December 2018

PCC insight

Formerly Commissioning Excellence

GP apps promise to change how we pay for primary care

Digital healthcare services will fundamentally challenge the basis of existing primary care contracting and payment systems.

Rob McGough, a partner with law firm Hill Dickinson, told a recent PCC event that the rise of large scale online and app providers was not foreseen when existing models were put in place. That, after all, was a different time – before the advances and ready access to technology we see today.

These providers are able to operate with the benefit of the previously little used GP choice policy introduced in 2015. It provided commuters and others with the right to register with a GP outside their home area.

McGough said: "From a GMS perspective there are then very limited grounds for NHS England or clinical commissioning groups (CCGs) to object to the subcontractor coming onto the contract.

That could be for clinical reasons or because of the nature of the financial impact upon the commissioner.

"That then creates a sort of contractor's right to operate in this more flexible way. There's also a gap – for example around premises – where the subcontractor's premises are joined to the main contract.

A primary care provider can then gain premises in additional areas and there is little that the commissioners can do to object.

"The digital practices then have registrations from across the country but the GMS, PMS and APMS were set up as locally based contracts.

McGough gave a hypothetical example to underline his point.

"An Ipswich resident could be registered with a Leeds-based GP practice which gets the patient funding under a GMS from a Leeds CCG while the Ipswich CCG picks up the cost of out of hours referrals and urgent care for the individual."

A London-based provider will also be getting enhancements worth £2.19 per patient for people hundreds from the capital. Digital providers could also pick up additional rurality related payments due to the physical distance between the practice and the patients.

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Wallsall network comes together in 60,000 patient super-practice

Work on bringing just two practices together is set to result in a constituent super-practice in Walsall.

The Portland and Northgate practices had operated from the same purpose-built building for nearly 20 years, so when they began sharing a practice manager on an interim basis in 2016, there was a certain inevitability that the relationship would be consummated.

As practice manager Chris Blunt explains: "I was saying to both the GP partnership teams that they were not as different as they thought they were and that there were opportunities to work together."

That started a process which saw Blunt and the GP partners securing funding from NHS England's resilience programme, allowing them to commission support from PCC to boost collaboration between the practices which at that time had a combined list size of 18,000.

"I looked for support and advice to take the idea forward. When we secured £10,000 from NHS England we asked PCC to provide that support. The first piece of work they did was coming in with a diagnostic tool to talk to the GPs and staff to see how we could move it forward. That work also highlighted the need for the GPs to look at their skills beyond the clinical care of patients – to get better at clinical management. That was a very useful first step."

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Wallsall network comes together in 60,000 patient super-practice

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The support was led by PCC primary care adviser Claire Deare, a former practice manager.

One of the GPs, who had already completed the NHS England general practice improvement leader programme, took part in PCC's Confident Leader programme for leadership development, while Blunt and a colleague attended a PCC workshop delivered by a lawyer from Hempsons solicitors. This provided information about practices' options for working collaboratively, both formally and informally.

The same session was repeated locally in Walsall followed by a "drop-in clinic" by a lawyer from Hempsons which allowed GPs from the two practices to discuss their individual concerns around collaborative working.

"That gave us a sense of purpose and ideas, as well as highlighting the pitfalls others had fallen into and how to avoid them," Blunt says.

Within a few months of embarking on the journey, Blunt and his colleagues realised that the two-practice collaboration could naturally extend to the small local GP federation of seven practices.

"I am managing director of the federation and I also talk to the other practice managers so we began to think that maybe this wasn't just for the two practices. We were already collaborating with the other practices because we had won CCG contracts so we began to consider what was happening with the federation. We invited the other member practices to the myth-busting workshop."

Less than a year on, five of the seven practices – including the two managed by Blunt – are conducting due diligence on the creation of a practice super-partnership.

"We will have one legal entity covering five practices with a list size of around 60,000 but for the first two or three years we will keep five income and spending streams. We'll gradually build the overarching partnership that will provide services centrally to build up economies of scale."

