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Commissioning **EXCELLENCE**

Leaders call for clarity in joint working with drugs industry

PCC-facilitated sessions involving the government, pharmaceutical industry and NHS organisations have called for better promotion of the value of joint working and the outcomes of individual projects.

The parties agreed that joint working between the pharma industry and clinical commissioning groups (CCGs) could deliver real benefits through combining the local knowledge of clinicians with the expertise and other resources of industry. This, they agreed, would help the NHS during difficult financial times while meeting the QIPP agenda.

However they stressed the need to share the outcomes of individual projects through case studies placed in a repository, together with supporting material such as business cases and research reports. The Commissioning Zone, a web portal backed by the clinical commissioning community, is seen as a possible repository and is currently being redesigned – partly for this purpose.

Other recommendations include:

- Agree criteria for assessing case studies – including a checklist to test project goals at the start and to enable evaluation
- Include educational benefits for patients and clinicians in the criteria
- Develop a communications programme to promote examples to key stakeholders such as emerging CCGs, pharma industry leaders, policymakers and the NHS Commissioning Board
- The Association of the British Pharmaceutical Industry and the Department of Health should lead a coordinated approach to promoting joint working.

The document emphasises that sharing results and lessons of individual projects – both positive and negative – will benefit the wider NHS and shape and improve future projects.

The briefing is available at <http://www.pcc.nhs.uk/better-joint-working-between-the-nhs-and-the-pharmaceutical-industry> See also page 5.

Forums offer pathfinder CCGs a sounding board

Newly created online forums for pathfinder clinical commissioning groups will allow CCG leads to discuss issues and share learning with their colleagues. The new forums, part of the existing Pathfinder Learning Network, are organised in themes corresponding to the six authorisation domains for CCGs and moderated by their members. Built on the NHS Networks platform, the forums will allow CCG leads to discuss issues with each other but also with the Department of Health and the team developing the NHS Commissioning Board Authority.

Paul Zollinger-Read, a GP and director of commissioning development for the east of England, said: “These forums give CCGs protected space to air their views and work through difficult issues with colleagues, but also the opportunity to widen the discussion to include the people in government responsible for making the policy work.”

The forums include a resources section for policy documents, guidance and case studies. Members will also be able to share their own plans, experience and good practice examples.

Contact maria.axford@networks.nhs.uk



PRIMARY CARE GEARS UP FOR OLYMPICS

The venues are on track and PCC is working with NHS London to ensure primary care is ready for next summer's London Olympics.

PCC London lead Sally Simmonds has drafted a briefing on issues for primary care.

NHS London's key assumptions about the games period centre on maintaining "business as usual" in health services for Londoners but recognise the possible pressures from increased demand through an influx of visitors and logistic challenges around transport.

Simmonds says: "The briefing is intended as a starting point for what primary care leads in London and commissioners and providers of primary care services should be thinking about.

"Up to now much of the focus has been on the acute sector but there will be issues for primary care around things like ensuring increased demand for services and ensuring that community services such as district nursing or palliative care providers are planning for parking and transport restrictions during the Games period."

Such travel restrictions could also affect patients' access to practices and other primary care centres as well as the delivery of essential supplies such as medication or home oxygen supplies.

Other issues covered in the briefing include:

- Planning for staff absence if they wish to volunteer at the Olympics

- Possible cost pressures incurred in increased medicines or activity due to large numbers of visitors
- Charging foreign visitors for primary care services.

The briefing says: "Commissioning organisations should see the 2012 games as an opportunity not only to ensure existing contract compliance but also to support the development of robust continuity, emergency and resilience plans in their primary care provider organisations across London."

The briefing is available on the PCC website at <http://www.pcc.nhs.uk/primary-and-community-care-for-the-london-olympic-games>

RESOURCES

NICE ADVICE ON COMMON MENTAL HEALTH DISORDERS

NICE has published a [guide](#) for commissioners on services for people with common mental health disorders. It includes a commissioning and benchmarking tool which commissioners can use to assess local service requirements.

PAYMENT BY RESULTS UPDATE - OCTOBER 2011

The latest [update](#) from DH's Payment by Results (PbR) team covers development of the 2012/13 tariff, mental health care clusters, Audit Commission annual report, best practice tariffs, HIV adult outpatients, ambulance services and reference costs.

