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The dual role of practice based commissioner and GP provider: avoiding conflicts of interest and ensuring probity

GPC guidance for LMCs and GPs
(England only)

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1 INTRODUCTION

The dual role of commissioner and GP provider is one which has drawn some attention and concern from within both primary and secondary care, as well as more widely. Despite being questioned by some, this unique role has been created as a result of Government policies on practice based commissioning (PBC) and the shift of services from secondary to primary care or 'care closer to home'. In addition, PCTs – some of which are the first to question GPs' dual role – have been both commissioner and provider for a number of years.

This guidance seeks to illustrate how adherence to national guidance from the Department of Health (DH), the General Medical Council's (GMC) 'Good Medical Practice'¹ (2006) and supplementary guidance allows GPs to perform in this role without compromising their position or care for patients. In doing so, this guidance addresses the potential for conflicts of interest and/or probity issues to arise from the dual role. It does not however seek to address the more practical issues that are adversely affecting GPs' ability to be effective commissioners and advocates for their patients, such as the problem of financial deficit across many PCT areas, or PCT pressures to commission in a certain way.

The BMA has produced a statement on principles for effective and successful commissioning, which can be accessed online at the following website address:

www.bma.org.uk/ap.nsf/Content/bmaeffectcomm

The GPC has produced extensive guidance on PBC, which can be accessed online via the following website address (log-on to access the full range of guidance):

www.bma.org.uk/ap.nsf/Content/Hubcommissioningserviceprovision

2 THE COMMISSIONING PROCESS

Although it goes without saying that there is a responsibility on GPs and practices to not abuse their position, more importantly, PCTs 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 very much 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.”

The current Department of Health guidance on PBC, 'Practical implementation', published in November 2006² sets out a number of structures and process that, if put in place by PCTs, and adhered to by practice based commissioners, will ensure that GPs are not able to simply commission services from themselves without appropriate check or balance as is sometimes assumed to be the case. In addition, the existence of other 'willing providers' in the area (see below) in part diminishes probity issues for GPs in their dual role as they will not (necessarily) have a monopoly on the services available to patients.

¹ Note that the GMC stresses that the GMC guidelines 'Good Medical Practice' 2006 and supplementary guidance is not intended to be exhaustive and that doctors should always review new arrangements and use their professional judgement to determine if there is a conflict of interest and how best to address it.

² This guidance originally applied to 2007-08, but is being carried over into 2008-09.

The following three sections highlight the key requirements within the DH guidance.

PBC/practices' commissioning plans

- PCTs have to approve the commissioning plans put forward by practices.
- Where practices' commissioning plans impact on secondary care services, practices should 'seek the involvement' of consultants and wider secondary care clinical teams.
- Where practices' commissioning plans propose new services as transferred from hospitals, they must '...demonstrate how a range of provision will be secured across a geographical area, ensuring equity of access and choice for patients'.
- One of the responsibilities of PCTs is to advise practices of the implications of their plans for service redesign (whilst respecting clinical and management decisions taken by consortia).
- Practices are to make their commissioning plans available for public scrutiny by their practice population and should be included in the annual PCT prospectus. All PBC plans are to be available for scrutiny by Overview and Scrutiny Committee of the local authority and by the general public.

Bidding to provide services

- If GP practices wish to develop their provider services in line with their commissioning plans, they need PCT approval via submission of a specific business plan/case.
- These business plans will be assessed by a dedicated PCT PBC committee/subcommittee set up for this (and other) purpose(s), which has accountability to the PCT Board.
- Clinicians on this committee/subcommittee should exclude themselves from decisions on PBC business cases in which they have an interest or association.
- [Note that this does not preclude clinicians from being present at *discussions* on the business case, as long as they declare their interests clearly. Indeed, clinicians will have a valuable contribution to make to these discussions, following which others may be in a better position to make the subsequent decision. PCTs' SFIs (Standing Financial Instructions) and Standing Orders should include details of the arrangement for the registration of declarations of interest.]
- Business plans will be assessed on a number of criteria, including evidence-based clinical effectiveness, clinical safety, quality and governance.
- Any such add-on services (i.e. to practices' existing GMS/PMS contracts and commissioned enhanced services) provided by practice based commissioners must meet all national standards of clinical governance including those set out in *Standards for Better Health*.