The five practices have secured an additional £20,000 from NHS England to support that work.

Chris Blunt

Blunt says the practices are making sure that GPs are involved all the way.

"A lot of this work tends to be management driven because GPs are busy with patients but we felt it was very important to widen the discussion to ensure it was something GPs want themselves. That's why for three to four months GPs from the five practices met every fortnight. It gave them a chance to discuss with each other what a super-partnership would mean for things like property when some practices rent their premises and others own theirs.

"After events that PCC facilitated they decided that yes, we could work together."

For the Northgate and Portland practices, that means pressing ahead with collaboration and potential new partnership models on two fronts simultaneously.

Blunt says: "The partners are talking about whether to form one partnership from the two practices or wait for the super-partnership.

"The two practices are sharing quite a lot of services – particularly the management team. We also share an anticoagulation nurse and nurses from one practice help out the other practice on an ad hoc basis."

Blunt continues: "We can see areas of scaling up outside our traditional four walls. We have the confidence to do that because Claire has told us in the workshops that practices have tried something similar and it has worked for them."

They share all training activity – reducing costs and allowing the two teams to learn from each other. Blunt says it's also important to keep the practices' patient participant groups informed of progress and plans.

The two teams of GP partners meet monthly, as well as maintaining their individual practice partners' meetings.

So far, GP concerns about any possible negative impact on patient care have been eased by patient survey results showing that nearly 100% of each practice's patients rate the services as good or better.

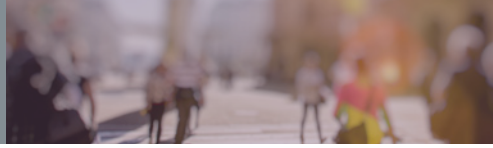
Blunt highlights another challenge that looked a little daunting back in 2017, when four of the practices' nine partners were due to retire within three years.

"That posed problems for succession planning but also raised questions about decision-making on collaboration. The four partners have been brilliant though and said they will advise and support their colleagues but that the remaining five partners must make the big decisions."

Meanwhile, the five practices have submitted a bid to run a prescribing hub for the CCG and are looking at developing a centralised hub for scanning and summarising patient records and the referrals work undertaken by medical secretaries.

As Blunt says:

> "The CCG is keen to see people scaling up and that seems to be the message from on high, so we'll keep on making progress."



Are GP partners the new worried well? BY HELEN NORTHALL

The interim report from the GP partnership review reminds us that medical melancholy over everything from premises to workload to digital disruption now represents a threat to traditional general practice.

The review's chairman, Nigel Watson, identified all those issues (and more) when the report appeared in October.

However, Watson declared his strong belief "that despite the headline challenges of a rising workload and changing workforce, the partnership model is not dead". One reason for that optimism is the policy context in which Watson and his colleagues are working. As his interim report said, they are not working in isolation.

It needs to be considered as part of a package that includes the long term plan for the NHS, the GMS contract negotiations, a GP premises review and the plan for reviving general practice, the GP Forward View.

At PCC we have been hammering away at some of the themes identified in the interim report for some time. Who can doubt the overwhelming need to modernise the primary care workforce to protect GPs from burnout as they face ever-increasing demand? That is why we developed general practice access and workload tools. We have also developed programmes to support shifting work away from GPs where appropriate.

We have worked with general practice, pharmacists, NHS England and other partners on the clinical pharmacist in general practice programme that has seen thousands of practices successfully deploy these highly-trained and skilled professionals.

Everyone involved in delivering or supporting general practice in England could look to a single-handed Scottish practice for confirmation that with innovation and energy, the best of general practice can thrive. Sue Arnott tends her Burnbrae practice list of 5000 by embracing skill mix and triaging patients efficiently and effectively.

We have worked with practices – and in some cases their clinical commissioning groups – to develop and implement the new business models that allow practices to adapt and survive.

Those models all envisage primary care delivered at scale – which is why we worked first with GPs seeking to collaborate, some formal GP federations and now with primary care networks (PCNs). As the building blocks of PCNs, practices have a chance to shape and integrate primary care in their communities, and find new ways of managing workload and sustainability, by working with like-minded practices.