MAKING DIFFICULT CHOICES: ETHICAL COMMISSIONING GUIDANCE TO GENERAL PRACTITIONERS

This [guidance](#) from the Royal College of General Practitioners will help GPs who will have a role in CCGs. It provides advice on possible ethical issues in the process of commissioning. These include fair resource allocation and addressing potential conflicts of interest.

NEW GUIDANCE ON DEVELOPING BEREAVEMENT SERVICES

The National End of Life Care Programme has supported the Bereavement Services Association and PCC in the [publication](#) of When a Person Dies: Guidance for Professionals on Developing Bereavement Services. The publication includes outcomes for bereavement care.

PATIENT AND PUBLIC ENGAGEMENT IN THE NEW COMMISSIONING SYSTEM

This [paper](#) considers the critical issues which clinical commissioning groups (CCGs) will need to address in developing approaches to meaningful and effective patient and public

engagement in health service design and delivery.

COMMISSIONING LOCAL VOLUNTARY SECTOR ORGANISATIONS

This [report](#) is the result of an investigation of five local voluntary sector organisations and uses case studies to show how voluntary sector organisations can become involved in the local healthcare agenda.

SOCIAL CARE AND CLINICAL COMMISSIONING FOR PEOPLE WITH LONG-TERM CONDITIONS

This [briefing](#) from the Social Care Institute for Excellence and the King's Fund summarises how working with adult social care can help clinical commissioning groups manage their new responsibilities.

COMMISSIONING INTEGRATED CARE IN A LIBERATED NHS

The Nuffield Trust has published a [report](#) exploring the role of commissioners in developing more joined-up and efficient services.

Godiva takes a step back to move forwards: facilitated development for CCGs

Stepping back for a moment is often a good idea – whether faced with some perceived personal affront or a difficult professional challenge.

Godiva Commissioning Consortium, one of the CCGs for Coventry, has encouraged selected grassroots GPs and practice staff to do just that in a half-day session organised by PCC.

Ten GPs, practice managers and practice nurses used small facilitated workshops to consider how a CCG board could respond to a series of challenges similar to some of those facing commissioners in Coventry.

They worked in the context of a fictional CCG, using background data created for the day covering factors such as demographics, health inequalities and financial status.

The workshop exercises helped the group move on to discuss more broadly Godiva's current ways of working and systems.

With discussion stimulated by the initial fictional session, they came up with an impressive list of recommendations after considering issues around:

- Chronic obstructive pulmonary disease (COPD) testing and services
- Engaging and supporting smaller practices and
- Prescribing.

The session proved a useful listening and engagement exercise for Godiva. In selecting individuals to approach, the CCG was keen to hear the views of a cross-section of its practices - with a particular emphasis on its disproportionate number of single-handers and two-person practices.

Patricia Barnett, programme manager at Godiva, says: "We were trying to involve some of the grass roots GPs in discussions around QIPP. We were seeking their ideas as part of the wider CCG community if you like and about what the Board can do for them in their general practice settings."

The scenarios used during the workshops were developed after Ms Barnett met the PCC facilitators to discuss local circumstances and priorities. The resulting exercises were not a mirror image of the CCG but would have sounded familiar.

Helen Ellis, the PCC adviser who facilitated the event, said: "There were enough factors in the fictional scenarios for delegates to recognise the situation as relevant to them locally. The scenarios proved a popular part of the event with people often referring back to experiences in their own organisation or area."

Working together in this way, with the support of a facilitator, helped forge new relationships, Ms Barnett said.

The 15 specific ideas outlined to the board as a result include:

- Developing a case study that shows the useful role non-clinical practice staff can play in prescribing meetings with PCT medicines management leads
- Small practices can collaborate in sharing a COPD nurse or practice manager and
- Review the CCG's use of web and social marketing.

A particularly interesting point in the list is the request for one to one meetings between board members and practices.

Ms Barnett concludes: "It was quite exciting from my point of view – we had a cross-section of real practices in attendance. It was good to see if we had our heads in the clouds or were on the right lines."

Bringing the right people together to take a step back can help provide that fresh perspective – one that is definitely not stuck in the clouds.

ABOUT THE FACILITATED DEVELOPMENT SERVICE

PCC is offering facilitated workshop and discussion sessions aimed at helping commissioners and their partners tackle local challenges and forge closer working relationships.

The training is shaped around the needs and roles of the participants - ranging from members of new clinical commissioning group (CCG) boards to groups of GPs and practice staff. The important thing is they are seeking to work together to address a particular local health challenge or issue.

