

Ensuring Transparency and Probity

GPC Guidance to ensure
the honest and transparent
operation of clinically-led
commissioning consortia

May 2011

NHS REFORM

Ensuring Transparency and Probity

GPC guidance to ensure the honest and transparent operation of clinically-led commissioning consortia

It is essential that the new commissioning arrangements proposed by the government put in place systems to ensure fairness, transparency and probity in the decision-making of consortia.

GPs on consortia management committees will for the first time be directly responsible for a real commissioning budget, and accountable to their local population for their commissioning decisions in spending this budget. This contrasts with the previous advisory role of GPs to their PCTs via practice based commissioning, in which the PCT Board shouldered responsibility and accountability. It is therefore absolutely vital that the public, patients, other doctors and health professionals have the utmost confidence and trust that the commissioning decisions of GP consortia will be solely in the interests of patients, and with no actual or preceived vested interests or motives. The trust our patients place upon us as GPs is the cornerstone of general practice, and underpins the success of the doctor-patient relationship, and it is crucial that this is maintained in the development of GP consortia.

Where GPs are both providing care and deciding where that care takes place, how it is provided and who provides it, there is a real risk that a doctor's probity may come into question. Conflicts of interest therefore need to be managed effectively and openly to prevent any such problems arising, and also to avoid the perception among patients and the public that these issues may be a problem. The taint of conflict of interest is almost as damaging as the reality and all doctors involved in commissioning at any level must always consider what adverse comment an observer might say about their activities before making commissioning decisions. Doctors should also reflect on the views the public might develop about doctors in general as a result of such criticisms, as well as the potential for adverse media publicity.

Background

There are a number of areas in the new commissioning proposals contained within the Health and Social Care Bill where conflicts of interest may develop:

- Where clinical commissioning leaders have a financial interest in a provider company;
- Where GPs may refer their patients to a provider company in which they have a financial interest;
- Where GPs make decisions regarding the care of their patients to influence the 'quality premium' they receive through their consortium;
- Where enhanced services are commissioned that could be provided by member practices;
- Where LMC officers are also key officials in the consortium.

This guidance emphasises the importance of the existing GMC Guidance on probity in situations where clinicians have a financial or commercial interest in commissioning decisions. It goes without saying that there is a responsibility on GPs and practices to not abuse their position, but consortia should put in place clinical and corporate governance structures to ensure that the processes around commissioning and practices' related service provision are sound and suitably robust. This is in line with the supplementary guidance to the GMC guidelines 'Good Medical Practice' 2006 on financial interests in institutions providing care or treatment, which says the following:

"5. If you have a financial interest in an institution and are working under an NHS or employers' policy, you should satisfy yourself, or seek assurances from your employing or contracting body, that systems are in place to ensure transparency and to avoid, or minimise the effects of, conflicts of interest. You must follow the procedures governing the schemes."

Below is a set of principles that will help ensure that conflicts of interest, perceived or real, do not arise.

Where clinical commissioning leaders have an interest in a provider company

The Directors of provider healthcare organisations, or those GPs having a significant financial holding in a provider organisation (equity interest in a business of more than 5%) should not be on a consortium management board at all if there is already a contract in place, or if there is the any likelihood that they could enter into a contract with that consortium at some stage.

Consortia must keep a register of interests of all members in the consortium who are able to influence commissioning decisions, whether in an executive arm of the consortium, a locality subcommittee, a task-specific lead or in an overview and scrutiny role. The register should be formally refreshed every 3 months. The consortium's Accountable Officer must be informed within 28 days of a member taking office of any interests requiring registration, or within 28 days of any change to a member's registered interests. The register of interests must be publicly available.

An interest should be registered if the well-being or financial position of those described above, or their family, or people with whom they have a close association, is likely to be affected by the decisions of the consortium more than it would affect the majority of patients living within the consortium area.

Members must declare if they have a personal interest, and the nature of that interest, before the matter is discussed or as soon as it becomes apparent. Even if an interest is detailed in the Register of Interests, it must be declared in meetings where matters relating to that interest are discussed. Members who declare a personal interest will be able to remain in the meeting but not speak on the issue unless the personal interest is deemed by the Accountable Officer, and confirmed by a quorate vote of the other members present, as not being a prejudicial interest. They will not be able to vote on the issue under any circumstances.

A prejudicial interest will be declared if the matter affects a member's financial interest AND a member of the public, knowing the relevant facts, would reasonably think that a personal interest is of such significance that it is likely to prejudice their judgement of the public interest. Where a prejudicial interest is identified, that person must leave the room during the discussion of the relevant item, and cannot seek to improperly influence the decision in which they have a prejudicial interest.

Where 50% of the membership of a consortium committee would be prevented from taking part in a meeting because of prejudicial interests, decisions could still be made with the remaining members of the committee, but should be referred to an appropriate independent body to be verified as appropriate decisions. Such an independent body could be a neighbouring consortium, the oversight or audit committee of the host consortium, or a body set up by a group of consortia for this purpose.