For Watson and his colleagues, these approaches and tools offer the prospect of restoring confidence in the partnership model amongst young GPs – helping to forge a virtuous circle as an influx of new GPs persuade their exhausted older colleagues to hang on in there for a few more years.

If general practice starts to draw more on our own work and that of others – and links in to the various strands Dr Watson identified – GP partners might start to see things in a different light.

GP apps promise to change how we pay for primary care

Rob McGough

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With young adults being the heaviest users of digital first primary care services so far, McGough argued, traditional practices could be left with a larger proportion of older patients who use more health services but without the funding to pay for them, some of which will have been lost to digital practices that take patient registrations away from them. Meanwhile, there is anecdotal evidence that most digital providers are not linking patients into local clinical pathways or national screening programmes.

McGough compared the rise of Babylon to the impact of First Direct on the banking sector two decades ago and the advent of competition in the utilities markets.

"There will be a lot of movement by patients when people realise how easy it is to switch and get access when compared to traditional models and areas where GP practices are struggling. This comes at a time when most practices are already facing heavy financial and clinical pressures and some are in real trouble.

"We need to consider the impact of these changes now to avoid having unintended consequences of the drive for innovation and digital access. For example are we inadvertently creating a potential scenario that when today's 18-30 year olds become parents they might find that their local community does not have a physical GP practice to care for their children?" he asked.

With one practice reportedly growing from 3-4000 patients to approximately 30,000 in little more than six months, NHS England "are becoming very interested and looking at the impact on CCG planning and the wider system as demonstrated in the recent digital services consultation", he said.

System leaders and policymakers need to fully understand such challenges and review the data of the impact from experiences we have had to date in England as well as other systems that have moved to a more digital based delivery approach before us – and ideally develop a new digital primary care contract as well as the current review of the primary care funding for such services, McGough said.

This comes at a time when most practices are already facing heavy financial and clinical pressures and some are in real trouble.

Flitwick practice finds clinical pharmacists ease workload, reduce costs and improve safety

Sally-Jane Hamilton

As general practices aspire to greater scale one of their biggest motives is to achieve the skill mix that will both compensate for current shortages of GPs and improve the services received by patients.

Clinical pharmacists working in general practice are a good example. Good ones can not only save GP time at lower cost but bring new skills and expertise that can help practices run more smoothly and patients to get better outcomes.

The programme to put more pharmacists in general practice has already involved several hundred clinical pharmacists and hundreds of practices with more to come. It is among the more conspicuously successful strands of the GP Forward View.

Practices were encouraged into the programme on the understanding that NHS England would meet part of the costs of employing pharmacists, with CPPE commissioned to provide clinical training and support and PCC brought in to provide the non-clinical support needed to embed pharmacists in their new roles.

Compared with many of her colleagues Sally-Jane Hamilton already knew what to expect from general practice when she arrived at Flitwick Surgery, Bedfordshire. As senior clinical pharmacist, she was responsible not just for getting on top of her new role but for supporting five other pharmacists working in nine practices to get up to speed with theirs.

Some with backgrounds in hospital or community services found general practice a shock, she says. "The biggest problem is professional isolation. I've formed a network to bring together colleagues in my area – that's a real help, but it's also important to work on relationships in the practice, with partners, practice managers, nurses and admin teams."

She can list a lot of other challenges for the new wave of clinical pharmacists, including mismatched expectations, struggles to balance training commitments against salary-paying work for the practice, anxiety on the part of some other staff who may feel threatened by the arrival of a pharmacist and lack of understanding about what pharmacists can bring.

Sally-Jane's surgery is a large dispensing practice with 16,000 patients. It now also has three full-time clinical pharmacists, each dividing their time equally between clinics and administrative work. Various figures have been plucked out of the air to suggest that a single pharmacist could deal with a practice that size or even a locality with upwards of 30,000 patients.