To stimulate discussion and forge that sense of working together, participants initially tackle scenarios set in a fictional health economy. The scenarios are selected before the session to ensure they are relevant to the local challenges that the CCG has identified.

These could include, for example, addressing health inequalities, dealing with poor performance in general practice or improving public engagement.

They allow participants to step back from the day job and local pressures to work through the fictional – but realistic - challenges with colleagues or partners. As well as stimulating possible solutions to real challenges, this should encourage collaborative working between colleagues and teams.

The scenarios are intended to build the confidence for frank discussion when the focus turns to those same challenges in their local community.

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DES SHOWS IT IS THE TAKING PART THAT COUNTS



Getting patients involved in the development of local services is an important policy goal which could help practices serve local populations more effectively and clinical commissioning groups provide evidence for authorisation.

It is therefore a little surprising that primary care practices have found it so difficult to foster genuine patient participation – only around of 40% of practices have a patient involvement group of any kind.

Agreement was reached between NHS Employers and the BMA to make patient participation a directed enhanced service, potentially increasing the income of the average practice in England by £13,000 over two years.

However when the DES and accompanying guidance were published earlier this year many GPs and practice managers complained that expectations on practices and how they would deliver on them remain opaque.

PCC has stepped into the breach by developing a practical toolkit for those suspicious of either the time commitment or complexity involved in achieving the DES.

Jane Dawes, practice manager at Sturminster Newton Medical Centre, was one of those who felt somewhat bereft after reading the official guidance.

“I thought it was very vague and left a lot of room for interpretation. I did not understand the process or some of the basics about how to get hold of patients. We have had virtually no patient engagement in our practice for many years as there has been a reticence on the part of the doctors.”

Like other practice managers and commissioners, Dawes faces an added challenge in ensuring any patient representation group (PRG) is representative of the practice population. Historically, such groups have been dominated by white, middle-class retired or middle-aged people.

Based in rural Dorset, the practice population is hardly a picture of ethnic diversity but Dawes is pleased to have recruited five eastern Europeans to the PRG.

“We went through our practice list looking for all people of non-White British ethnic background and sent out around 150 letters,” she says.

Her practice is making slow but steady progress on recruitment with just over 100 members by early September.

Dawes hopes to boost that figure to 200 before autumn is out, with recruitment tactics that have included attaching leaflets to prescriptions. Other recruits have come both via the practice website and through district nurses and health visitors raising the issue with young mothers and patients.

Recognising the importance of human interaction, Dawes plans to develop a smaller in-house group whose work will be backed up by the larger virtual group.

Having found many of the people she hopes will help shape the practice’s future, Dawes is also relieved that the PCC toolkit provides templates and guides for data management, developing survey questions and reports.

For the practice the reward should be much more than the £13,000 DES money on offer if the qualifications are met.

Dawes concludes: “As well as looking at the services the practice offers and getting patient feedback on the quality of services, we will be asking about customer service. That will be increasingly important with wider competition between practices.”

- The toolkit is available at a cost of £300 plus VAT. To order or for more information please email enquiries@pcc-cic.org.uk or call **Peter Bullivant** on **07717 300633**.

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Toolkit contents

- A step-by-step guide to achieving the DES
- A patient representative group (PRG) recruitment pack, including template posters, leaflets and recruitment letters
- An Excel tool for collating PRG data
- A practice-specific survey tool
- A guide to establishing a virtual network
- Template local patient reports and achievement reports for recording and reporting actions and achievements and
- A helpdesk to provide support.

Working together to help the medicine go down

The use of medicines in today's NHS is no longer just about handing out pills and leaving the patient to get on with it.

Prescribing and supplying medications is seen as part of a package as the patient travels along a care pathway. Issues of compliance and informed choice are high on the agenda.

It is surprising, therefore, that medicine manufacturers are not a bigger part of this wider approach to patient care.

Ministerial strategy groups, government toolkits and industry guidelines have so far largely failed to bridge the cultural divide – which means joint working between the NHS and pharmaceutical companies are unusual.

A Department of Health (DH) toolkit was published in 2008 and updated last year, alongside guidelines from the Association of the British Pharmaceutical Industry (ABPI). These highlighted how pharmaceutical companies and individual NHS organisations have worked together on projects ranging from redesigned clinical pathways to education initiatives (see links below). PCC pharmaceutical services development manager Marion Todd suspects the slow response of both the industry and the NHS to such success stories and government exhortations is down to lingering mutual wariness and cultural differences.

