Londonwide LMCs
The professional voice of London general practice

Lighting the Path
Supplement 2

Guidance on:
Conflicts of Interest
Shadow Board Elections

Supplement 2: 8 December 2011

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1. Introduction

This is the third issue in Londonwide LMC's Lighting the Path series, which is designed to assist GP commissioning leaders and frontline practices forming pathfinder and shadow clinical commissioning groups (CCGs) to work through essential issues and arrangements during this transitional period. It covers key elements of practicality and law that ALL developing CCGs should be considering NOW to provide a firm base for the future.

With this guidance Londonwide LMCs aims to support developing CCGs to focus on their core commissioning functions rather than tie up their precious resources in unnecessary diversionary activity on process, form and structure.

Our last supplement covered: guidance on delegated responsibilities, shadow board elections, developing CCGs functions and governance. Since then, the Government has responded to the Future Forum; Pathfinders have been renamed clinical commissioning groups (CCGs); there have been some changes to CCG governance arrangements, arrangements for authorisation have now been published, and further changes are planned in relation to the wider NHS environment.

Key issues covered in this supplement are:

- Conflicts of interest.
- Engagement with GPs.
- Selections and elections, update.

In support of the guidance contained in this publication, Londonwide LMCs, in collaboration with BMA Law have now produced a model constitution which developing CCGs will find useful in establishing the governance arrangements required as part of the authorisation process. Like many of you we had anticipated that there would be a national CCG constitution, although latest information indicates that governance arrangements will be described in a national framework, rather than prescribed as a series of processes supported by national documentation. The model constitution, which can be accessed here: http://www.lmc.org.uk/uploads/files/news/2011/ccgmodelconstitutiondecember2011.pdf has informed discussions both at NHS London and the NHS nationally. It is therefore unlikely that any future guidance will significantly change the arrangements set out in this document.

2. Conflicts of Interest

A number of publications have been circulated recently focussing on conflicts of interest for developing CCGs. The following summarises key issues for GPs, CCGs, and also for LMCs as statutory bodies representing the interests of GPs.

As GPs you are responsible for the care of individual patients, and must work solely in the interest of the patient guided by the requirements of the GMC & GMC Good Medical Practice. As part of the new commissioning landscape there will however be a number of risks for GPs:

- Commissioning and providing are separate roles. New arrangements could put GPs at risk as certain inherent flaws may be built into the new system, ie, commissioning/providing by GPs.
- Financial interests can be corrupting. With the dual role of GP as provider/commissioner, GPs/practices may now be faced with risk of economic interest corrupting the integrity/motivation of the GPs thus potentially distorting/misrepresenting interests in decision making processes.

- Transparency is essential. GPs must be able to perform their role without compromising/abusing their position or care for patients, and be able to demonstrate this clearly/openly/transparently to the public.
- This is a time of financial pressure. GPs risk serious reputational risk as taking responsibility for commissioning in a time of severe financial pressure will inevitably lead to suggestions that treatment has been affected by financial considerations.
- These new arrangements will be scrutinised. There will be intense scrutiny on the functions/responsibilities/outcomes of these new arrangements, and GPs must be extremely cautious to make sure that their actions are represented in the right way and could not be misconstrued.

These potential conflicts of interest are not all new, however as GPs become increasingly involved in commissioning, and also possibly service provision outside existing contracts, it is essential that existing professional standards continue to be reflected in all aspects of General Practice. You will need to ensure that any possible conflict between your professional role, and your involvement either in a commissioning or provider role are clearly identified, and any possible conflicts of interest made clear to your patients, and other interested parties. Financial issues are likely to come under increased scrutiny, so it is imperative that financial considerations do not adversely affect your professional and clinical decision making or your relationship with patients.

In relation to financial arrangements GMC guidance (***GMC Good Medical Practice 2006)*** highlights a number of important issues, with key points identified below.

- You must be honest and open in any financial arrangements with patients.
- You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals.
- You must act in your patients' best interests when making referrals and when providing or arranging treatment or care.
- 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.
- 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.

Supplementary Guidance to the GMC Guidelines ***Good Medical Practice*** **2006** also states:

- Trust between you and your patients is essential to successful professional relationships, and may be damaged by situations in which your financial or other personal interests affect, or are seen to affect, your professional judgement.
- You should always review new arrangements and use your professional judgement to determine if there is a conflict of interest and how best to address it. If you are not sure what to do, contact your defence body, a professional organisation or the GMC Standards and Ethics team for advice.
- 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 that may arise, or where this is not possible, ensure that such conflicts do not adversely affect your clinical judgment.
- In all cases you must make sure that your patients and anyone funding their treatment is made aware of your financial interest.