Sally-Jane thinks that's too optimistic. "I'd love to have just 5000 patients to worry about," she says. "You could make a tremendous difference for a cohort that size."

While practice demographics vary, as a rule of thumb around half of patients will be on repeat medications and therefore likely to benefit from interventions by a clinical pharmacist, Hamilton says. That's a potentially large number of medication reviews and repeat prescriptions to process, but it also represents a big potential time-saving for GPs who no longer have to worry about them. Pharmacist consultations also reduce demand from patients who might otherwise have seen a GP.

All three clinical pharmacists at Flitwick divide their time equally between patient-facing and office work.

PATIENT FACING

- Minor illness
- Medications review
- Asthma, COPD, diabetes, depression and anxiety review
- Patient education including how to manage their condition, use of medicines and devices, and effective strategies for self-care
- Care home visits (including all the above in a care home setting)
- Home visits

OFFICE

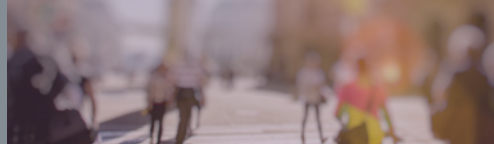
- All medication queries (dispensary, doctors, patients)
- Some discharge letters (typically only when complex; otherwise handled by dispensary)
- General prescribing advice to doctors (useful as this is a training practice)
- Liaison with CCG (together with the practice prescribing lead)
- Clinical audits (what are we doing – is it what we should be doing?) looking at safety, costs, clinical aspects

The results are impressive. In the first six months, a single pharmacist carried out 1490 tasks that would otherwise have fallen to GPs. Of these 81% required no GP approval or intervention.

In the same period the same pharmacist made 1224 clinical interventions including stopping 618 drugs, starting 221 and changing 153 dosages.

At the end of two years, by which time the practice had already taken on a second and third pharmacist, there was also a clear impact on prescribing volumes with79 fewer patients per 1000 having an item on repeat prescriptions and 243 fewer medicines on repeat for every 1000 patients.

Sally-Jane sees three big benefits for practices in embedding clinical pharmacists in the team.



"First of all, there are cost savings. The care home savings alone could pay pharmacists' salaries. I am cheaper than a GP, doing things that would otherwise have to be done by a GP, and doing them better than a GP.

"Then there is safety. A 10 minute GP appointment may not be enough for a patient on 16 medications. A pharmacist is able to offer 20 or even 30 minute appointments for complicated cases which gives me time to look at everything – why are they taking hay fever tablets all year round? Why are they taking anti-sickness pills when the medication causing the sickness was stopped years ago?"

The third benefit, borne out by a patient experience survey earlier this year, is that patients report a positive experience of the care they receive from the pharmacists on the team. When patients were asked to score 11 aspects of their care from 1 (poor) to 7 (outstanding) the mean score for each area was 6 (excellent).

Sally-Jane believes that success stories like hers send a clear message to other practices and commissioners about the value of building multi-skilled teams. "Much of our thinking is still organised along traditional professional or contracting lines, but I see a growing enthusiasm on the part of commissioners to promote a more rounded primary care offering. I want to be part of keeping that change going."

Evidence based approach reduces the risk of building multidisciplinary teams

As general practice is changing to meet the evolving needs of patients, new clinicians are joining multidisciplinary practice teams to make a wider range of skills and specialisms available in more patient-centred services.

As part of workforce development under the General Practice Forward View (GPFV), clinical pharmacists are being recruited into practices across the country through an NHS England (NHSE)-funded initiative. Some GPs have struggled to find the time and resources needed to persuade partners of the potential value of a practice-based clinical pharmacist and to invest in the necessary induction and support for a new patient-facing role in their practices.

Primary Integrated Community Services (PICS), an NHS provider in Nottinghamshire has developed an evidence-based model of support for GPs based on the effective delivery of a pilot clinical pharmacist scheme in 2015-16, the learning from which is informing the implementation of the NHSE programme across the county.