These cultural differences were acknowledged in discussions between the industry, the NHS and the DH facilitated by PCC late last year. Todd does believe they are narrowing. On the NHS side, she says the arrival of clinical commissioning groups could finally usher in a less suspicious mindset. That trend is likely to be quietly nudged along by the financial squeeze and the opportunities for pharma and the NHS to work together to take forward the quality, innovation, productivity and prevention (QIPP) agenda.

"In reality the two have a joint starting point around patient engagement, self-care and a focus on outcomes," says Todd.

She continues: "Both sides want to boost concordance and compliance because that will improve outcomes."

Anthony McKeever, a former primary care trust chief executive and a member of the NHS Future Forum, agrees the two sides have an unfortunate history of suspicion but that the shared objective of improved outcomes will increasingly bring them together.

"The NHS and the pharmaceutical industry share patients for a long time. Commissioning is increasingly likely to be about promoting health and wellbeing and commissioners will look at the package of what benefits patients."

The arrival of the new medicines services and targeted medicines-use reviews could also stimulate joint working if the parties are prepared to dip a toe in the water.

Eager to keep a step ahead of their rivals, some companies seem reluctant to shout about successful partnerships.

GlaxoSmithKline and the Wearside Practice Based Commissioning Consortium were shortlisted in national awards for joint working. Their partnership aimed to improve the quality and productivity of chronic obstructive pulmonary disease management (COPD).

This involved training, patient surveys and financial incentives for practices to achieve specific objectives. In the 12 months to June 2010 there was a 12% reduction in non-elective COPD admissions. Neighbouring practices recorded a slight increase in admissions over the same period. There was an 18% improvement in the quality of patient reviews. The number of patients receiving reviews and patient understanding of their condition both rose.

Figures supplied for the award show there was a 6% rise in the proportion of patients receiving combination therapy in line with National Institute for Health and Clinical Excellence guidelines – presumably a benefit for GSK to place alongside reported improved working relationships with the NHS.

On Wearside, the NHS contribution was valued at £162,000 and GSK's at £91,000. In both cases this was not a straight cash injection and Todd emphasises that the NHS should look beyond the pound signs.

"It is very much also about the other skills the companies can bring – things like facilitation and business planning skills."

McKeever agrees, while acknowledging the sector can often put up the cash for pump-priming service changes – a regular impediment to improving services within the NHS. Pharma companies, he says, often have a deep knowledge of healthcare and huge management capability – including working with patients as customers.

With the pharma industry seemingly signed up to integrated care, the NHS seems likely to be working with these companies more often.

Further reading

Moving beyond sponsorship: Interactive toolkit for joint working between the NHS and the pharmaceutical industry

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082840

ABPI guidance notes on joint working between pharmaceutical companies and the NHS and others

<http://www.abpi.org.uk/our-work/library/guidelines/Pages/code-guidance.aspx>

DIABETES CARE sharpened up

BY CHRIS MAHONY



People with diabetes are used to having a hand in their own care – quite literally given the self-administration of insulin.

In Bexley, south east London however, they have become active partners in a radical overhaul that has seen much of their care transferred from secondary to primary care.

Historic patterns of care and the high and rising numbers of people with the condition mean diabetes poses a major financial challenge to the NHS. It accounts for 10% of NHS resources with diabetes patients occupying 15-20% of a typical hospital's beds.

UK prevalence of the disease is expected to soar from 3.5 million today to 5 million in 2025 as obesity rises.

The Bexley Community Diabetes Project has had some form of contact with nearly all the 11,000 diabetes patients in its area. Of those, around 1,000 are now expert patients.

This has underpinned the transformation in how their services are delivered.

Changes include:

- GPs, practice nurses and other health professionals were trained in insulin conversion, patient reviews, care planning and management of Type 2 diabetes
- More than 80% of practices provide care planning for diabetes patients and their services are audited twice a year – ensuring that response to patient need is based on strong evidence
- Ongoing training, mentoring and advice for health professionals has supported the safe, effective transfer of the care of hundreds of people from secondary to primary care
- Specialists work with patients and health professionals in virtual clinics to address specific concerns.

Since launching in the spring of 2010, the initiative has seen patients working with their GPs and other primary care team members to take greater control of their care – and produce savings.

Project manager John Grumitt emphasises that engaging both patients and GPs and other primary care professionals has been crucial.

“There was real enthusiasm from GPs with 100% representation of practices at the first engagement session.”

Meanwhile, a survey of patients showed enthusiasm for a structured patient education programme.