As Commissioners of health services, the Nolan principles in respect of conduct and openness provide a useful framework, covering selflessness; integrity; objectivity; accountability; openness; honesty and leadership.

Roles and responsibilities

The following principles may be useful as a framework for GPs involved in commissioning:

- The CCG must establish effective governance arrangements. New commissioning arrangements must ensure fairness, transparency and probity in decision making processes of CCGs. There must be robust clinical and corporate governance arrangements that are adhered to and monitored/regulated.
- The CCG should be prepared to manage conflicts of interest at a local level. As the Health Bill has not reconciled GPs' dual role as provider/commissioner and there may not be a prescriptive approach regarding how CCGs should manage conflicts of interest, these must be managed/monitored by CCGs and NCB and public.
- Conflicts of interest must not jeopardise quality/delay care to patients.
- Transparency is essential. The focus on CCGs/GPs will continue so there needs to be transparency to deflect potential for criticism for GPs benefiting financially from new commissioning arrangements.
- LMCs must be honest brokers. LMCs will have an increased role in representing their GPs, and acting as 'honest broker' and must consider new ways to provide advice/support/information as the new arrangements could destabilise/threaten relationships amongst GPs and practices/CCGs.

What are the potential areas of conflict?

Conflicts for CCGs

- **Where clinical commissioning leaders have a significant interest in a provider organisation (defined by GPC as more than 5%);** financial involvement may influence commissioning decision making with potential for GPs profiting by referring patients to providers they have a stake in.

  GPC May 2011 guidance states: *Director of provider healthcare organisation, having a significant financial interest/holding in a provider organisation should not be on a consortium management board if contract already in place*

- **No GP should simultaneously sit on a GP Commissioning Board and a Board of GPCo**

  How to manage:

  - Register of interests of those on shadow CCGs/formalised CCGs Boards: should be made publicly available, monitored, updated on a regular basis (GPC advises every 3 months) should include all members of CCG and any others who are able to exert influence over commissioning decisions.
  - Have an appointed Accountable Officer; who 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. (from BMA).
  - Interests need to be registered if well-being or financial position of those above, or family member or those with close association like be affected by decisions of a CCG more than would affect majority of patients living within CCG area.

- Appoint external representatives to assist in scrutiny of primary care commissioning/lay representation to assist identifying conflicts of interest to maintain transparency/ to help reconcile potential conflicts of interest between patient choice and commissioning of ESs/delivering CCG clinical/financial priorities.
- Declare personal interest, nature of interest and must be declared during meeting before matter discussed. Can remain in meeting, but not speak unless deemed non-prejudicial by accountable officer and confirmed by quorate vote of others present, not able to vote on issue under any circumstance.
- If prejudicial – must be declared and is of such significance that it prejudices judgement of public interest, when identified, must leave the room during discussion of that item, and cannot seek to influence decision.
- BMA suggests where 50% of membership prevented from taking part in meeting because of prejudicial interest; decisions could still be made by remaining members but should be referred to an independent body to be verified as appropriate decisions.
- ***CCGs should be aware that it may be perceived by the public and colleagues that there are conflicts of interest if they are acting both as commissioners and service providers.***

- **Remuneration for CCG Board Members/Chairs –** Shadow CCGs have in some cases been responsible determining payment/reimbursement rates; this could be viewed as a conflict of interest. DH noted that these decisions are local. In order to maintain transparency and avoid criticism, non-executive Board members should be involved in agreeing reimbursement arrangements.

  How to manage: Must be able to demonstrate that rates of pay were based on some set of standards/protocol and that the figures were not too aspirational.

Conflicts for GPs more widely

GPs need to be aware of potential conflicts of interest, not only in their developing role as commissioners, but also in their role as clinicians. It is therefore important to reinforce the following points which apply to all GPs, whether directly engaged in commissioning activities or not.

- **GPs referring patients to a provider company that they have an interest/financial interest in.**

  - GPs must treat patients and ensure that decisions made are central to the needs of the patient. GPs must make referral decisions based on their professional opinion, in the interest of the patient and believe that it is most appropriate for patient's condition.
  - When the most appropriate referral happens to be made to an institution that the GP has a vested financial interest, the GP must inform the patient.
  - Must ensure that ability to demonstrate that patient choice was not thwarted.

  How to manage:

  - 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, GPs may advise patients that;
- The 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.

- **Prescribing probity:** practices cannot be seen as rationing necessary treatment to avoid the commissioning costs and must act within the interest of the patient (same principles as referral probity).