Gerald Ellis, programme manager for GP clinical pharmacy transformation for PICS explains how important it is to engage directly with GPs and practice teams from the beginning, sharing evidence of the benefits clinical pharmacists bring and encouraging people to think how a pharmacist might fit within their teams.

Benefits of clinical pharmacists in general practice

* includes GP clinical supervisor time
Source: GP pharmacy transformation project evaluation report: University of Nottingham (2017)

Key findings from the pilot scheme were that to be effective clinical pharmacists need enough time in practice to provide continuity of expertise and care. With one day a week, progress was slow, it took longer to develop relationships with the team and for people to understand what the skill set is and how to use it. It was difficult to change behaviours or introduce new ways of working and many of the potential benefits were lost.

PICS has encouraged practices to think about employing clinical pharmacists for a minimum of two days a week, even where the NHSE funding does not cover the full investment, and GPs are looking at the evidence and making the investment in additional time. PICS provides ongoing support as clinical pharmacists embed in practices and a peer network for the pharmacists themselves.

Employing clinical pharmacists on behalf of GP practices

A key concern of GPs is the risk of employing a clinician in a new role within primary care when they are not sure if it will work for them. The PICS model has evolved to provide a full recruitment service that matches clinical pharmacists to the needs of individual practices. Practices can then employ the pharmacist directly or PICS will employ them for the duration of the NHSE programme.

This approach takes the employment risk away from GPs, the advertising, shortlisting and interviewing, DBS checks and references are done for them before they meet potential matched candidates.

Ellis says: "Generally the people we put in front of them are good enough to do the role, we then need to see if personally they click, see can the parties work together. If they don't click, PICs will find an alternative and re-locate the clinical pharmacist in another practice – this has worked well already – finding the right match between practice and clinician."

At the end of the programme, PICS will meet practices and agree how they want to go forward. Practices welcome the idea that PICS is not saying they have to employ the pharmacist at the end of three years, that PICS could continue to employ them or they could choose to employ them directly, and they are not required to make a decision at this point.

"Practices are unlikely to say 'thanks very much and goodbye'. The reality is if they (clinical pharmacists) have been there for three years they can't do without them, they are part of the furniture."

The quest continues for perfection at scale

The search for the best form of collaboration for general practice – and the wider system – goes on. That was one of the big messages from a recent PCC event in Manchester.

Ruth Griffiths from law firm Hill Dickinson said that although some 85% of collaborations involve practices working with counterparts within the same CCG boundaries, the number spanning two or more CCGs is rising.

There is other evidence that collaboration remains in a state of flux. Two-thirds of collaborations involve populations of more than 50,000 patients – the notional upper limit for the ideal size of GP collaborations promoted by NHS England and others.

Griffiths said: "We are talking about lots of different tiers in the system – from one practice working with a neighbour down the road to an integrated care system. CCGs are continuing to fund the development of collaboration, including by bringing in external expertise, but then most stop the funding. Don't be afraid to ask if funding is available to support collaboration."

Collaboration, she suggested, can appeal to general practice as a way of meeting several challenges including:

- Falling income
- The threat from alternative providers
- Rising demand and workforce problems
- The requirement for extended access
- Succession problems
- Estates issues.

Practice leaders need to understand the purpose of collaboration and both the clinical and business case for change.

"The advantage (of practice-led approaches) is that collaboration will be primary care led and owned and primary care is best placed to understand the clinical case for change. Practices need to ask what they want to achieve for member practices as well as at the ICS (integrated care system) level. If the new organisation has the patient list for the whole CCG then it will be the sole potential prime provider."

Mike Smith

While CCGs had supported the rise of federations (including through providing seed funding), they now prefer to award contracts to alliances or prime provider type groupings, Griffiths said.

Meanwhile federation has become a "toxic word" in general practice because most have failed to deliver what they promised their GP members, Griffiths said.

"A lot of federations have forgotten they are there to serve their members and are used as a reserve model for practices in distress. The membership can start to become disengaged because the federation is not delivering income and is instead asking for more capital. Federations need to change by responding to what is happening in the system."