A range of providers

- For the development of add-on or extended primary care services through PBC, PCTs are encouraged to create a provider environment where in one area there will be any number of 'willing providers' for the same service.
- PCTs are to establish this range of providers, including GP limited companies, third sector organisations that are 'values-driven', community pharmacies, private companies and PCT provider services.
- Under this arrangement, the PCT will not (in theory) give activity and/or payment guarantees to any of these providers, leaving it down to patient choice as to which provider/service is chosen and subsequently, which one(s) receive payment for their service.

- These services should be added to the local choice menus (i.e. Choose & Book) where appropriate.

Building upon the governance arrangements above, in guidance issued in December 2007³ the DH has reiterated the importance in 2008-09 of PCTs ensuring ‘...clear governance and accountability to manage transparently any potential conflicts of interest of GPs working within a PCT and on the PEC or other decision making boards.’ In addition, it has given a list of situations where a clinician would be considered having a conflict of interest in relation to involvement in decisions around provider business cases as follows:

- The clinician is a director of, has ownership of or part-ownership of, or is in the employment of, the body submitting the business case (including non-executive directorships);
- The clinician is a partner of, or is in the employment of, or is a close relative of, a person who is a director of a body submitting the business case;
- The clinician is a close relative of a member of a practice that is submitting the business case;
- The clinician is a close relative a person in the employment of the body submitting the business case;
- The clinician has a beneficial interest in the securities of the body submitting the business case; and/or
- The clinician provides or has provided any services to that body submitting the business case.

3 REFERRAL PROBITY

Given that the PBC indicative budget covers all services under payment by results, PBC inherently encourages GPs to make the most appropriate use of secondary care services. GP practices are likely therefore to analyse their referral patterns, compare them with local and/or national benchmarks and ultimately, may seek to reduce the number of referrals being made to secondary care. PCT local incentive schemes designed to support and encourage practices’ involvement in commissioning are often directly linked with a reduction in referrals, in some cases, to a particular specialty. In addition, practices/groups of practices may be offering extended, ‘in-house’ services, which would provide an alternative to some secondary care services and which would cost less than the national tariff price.

There is clearly therefore the potential for conflicts of interest to arise here 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, whether that be secondary care or other ‘care closer to home’ and/or ‘in house’ services. This is in line with paragraphs 74 & 75 of the GMC guidelines ‘Good Medical Practice’ 2006, on conflicts of interest, as pasted 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.

³ The Department of Health (December 2007) *Practice based commissioning – budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance.*

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.”

Paragraph 4 of the GMC’s Conflicts of interest supplementary guidance to ‘Good Medical Practice’ 2006 (specifically 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.”

It is not acceptable for practices to continue reducing their referrals to secondary care when this means that decisions are being taken that are not clinically appropriate and will have a detrimental effect on the health care of patients. Referral decisions must be driven by patients’ best interests and choices.

The existence of services in the primary care setting that may also be available in a secondary care setting is not new. Many GP practices already offer an extended range of services to their patients, having been commissioned by the PCT to do so via the enhanced services contracting route. In some areas patients will be able to access a certain services directly at their GP practice, whereas patients of another practice may have to attend the local hospital in order to access this same service. The act of being commissioned to provide a particular service that would otherwise be available in the secondary care setting is therefore already embedded in the provision of GP services.

Doctors referring patients have a responsibility to make it clear as to what type of service they are making the referral. The terms ‘specialist’ or ‘consultant’ are not restricted in law, or by the GMC, but most patients would expect those with these titles to be on the GMC’s Specialist Register and to carry responsibility for the service they are providing. If a doctor is making a referral to a ‘specialist service’ where the medical responsibility is not held by a person holding a Certificate of Completion of Specialist Training (CCST)/ included in the Specialist Register, then that information should be made clear to the patient. A similar responsibility rests with the provider of the service not to ‘over sell’ the service.

4 PRESCRIBING PROBITY

Although prescribing incentive schemes have been around for some time, the fact that the PBC indicative budget includes prescribing gives further potential for conflicts of interest to arise akin to those relating to a reduction in referrals to secondary care. The same principles above that apply in order to ensure referral probity therefore also apply to prescribing.