- **Patient registration probity:** forms of patient selection i.e. refusing to register unprofitable patients such as housebound, mental illness, chronic disease, drug addicts, homeless, most vulnerable (same principles as referral probity)

  How to manage: practice must have safeguards to prevent this from happening and ensure that every patient's has the right to primary care access regardless of their condition

Transition from Shadow Boards towards authorisation
During the transition towards authorisation, CCGs will be established as sub-committees of PCT Boards. PCT Boards will retain accountability during this period, and developing CCGs will therefore need to be aware of, and comply with current PCT guidance regarding conflicts of interest.

Guidance for PCTs requires **'…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*.'** Key elements of PCT guidance include the following which outline where a clinician would be considered to have a conflict of interest:

a) 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);
b) 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;
c) The clinician is a close relative of a member of a practice that is submitting the business case;
d) The clinician is a close relative a person in the employment of the body submitting the business case;
e) The clinician has a beneficial interest in the securities of the body submitting the business case; and/or
f) The clinician provides or has provided any services to that body submitting the business case.

- **Where GPs make decisions regarding the care of their patients that influences incentives they may receive through their CCG**
  Guidance on incentives for CCGs remains to be clarified. However, there are a number of principles that should guide developing CCGs, as follows:

- CCGs must ensure that there is a clear division between individual practice budgets and commissioning budgets allocated to CCGs; should have standards to meet in terms of level of documentation of CCGs finances including levels of scrutiny (including arrangements for independent scrutiny) over documents which should also be publicly available.
- Remind GPs that BMA warns against incentives/financial reward for taking away access of patients to elements of healthcare.
- Any incentives gained should be channelled back into commissioning budgets for patient care, and not be directed to practice budgets/individual GPs (must be able to demonstrate that).

- **Where enhanced services are commissioned that could be provided by member practices**
  CCGs may be responsible for commissioning enhanced services from their member practices, viewed as fundamental to impact on service redesign and moving care into the community and to work within the limited financial envelope

  How to manage:

  - Need safeguards and transparency to ensure that decisions around commissioning enhanced services are made in the interest of the patient and no perceived conflict of interest. Role of LMC as oversight/OSC, verification to ensure fair and appropriate decision.
  - Strong/transparent governance arrangements to manage risk between GPs as providers/commissioners; to avoid loss of expertise from GPs who are able to make useful contributions to care pathways.
  - Appoint external representatives to assist in scrutiny of primary care commissioning/lay representation to assist identifying conflicts of interest to maintain transparency/ to help reconcile potential COI between patient choice and commissioning of enhances services/delivering CCG clinical/financial priorities.

The GPC guidance indicates that there may be conflicts of interest in relation to the commissioning of Enhanced Services. It is important to recognise that although the GPC guidance relates to future GP/Clinical Commissioning arrangements, Enhanced Services are an integral part of GP Practice income, and are related to the GP Provider role as reflected in current contractual arrangements. As such LESs are a legitimate focus for Practices and LMCs and it is essential therefore that current processes should not be eroded, particularly as strong General Practice is a prerequisite to delivering service redesign and improvement, requiring collaboration between GP Practices, LMCs, Clusters and GP Commissioners.

- Future ES commissioning arrangements are not yet clear, and it is also unclear exactly how conflicts of interest will be managed. Although it is unlikely that LMCs will become involved in discussions regarding conflicts of interest with individual GPs, LMCs will have an ongoing and important role in approving ES's and validating service specifications and associated SLAs.

For LMCs

- **Where LMC officers are key officials in CCGs**

  LMCs have been involved in the development of commissioning CCGs and will continue to have an assurance/oversight role as developments continue. It is likely that the role of LMCs in commissioning will become more hands off and about oversight/holding CCGs to account particularly around management of practice

commissioning performance. For matters which will impact on Primary Care provision, and also matters of strategic importance the LMC will continue to make its voice heard.

Many LMC members will have the capabilities/knowledge to play a critical role in CCGs. Currently, and commonly, incumbent LMC members are involved in emerging/developing CCGs/shadow commissioning boards. However, once transition stage completed after April 2013, LMCs and LMC members will need to consider their position where GPs hold a substantive role within their LMC and be a member of the Board of their CCG. Conflicts involving LMC members may undermine the legitimacy of LMC work; damage reputation so that decisions could be liable to challenge.

However, it is unlikely that conflicts will be so significant/material as to cause difficulties.

How to manage: Consider revising LMC TORs depending on LwLMC view?

How does this apply to CCGs, is it different for Shadow CCGs (as PCT Board sub-committees)?

- Shadow CCGs not authorised, do not have full delegated responsibility and fiscal responsibility.
- Shadow CCGs are not wholly accountable and PCT Board remains accountable organisation.
- General principles should still apply.

Where do go to get help/advice if we can't manage it?