She set out her firm's experiences working with federations in Leeds that formed a new city-wide organisation. The large federation also has a very different approach to governance to the early federations – something speakers at the event agreed is key to success.

"The federations in Leeds realised they were not going to be taken seriously unless they saw themselves at a commercial organisation at that city-wide scale. They have an executive board, none of whom are GPs and who have no competing interests. A locality-based partnership council acts as the non-executive board. It sets the annual business plan and then holds the executives to account for implementing it. If the executive team want to do something on top of the business plan they seek permission from the partnership council."

GPs providing such oversight should be given training in the role of non-executive directors, she said.

GP partner and primary care consultant Mike Smith escalated the onslaught against federations in their current guise, agreeing they had lost their way.

"Federations are not working: their purpose was not clear and GPs don't like top-down leadership and management. They are often too big to notice the nuances of small communities. Many of them spent too long doing nothing – partly because CCGs never really believed in them and the contracts they were chasing were too big for organisations that were too immature.

"The practices don't trust the federation board just like they don't trust their CCG, which is also a membership organisation, or even the local medical committee sometimes. What makes us think they would trust a limited company? CCGs and practices should start building collaboration from the neighbourhood level instead."

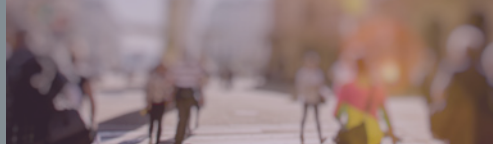
Federations, he suggested, could be commissioning support unit-type organisations for general practice, with practices seeking support from them as needed.

Ruth Griffiths

He also questioned the use of the term mergers in the context of general practice and the need to label well-established joint working practices.

"It's never a merger, there's always a dominant practice. We are not a partnership, we are a business.

"Since 2015 there has been lots of talk about neighbourhoods and primary care homes which is fine but I don't need a badge. This is how practices used to work – we were sharing district nurses, health visitors and ECG machines 25 years ago. Practices don't need permission



to employ a cardiac nurse that they will share."

Successful relationships, Smith suggested, would be based on strong relationships not arbitrary business cases.

"GPs pick their friends: one of the advantages of being a GP is that you don't have to work with someone if you don't like them. In terms of size and relationships it has got to be about what feels right and what you are trying to achieve."

Urging commissioners to seek partnerships between practices that are philosophically aligned rather than on the basis of geographical proximity, he said they should be "clinical enablers rather than clinical commissioners".

"Start at the neighbourhood level and build up."

"GPs are worried about workload, workforce, estates and a £30,000 fall in their income over five years. They have been promised that the cavalry is coming for years but they never arrive and there is sort of a learned helplessness among GPs. Commissioners should not be tied to a minimum or maximum patient list size. If someone does not come to the table, don't wait for them."

Practice managers – now with PM approval

Announcing the NHS long term funding settlement in June, no less a figure than the prime minister name-checked practice managers as among those who can transform patient care and ensure a sustainable service.

As with the doctors and nurses (whose role is rather more regularly highlighted in political speeches on the NHS), Theresa May said that those "who manage GP surgeries, outpatient clinics and operating theatres…will bring about change if they are empowered and if we have enough of them with the right training and the right skills".

Which suggests that PCC's unique personal and team development offer for primary care teams and leaders has never been more relevant.

We like to think that the Confident Leader and Confident Practice Manager programmes are its crown jewels.

The former supports GPs to guide their practices through a fast-changing environment while the latter does that while meeting the needs of people with a huge workload and few training and education options.

Helen Ellis says: "The Confident Practice Manager programme brings together a small group of practice managers for eight half day sessions over nine months. The programme allows them to develop their skills and their understanding of the challenges facing general practice. With one session each month, participants can think about issues and talk to others on the programme in between sessions. With many practices facing significant change, they don't have the luxury of endless time spent developing leadership skills away from work."