Where GPs may refer their patients to a provider company in which they have a financial interest

There is clearly the potential for conflicts of interest to arise under such circumstances and in order to ensure that patients' interests remain central to the referral process, GPs must continue to refer patients to the service that they in their professional opinion believe is most appropriate for that patient's condition, whilst responding to the wishes and choices of the patient. This is in line with paragraphs 74 & 75 of the GMC guidelines 'Good Medical Practice' 2006, on conflicts of interest, as set out below.

"74. You must act in your patients' best interests when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues.

75. If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients.”

Where the most appropriate service to which the patient is to be referred happens to be one in which the GP has a vested financial interest, then the GP must inform the patient of this fact. This is in line with paragraph 76 of the GMC guidelines ‘Good Medical Practice’ 2006, on conflicts of interest, as set out below.

“76. If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser.”

Paragraphs 4 & 7 of the supplementary guidance to the GMC guidelines ‘Good Medical Practice’ 2006 on financial interests in institutions providing care or treatment also applies here, which says the following:

“4. Some doctors or members of their immediate family own or have financial interests in care homes, nursing homes or other institutions providing care or treatment. Where this is the case, you should avoid conflicts of interest which may arise, or where this is not possible, ensure that such conflicts do not adversely affect your clinical judgment. You may wish to note on the patient’s record when an unavoidable conflict of interest arises.

7. In all cases you must make sure that your patients and anyone funding their treatment is made aware of your financial interest.”

Where GPs make decisions regarding the care of their patients to influence a financial incentive scheme, such as the proposed 'quality premium', they receive through their consortium

This issue is closely related to the points discussed above, and the same GMC standards will apply. Nonetheless, there are very serious concerns that incentives linked to commissioning budgetary performance have the potential to damage the doctor/patient relationship, and may threaten GPs' role as the advocate for the individual patient and their professional duty to place care of the patient as their primary concern. The perception of a conflict of interest under these arrangements is high, whether one exists or not. There must be a clear divide between the commissioning budget allocated to consortia, and the individual practice budgets held by GPs.

There are better and more effective methods of engaging with the clinical behaviour of doctors, such the development of peer groups and the promoting of quality care, excellence and achievements. These options should be explored in detail instead of pursuing the concept of a quality premium as described in the government's proposals.

GPC continue to believe that there should be no possibility that any patient should be able to believe that their access to an element of healthcare has been diminished in some way and that the GP has received a financial reward for so doing. Incentive schemes, if they are introduced against our advice, should only generate awards for consortia to spend on patient care via consortium activity – NOT become funds for individual GPs or practices. We do not believe it is ethical for practices to receive payments that arise in any way from diminishing patients' services.

Where enhanced services are commissioned that could be provided by all member practices

The government's white paper stated the intention for GP consortia to be able to commission enhanced services from member practices, which will be vital in order for consortia to redesign services and move care into the community, which in turn will be necessary to meet the financial challenges under QIPP.

Given that GP consortia boards will be commissioning such services from their own member practices, it is vital that there is transparency and safeguards to ensure confidence that these decisions are based upon the best interests of patients and with no perceived conflicts of interest, and it will need to be seen that the GMC guidelines above have been followed.

It is important that decisions are taken transparently, and all background considerations relating to the decisions are publicly available. Where these services are commissioned, the decisions should automatically be referred to the consortium's oversight and scrutiny committee (or equivalent body containing a broad mix of patient representatives, other clinicians, local councillors (where appropriate), etc.) for verification and to ensure that this is a fair and appropriate decision.

Where LMC officers are also key officials on the consortium

Many current LMC officers will have the requisite qualities to play a role within their consortium. This is potentially a difficult area, and all such GPs should consider whether any conflicts of interest would arise by their acceptance of such posts. However, in general terms, it is advantageous to both an emerging consortium and the local GP population if the LMC leaders are involved in the development of the consortium through the shadow or pathfinder stage. They will be well placed to assist with the forming of an organisation that carries with it its constituent GPs and practices – an element essential to the success of consortia.

Nonetheless, the GPC would expect all GPs to declare any conflicts of interest they may have in working with shadow consortia, and to remove themselves from any decisions where this may be considered a factor in the decision. The GPC would also like to see PCTs keep a register of interests of the members of shadow consortia during the transition period.

However, it would be improper for a GP to hold a substantial role within their LMC and be a clinical leader in the consortium once the transition stage was completed or after April 2013 and the formal transfer of commissioning responsibility to consortia. LMCs will have an important role in holding consortia to account, especially in the management of practice commissioning performance, and any conflicts of interest at this point would be unacceptable. It would be acceptable for LMC officers to be observers on the consortium, in a purely monitoring, scrutiny and advisory capacity.

The issue of conflicts of interest has the potential to seriously undermine the regard with which the profession is held by the public. Doctors must always be mindful that their actions reflect on all their colleagues, and always have regard to their ethical duties.