- NCB once developed/authorised may have procedures on how to handle these areas.
- Constitution adopted should include areas on how to manage
- Consult neighbouring CCGs for advice?
- LMCs will be able to provide advice on how to deal with conflicts of interest

3. Selection and Election to CCG Boards – Update

As this is a 'shadow' phase, CCGs will need to become subcommittees of their PCT to take on delegated responsibilities, with PCTs remaining as accountable statutory bodies until 2013. However, in 2013 current CCGs will have to ensure that they are properly constituted in order to qualify as statutory bodies. As part of this authorisation process, CCGs will need to have in place robust governance and decision making processes, and it should not therefore be assumed that your current shadow board will continue. It will be a requirement of authorisation that developing CCGs are able to demonstrate effective processes for engagement with all constituent GPs, and in order for CCGs to ensure that they have effective engagement and a clear mandate from all constituent GPs you will need to carry out a new round of elections.

There remain a number of important questions to be answered in relation to the membership and constitution of CCG Boards, including arrangements for Chairs, Vice Chairs and other members of the board.

Experience with Pathfinder, developing CCGs election processes does however identify a number of important issues which you will need to consider for this second round of election processes. Notwithstanding issues raised in some areas, overarching principles for developing and electing Boards remain as follows:

1. All GPs within a CCG area shall be eligible to vote, irrespective of contractual status, subject to them confirming current and ongoing employment within the defined area.
2. All GPs within the specified area shall be able to stand for election, subject to confirmation of current and continuing employment, reflecting agreed Board membership arrangements e.g. for Sessional/Locum/Freelance GPs.
3. Leadership of Boards will reflect robust processes based on selection against agreed competencies, roles and responsibilities.

Sessional GPs (SGPs)

For the purposes of this document, SGPs will be used to refer to sessional, salaried, and freelance locum GPs on your PCT area performers list, that work at least one session a year in the area.

In time for full authorisation of CCGs, fresh elections must be held ahead of going 'live'. These elections must include sessional GPs. We have provided clear guidance on this (our previous Lighting the Path guidance available on our website at www.lmc.org.uk), as have the GPC.

If you recognise that your current arrangements have excluded SGPs or put conditions on them other than being on the local performers list and confirming that they wish to be a part of your CCG, you may wish to consider whether you wish to create a ringfenced place on the board for Sessional GPs and run a SGP election until you repeat your full elections for authorisation.

4. Related resources: Practical tools for commissioners

Details of how to run elections can be found in our first **Lighting the Path** document, **http://www.lmc.org.uk/news/news-detail.aspx?dsid=12033** and the **GPC guidance Shadow CCGs: Developing and electing a transitional leadership, GPC Guide, November 2010 http://uk.sitestat.com/bma/bma/s?WP-GPCguidance-6&ns_type=clickin**.

Guidance on delegated responsibilities, further guidance on shadow board elections, developing CCGs functions and governance can be found in our Lighting the Path Supplement 1 **http://www.lmc.org.uk/news/news-detail.aspx?dsid=12220.**

Department of Health (DH) 'ready reckoner' for CCG running costs tool - an interactive running costs tool for CCGs. More information can be found on the following link: **http://www.pathfinders.london.nhs.uk/tools-for-pathfinders/clinical-commissioning-group-running-cost-tool/**.

Draft DH guidance/practical framework on building patient engagement: Better Health, Better Experience, Better Engagement – a practical framework to help emerging clinical commissioning groups think through how they build engagement and insight into the care experience and into commissioning from the outset. The current draft can be found on the following link: **http://www.pathfinders.london.nhs.uk/_uploads/documents/doc-l/bhbebe_aug2011.pdf**.

Pre-authorisation diagnostic tool - allows members of your CCG leadership team to assess the capability of your emerging CCG across six domains. The tool has been made available on the Pathfinder Learning Network website: **http://healthandcare.dh.gov.uk/diagnostic-tool-for-emerging-clinical-commissioning-groups/**.

Policy development updates

Delegation and the NHS London planning timetable
Key messages for pathfinders and their supporting PCTs/Clusters
(The process to be GP commissioner -led, with the full engagement of stakeholders especially constituent practices and their statutory representatives, LMCs).

Planning Principles link **http://www.pathfinders.london.nhs.uk/_uploads/documents/doc-l/strategic-planning-2011-12-2014-15/londons-strategic-planning-principles-for-2012-13-2014-15.pdf.**

Developing Clinical Commissioning Groups: Towards Authorisation
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293. The main document and four technical appendices outline current DH thinking on how to prepare for authorisation. They supersede the draft documents published in August 2011. The authorisation process is work in progress, with areas still needing clarification. The DH anticipates that the shadow NHS Commissioning Board will publish another update of the framework in spring 2012 following further engagement with emerging clinical commissioning groups and stakeholders.