Referrals to hospitals have halved, leading to significant direct and indirect savings.

Patients starting on insulin no longer attend hospital but are instead advised and supported in the community – saving £510 per patient.

The Bexley figures are impressive but its legacy on both patient health and NHS finances might be even greater in the years ahead. It is well known that the disease can wreak traumatic damage on people over time, sometimes resulting in blindness, kidney disease and amputations.

Supporting and incentivising GPs to reduce HbA1c (an indicator of blood glucose levels) has seen a 1.3% reduction – the highest fall anywhere in the UK. A 1% fall in HbA1c equates to huge reductions in microvascular complications such as kidney disease and blindness (37%), amputations (43%) and heart attacks (14%). It cuts overall deaths related to diabetes by more than 20%.

David Colin-Thomé, former national clinical director for primary care, described the initiative as “the most impressive application of QIPP” he has seen.

For those seeking to follow however, even Grumitt acknowledges that Bexley has worked particularly intensively in researching and developing options.

“Diabetes commissioning has typically been done by an overgrown practice manager in the morning who does stroke in the afternoon and end of life care in the evening. Ideally it would be done at cluster level,” he suggests.

“There was real enthusiasm from GPs with 100% representation of practices at the first engagement session.”

BREATHING NEW LIFE into home oxygen

BY HELEN ELLIS AND REBECCA THORNLEY



With around 30% of its product going unused or of no clinical benefit to the patient, home oxygen provision is ripe for efficiency gains and improved patient care.

Home oxygen services (HOS) are used by 85,000 patients each year in England at an annual cost to the NHS of £110m and they offer scope for supporting PCT QIPP plans.

Recent events in London and Manchester organised by PCC heard from experts that commissioners could achieve significant savings and improve patient care by commissioning a home oxygen assessment and review service (HOS-AR).

Professor Sue Hill, chief scientific adviser at the Department of Health, pointed out that effective assessment and review services may deliver savings of up to 40% on the cost of providing home oxygen. That equates to a national saving of £45m – or up to £300,000 per PCT.

While assessment and review services may produce significant savings, they will also ensure that patients receive appropriate oxygen prescriptions and equipment – and teach them to use it. The events heard that while over-prescribing or unnecessary prescribing may incur major costs, significant numbers of people are prescribed too little oxygen. In one area, 20% of those receiving oxygen had their prescriptions increased following a clinical review by a new assessment and review service.

However in leading the drive for the commissioning of assessment and review services, Professor Hill was one of several speakers to set this within the context of national initiatives for improving services to patients.

Professor Hill said that an effective home oxygen service – including assessment and review – was vital if local NHS commissioners and providers are to achieve the objectives of the outcomes strategy for chronic obstructive pulmonary disease and asthma published last summer. Objectives in the strategy include enhancing quality of life – something HOS-AR can play a vital role in.

She also emphasised that the clinical standards for COPD developed by the National Institute for Health and Clinical Excellence state that people requiring long term oxygen therapy are assessed and reviewed at least annually.

Sandie Bisset, HOS programme manager for the DH, said that communication and effective use of data and information – such as concordance reports filed by suppliers – are useful when commissioning home oxygen services and assessment and review services.

“You would be surprised how many areas do not know how many people are on oxygen. There are currently an unknown but large number of home oxygen patients who have never been assessed and followed up. Suppliers are one of the best sources of information

about your patients. The concordance report is a big beast but has got a lot of good information in there that will help identify patients who are either over-using or under-using oxygen.”

She urged commissioners to study Appendix 6 of the HOS good practice guide (see link below) for a comprehensive list of the components of a good quality HOS-AR.

Ore Okosi, national improvement lead at NHS Improvement, said Lung Improvement Programme HOS-AR pilots showed that effective use of data is a quick win for commissioners.

Top tips from the pilots included:

- Ensure clinicians have access to oxygen usage data and work with managers to review it
- Develop and deliver consistent messages to patients – such as, when discussing access to oxygen therapy, and emphasising that oxygen is not a treatment for breathlessness
- Have an integrated service with a pathway and prescribing consensus between the HOS-AR team and relevant clinicians and managers across primary and secondary care (with the HOS-AR service specification integrated within the wider respiratory care pathway)
- Ensure you have access to an administrative support team to help shape and deliver the project.

Nine of the 12 pilots had made prescribing savings of nearly £650,000 – even though several of the nine had already achieved significant savings through pre-pilot activity in assessment and review.