The GPC has produced a guidance note ‘Focus on excessive prescribing’ which covers appropriate and cost-effective prescribing, drugs switches and general points to consider when negotiating with PCTs. In addition, the DH has produced guidance on ‘Strategies to achieve cost-effective prescribing: Interim guidance for primary care trusts (PCTs)’ (June 2007), which covers prescribing incentive schemes and the basis upon which encouraging a reduction in expenditure on prescribing is acceptable. Both these documents can be accessed online at the following website addresses:

www.bma.org.uk/ap.nsf/Content/focusexcessive (log-in required)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076350

It is not acceptable for practices to continue reducing their prescribing expenditure when this means that decisions are being taken that are not in the best interests of the patient and their health needs. Prescribing decisions must be driven by patients' best interests and choices.

5 DECLARING A FINANCIAL INTEREST

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 pasted 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.”

The GMC guidance does not dictate whether this should be done verbally, during the consultation, or through generic information included in practice newsletters, websites or leaflets. At least one of these methods should be used however and GPs should use their professional judgement as to what would be most appropriate. For example, if there is a concern that a referral decision may later be questioned, or the patient has specifically requested a particular service, then the GP may wish to declare the financial interest in the service during the course of the consultation.

If informing a patient of a financial interest during a consultation, the following points could be made by GPs during their conversation with the patient, the first one being the most important.

- I should inform you that this particular service is one in which this practice has a financial interest;
- The service has been approved by the PCT, having been assessed on a number of criteria, including evidence-based clinical effectiveness, clinical safety, quality and governance;
- The service is in line with local commissioning plans;
- The service is also in line with Government policy that encourages the development of a wider range of services to be available to patients in the primary and/or community care setting.

The same points could be made if informing patients via newsletters, websites, letters or leaflets that the practice has a financial interest in a provider service to which they may potentially be referred. Information about GPs'/practices' financial interests should not make patients feel pressured into choosing/accepting a particular service, i.e. because it benefits the GP/practice.

It would be inappropriate for the profit share of a member of an entity set up from which to provide services, for example a Limited Liability Partnership, to be dependent on the number of referrals that individual makes to the service/entity.

6 PATIENT CHOICE AND 'IN-HOUSE' SERVICES

Early Department of Health guidance on PBC ('Technical guidance' published in February 2005) set out that, in order to fulfil their obligations under the choice agenda, practices should not coerce patients into choosing an in-house service. Although this principle has not been re-stated in later guidance, it is one which we believe is important to uphold and should apply particularly to services in which the referring GP/practice has a vested financial interest.

7 PARTNERSHIPS WITH THE PRIVATE SECTOR

There are a number of private sector companies currently seeking to form subsidiary companies with groups of GP practices. The most common proposition is for the private company to provide or fund new premises from which GPs will be able to provide extended services; any profits generated from the provider services would then be split 50/50.

In such situations, we would advise GPs to abide by all the guidance above (referral probity, declaring financial interest etc.) but also ensure that this relationship does not stray into any clinical and/or commissioning decisions taken. In addition, where the private sector partner runs other provider services available to NHS patients, it would not be appropriate for the agreement between the two parties to oblige the GP practice to refer to those services in particular, in the same way that incentives for GPs to refer in a particular way are not acceptable.

8 PARTNERSHIPS WITH THE PHARMACEUTICAL INDUSTRY

It is possible that in time, the pharmaceutical industry may start to take an increased interest in PBC, related service provision and becoming involved in the process in some way. This involvement could take a number of different forms such as training, providing information sources and/or support for practices with the tendering/bidding process. Where such a relationship develops between a practice/group of practices and a pharmaceutical company, there should be open discussion and a shared understanding of the expectations the pharmaceutical company has of the practice/group of practices as a result. At all times, GPs should abide by the guidance above on prescribing probity.

Depending on the extent of the relationship, paragraph 75 of the GMC guidelines 'Good Medical Practice' 2006 may also apply:

“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.”

9 CONCLUSION

With the development of PBC and related service provision, a better understanding of the

potential for conflicts of interest to arise from the dual role of commissioner and GP provider will emerge and it may be that in the future, more formal requirements for avoidance of such conflicts of interest will be deemed necessary. At the present time however, in addition to using the principles and advice set out in this document, where new arrangements and situations arise, GPs should use their professional judgement to determine if there is a conflict of interest or potential for lack of probity and how best to address it.