: Do you agree with our proposals on breaches and sanctions? Yes / No

No.

We support the principle. However we do not expect these proposals to apply to optical practices/practitioners and their staff in the course of their normal contractual service delivery role, where they will already be covered by the contractual requirements (and sanctions) of either the GOS or Standard contract. Optical practitioners are also subject to regulation by the GOC, which can sanction practitioners for breach of its Standards.

In relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups), then in our view it will be for the body on which they are serving, or to which they are providing advice to publish information.

Q26: Do you agree that the underlying principles and rules in this consultation should (perhaps with some amendment) also apply to non NHS providers in respect of NHS funded services they provide? Yes / No

No.

We have set out throughout our response that we do not believe that the principles and rules set out in this consultation should apply to optical practices and optical practitioners as providers of NHS funded services. These principles and rules should only apply in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups).

We fully support the intent of the proposed guidance: to ensure appropriate use of taxpayers' money and the responsibility of those providing care to NHS patients to justify the use of public funds. We welcome the recognition that greater partnership working between public, private and voluntary sector bodies will be essential in the future, but that for all three there are risks of conflicts of interest that must be managed. We agree that consistency and transparency are key.

On that basis the principles and guidance should apply to all of those **but only those** who are actually in a position to make decisions or influence decisions about the design, commissioning or procurement of goods or services.

In the case of optical practices and optical practitioners there is virtually no scope for conflict of interest in their normal activity as a provider of NHS funded services. Although part of primary care, optical practitioners do not sit on or advise Clinical Commissioning Groups and have no role in procuring goods or services with public funds.

Optical practitioners primarily deliver sight tests under the General Optical Service (GOS) contract. These contracts are available on an any qualified provider basis, and patients entitled to NHS treatment are completely free to choose which provider they use. The only decisions with cost implications for the NHS that an optometrist can make are to refer a patient to hospital for further treatment (usually via their GP) or to prescribe spectacles, for which some people will be entitled to an NHS voucher to help meet that cost: optometrists do not procure spectacle frames or lenses on behalf of the NHS. These are clinical decisions

Some optical practitioners (a growing number) also deliver a number of other primary eye care services, commissioned by CCGs under the Standard Contract. Here again the scope for conflicts of interest in the delivery of these services is very limited. Furthermore these contracts are negotiated and managed at a local level by Local Optical Committees (LOCs) and the Optical Confederation and LOCSU have provided guidance for LOC company providers when talking to commissioners.

Individual practitioners – optometrists and dispensing opticians – are regulated by the General Optical Council (GOC), as are registered optical businesses. GOC Standards draw attention to the need to manage any conflicts of interest, and make very clear that the clinician must always act according to clinical need and in the best interests of the patient. Failure to do so would put a practitioner at risk of a Fitness to Practice investigation. As private businesses optical practices are also governed by company law, and by the Bribery Act.

It would be excessive – and in some cases inappropriate – to expect private businesses and private employees to comply with these proposals where they are simply delivering a service under contract to an NHS body and with no financial decision making powers or influence. It would provide no public benefit, while creating additional unnecessary and unfunded costs for the businesses and practitioners.

We do however agree that where a member of the optical professions – which may be an optometrist, dispensing optician, optical contractor or owner or director of an optical business - has any wider role for the NHS in providing advice on or in deciding the design, planning or commissioning of services or goods, then they should of course be covered by these provisions.

We would therefore hope that the final guidance will make clear that these proposals only apply to optical practices, optical practitioners and their staff in relation to any wider NHS roles they may undertake that have an actual or potential opportunity to create a conflict of interest (eg as members of advisory groups) but not to their normal contractual service delivery role.

We, along with colleagues in other primary care professions (dentistry, pharmacy and community hearing) would welcome the opportunity to meet with officials to discuss how to take forward guidance appropriate for our professions.