The sessions, which include regular opportunities to discuss current issues and challenges, focus on the practical. They include:

- Understanding people and leadership styles
- Influencing skills
- Leading general practice through change
- Working with and developing your patients and community.

Kim Foran, an assistant practice manager in Liverpool, completed the programme last year when she was reception manager.

"I found the course brilliant – I got something out of every module and I'm sure it helped me when I applied to be assistant practice manager. There were a couple of days where I didn't feel like going to the sessions – including one time when I had a real challenge at work – but I went along and talked about it on an anonymous basis. They all helped come up with a solution and I came out feeling a different woman in terms of confidence."

Ellis says that is a fairly typical reaction: "There is an upbeat feel about the sessions: participants like the open style. Practice managers can be very isolated and learning from each other's experiences is fantastic for them."

Some 70% of people who have completed the programme said it exceeded their expectations, with the rest saying it met their expectations.

These programmes aimed at practice managers and GPs are not the only support PCC offers primary care leaders and their teams. Several team members have ILM Level 7 coaching qualifications which equip them to work with senior leaders on their confidence and in improving their skills in particular areas.

The training and personal development team has recently been boosted with the arrival of Polly Goodwin and Karen Garry, who each bring experience from the voluntary sector. Meanwhile, Colin Murray also provides individual coaching and team development sessions – drawing on his extensive experience in the private sector to provide a different perspective.

However, as the prime minister pointed out, developing a sustainable NHS with general practice at its core will need an empowered team supporting those empowered leaders.

That's why we also offer a range of personal and training/developments events and workshops for practice teams and for non-clinical staff at all levels.

Primary care organisations can access a wide range of courses and training aimed at an equally wide range of team members – or the whole team.

These include:

- Practice team development (including smarter working, effective communication and care navigation)
- Myers Briggs and Belbin team roles
- The leader as a coach.

With key initiatives such as the General Practice Forward View highlighting how signposting patients to a range of non-NHS community support can reduce practice workload, educating reception staff in those skills can have a significant and rapid impact.

Developing a sustainable NHS will require informed and confident staff at all levels of primary care. We can help you achieve that.

For information on accessing any of this support please email **enquiries@pcc-cic.org.uk.**

Clarity, openness and trust: Avoiding contract disputes

Karen Garry

Contract disputes are stressful, demoralising, counterproductive and a waste of resources. Commissioners and contractors both need to know what to do to avoid them.

Contract disputes arise for many reasons. These include poor drafting, ambiguity, changing circumstances, differences of interpretation, failure to document local variations, contested payments, historic issues, and alleged breaches of contractual terms.

By the time both sides are reaching for third-party mediators or lawyers much of the damage will already have been done.

Disputes may be costly to resolve - and not just financially. Reputations may be harmed, particularly if the fall out reaches the media, services to patients may be affected, and the damage to relationships between commissioner and contractor may take years to heal.

No-one wants to reach a point where conflict resolution between commissioner, contract manager and provider is necessary. Constructive relationships are vital for the successful provision of high quality services that meet the needs of patients.

Investment in building relationships can save a lot of time and stress later on should performance or contract compliance issues arise.

A new event from PCC promises to equip delegates to prevent conflict in commissioning and contract management relationships. It also aims to increase their confidence in managing situations where conflict may arise.

This one day training session focuses first on preventing conflict, providing tips to build collaborative relationships and processes to make them work.

It looks at mechanisms to pre-empt conflict and practical solutions to prevent escalation to a formal conflict resolution process.

Delegates have the opportunity to put this knowledge to the test in an afternoon session where they can practice conflict management strategies using a combination of realistic scenarios and role play.

PCC adviser Karen Garry, one of the facilitation team, says: "We want people to leave with a clear understanding of the practical steps they can take to avoid conflict, and to go back to their organisations with more confidence about how to deal with situations where conflict is impossible to avoid.

"Most of all we want commissioners to grasp the importance of investing in relationships. Conflict is much less likely to occur where there is clarity, openness and trust."

For details about events in your area please contact **enquiries@pcc-cic.org.uk**