Oxfordshire respiratory nurse specialist Jo Riley outlined her own experience in persuading her PCT to commission a full HOS-AR and revealed both the dramatic improvement in prescribing and use and cost savings.

The PCT’s HOS budget was more than £300,000 overspent. Preliminary work by Riley and her colleagues revealed startling findings such as the continuing invoicing for supply of oxygen to 17 people who had died up to four years earlier and the prescribing of ambulatory oxygen to patients who respiratory nurses knew were housebound.

Few commissioning organisations will want to be seen to be commissioning for deceased or unsuitable patient groups. The answer, more timely now than ever, is to breathe new life into assessment and review services.

http://www.pcc.nhs.uk/uploads/HOS/2011/08/home_oxygen_service_assessment_and_review_v4.pdf

PRACTICE MANAGERS OUT TO MAKE NEW FRIENDS FOR NEW TIMES

Practices are gearing up for the new commissioning world by seeking to work more closely with other professionals and with patients, PCC's 2011 practice management survey suggests.

Concerns over workload and the potential business impact of the NHS reforms are running high – but the findings indicate that practice managers and their employers recognise that the new era will require new relationships.

Asked to identify strategic priorities for their practice from a list of 12, 94% agreed developing effective working relationships with secondary care colleagues was important or very important. An even higher figure, 97%, said the same about developing effective working relationships with other professionals – such as district nurses. Working more closely with patients to understand their needs was seen as important or very important by some 95%.

Commissioning Excellence spoke to two practice managers who took part in the survey. The manager of a practice with around 10 clinicians said his CCG “feels very strongly about talking to secondary care”.

“The PCT was a bit “them-and-us” but the GPs in our CCG are very keen to talk to consultants. In the past GPs and secondary care were not talking but there is a great drive for us to talk to each other.”

He is involved in talking to secondary care about IT issues and also takes part in discussions with the voluntary sector and social care. Our second practice manager welcomes signs of improved communication with secondary care and is aware of clinical groups spanning primary and secondary care which are working on new pathways. These do not have practice management representation however.

Identifying potential savings or improvement through commissioning emerged as a higher priority in our survey than active involvement in CCG development, although the differences were small.

As well as reflecting the financial challenges facing the NHS and GPs' increased responsibility for the health service budget, this could arise from the minimal formal role accorded practice management in CCGs.

The two practice managers Commissioning Excellence spoke to had contrasting views on whether practice managers would be actively involved in CCG development and operation.

One said: “My job will not change because it is to ensure the practice is as efficient as it can be and works to support the rest of the CCG. You can't take practice managers with the skills out of the practice – they should be using the skills and expertise of PCT managers who have been doing the job for a long time.”

However, the other manager is “very much involved in the workings of the CCG”.

“We have practice manager groups for things like redesigning services and pathways and have a non-voting board member. They are starting to redesign services and renegotiate contracts and our input is very much sought around areas like mental health and redesign of district nursing.”

He feels that practice managers can provide impetus to CCG activity and adds that the mistake of excluding them from practice based commissioning processes should not be repeated. Close scrutiny of the practice budget to ensure it is meeting CCG expectations is likely to be an increasing part of this practice manager's work.

It will be part of a workload that our survey suggests is a real issue for practice management. When prompted, some 97% agreed that workload is a challenge for them.

With practice managers having transferrable management skills, particularly in finance, it could be thought that this workload might see an exodus at some point unless pay improves. Our two managers' own experiences and views differed sharply on the issue of pay and status however, even though both strongly agreed that they have an intense workload.

One said: “The workload is high but I get paid the salary. I always feel that I have good status within the practice but I can see it could still be a problem in smaller practices.”

However, our second practice manager feels that the pay simply does not match either the challenges or intensity of the work.

“The workload is coming from the requirements of all the enhanced services and QOF (the Quality and Outcomes Framework). At some point practices will have to acknowledge that the workload is too great for the role of practice manager as originally created. The pay is ludicrous for the complexity of the job I do.”

The survey suggests that practices could usefully engage in internal re-design as well as re-designing clinical services.

A summary of the survey is available from http://www.pcc.nhs.uk/uploads/research/summary_report_15_september.pdf

For details of PCC events for commissioners and primary care providers see www.pcc-events.co.uk

To access documents mentioned in this issue, an online version is available at www.pcc.nhs.uk/ce

If you have a case study for Commissioning Excellence please contact julian.patterson@pcc.nhs.uk