



Personal medical services

A bulletin for primary care trust chairs and chief executives

The Audit Commission is an independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high-quality local and national services for the public. Our work covers local government, health and criminal justice services.

As an independent watchdog, we provide important information on the quality of public services. As a driving force for improvement in those services, we provide practical recommendations and spread best practice. As an independent auditor, we monitor spending to ensure public services are good value for money.

This short bulletin presents the Audit Commission's findings during the course of our work with commissioners of Personal Medical Services (PMS) pilots. It highlights examples of good practice that PCTs with PMS pilots can use to maximise the effectiveness of their own arrangements. Aimed at primary care trust chairs and chief executives, it will also be of interest to anyone involved in PMS pilots, particularly those currently establishing fifth wave pilots.

What are personal medical services?

- 1 The introduction of Personal Medical Services (PMS) in 1997 reflected a growing consensus that the nationally negotiated general medical services (GMS) system for contracting with GPs was too bureaucratic and did not always encourage GPs to innovate or contribute to the overall improvement of health and healthcare. Among the intended outcomes and benefits of PMS are:
 - faster, more convenient and accessible services for local patients;
 - extending primary care services for populations that have previously not received their fair share of such services;
 - giving healthcare professionals more opportunity to use their skills to the full;
 - offering more flexible employment opportunities in general practice;
 - reducing the bureaucracy in administering the GMS fees and allowances regime; and
 - informing national policy formulation.

Box A

Examples of PMS pilot initiatives

- Nurse-led or joint nurse/doctor-led practices.
- Providing varied surgery times.
- Widening the primary healthcare team to include other staff groups, such as practice-based social workers, therapists, nurse practitioners and specialist nurses.
- Primary care trusts (PCTs) employing salaried GPs.
- Practices established to cater for homeless people and for those with a substance dependency.

Source: *Audit Commission review*

- 2 The first wave of PMS pilots went live on 1 April 1998. These have been followed up by a series of further waves, culminating in the recent announcement that a fifth wave will go live on 1 April 2003. Pilot providers can be an individual GP, a practice, a PCT, or a group of practitioners, including GPs and nurses.

Case study 1

Linking targets to priorities

North Peterborough PCT has a clear strategy for using PMS as a means of improving the equity, quality and stability of services, as well as addressing specific problems, such as recruitment. They see PMS as the start of a longer-term organisational development programme for practices, based on quality-driven contracts. The PMS pilots have clear targets linked to local health improvement priorities, especially coronary heart disease and diabetes, but also asthma and mental health, as well as broader targets linked to improving access.

Source: Audit Commission review

- 3 The NHS Plan^I, published in 2000, added momentum to the number of practices applying for PMS pilot status. It incorporated an expectation that one-third of GPs would work in PMS by April 2002 and ‘a majority of GPs’ by 2004.

Why focus on PMS?

- 4 PMS pilots are an important part of the NHS modernisation programme. They aim to give commissioners^{II} flexibility to provide locally tailored primary care, and as such, are one of the few tools available for modernising primary care.
- 5 The impact of individual pilots on patient care has been the subject of evaluation commissioned by the Department of Health^{III}. In addition, a book has been published by the King’s Fund^{IV}.
- 6 As the nature of PMS schemes varies widely, it can be difficult to separate the benefits of PMS from those of other initiatives being undertaken. This means that the messages from the evaluation are complex, and those involved in establishing pilots would be advised to review the evaluation.
- 7 Nevertheless, the evaluations do suggest that PMS is responsible for a number of improvements in patient care, including:
- improved services for disadvantaged groups;
 - filling previously hard-to-fill clinical posts; and
 - expanding primary care services to include those usually provided in hospital.
- 8 PMS pilots can be most effective where they link to the PCT’s overall strategic intentions. These can include, for example, implementing national service frameworks (NSFs), improving the primary care infrastructure, reducing inequalities in provision and addressing recruitment or retention problems.
- 9 One of the ‘carrots’ that goes with PMS is the opportunity to accrue growth money to recruit additional GPs or nurse practitioners for ‘under-doctored’ areas or for populations that are not adequately served by current services. Some commissioners have used this facility while others have not.
- 10 Overall, we found that many commissioners are only now beginning to understand and recognise the full potential of PMS and the flexibilities that it offers.

^I *The NHS Plan*, Department of Health, 2000.

^{II} The term ‘commissioner’ is used to denote both former and new health authorities, primary care groups and trusts – all of whom are or were responsible for commissioning healthcare services. In PMS, the vast majority of commissioners are now PCTs.

^{III} The evaluations commissioned by the Department of Health can be accessed via their PMS website (address given at end of bulletin).

^{IV} *Personal Medical Services – Modernising Primary Care?* Edited by Richard Lewis, Stephen Gillam and Clare Jenkins (2001).

Case study 2

Addressing a specific need

In recognition of a long-standing drug abuse problem in one part of the district, North Yorkshire Health Authority established a doctor-led drug rehabilitation clinic at a surgery adjacent to a bail hostel where a large number of residents suffered from drug abuse problems. A key objective of the pilot was to provide a comprehensive substitute prescribing and detoxification service.

Source: Audit Commission review

Case study 3

Addressing local deficiencies

Sunderland Health Authority identified that it had significantly fewer GPs than the national average and, since it was a relatively deprived area, also had greater health needs. It saw PMS as a key tool to address this deficiency and, using PMS growth funding, recruited additional doctors to the area. It also focused pilots' targets on NSFs that are especially relevant to the local community, particularly heart disease.

Source: Audit Commission review

Our work to date

- 11 As we have highlighted above, PMS pilots can provide important benefits. But they can also present significant financial and operational risks. Our audit work with individual PCTs has therefore focused on:
 - reviewing how PMS pilots have been set up and managed;
 - assessing whether aspects of PMS represented a significant risk for the audited body; and
 - recommending ways of managing and minimising the risks involved.
- 12 We found that some commissioners are using PMS as part of an overall primary care strategy. North Peterborough, for example, has embraced PMS as a strategic tool for improving the equity, quality and stability of services. We also found that commissioners that had put in place arrangements to demonstrate the improvements resulting from PMS, notably Halton, who have implemented a clinical outcomes monitoring system.
- 13 However, some other commissioners have not yet fully utilised PMS, despite it being relevant to their need to improve primary care services. In addition, some commissioners have a number of PMS pilots, but have failed to put in place a system for monitoring service improvements – meaning that they are unable to demonstrate that they receive value for money from their pilots.
- 14 In the following sections we explore these issues and illustrate the common weaknesses and good practice that we have encountered.

National take-up

Box B

Reasons given for not piloting PMS

- *We don't have any evidence of the benefits.*
- *Our GPs aren't interested.*
- *Our GPs are already signed up to working together on initiatives such as the coronary heart disease NSF implementation scheme.*
- *Our management capacity is limited.*
- *We are going through substantial organisational change.*

Source: Audit Commission review

- 15 For many commissioners, the NHS Plan targets have been instrumental in increasing PMS pilot numbers. But while some PCTs now have nearly 100 per cent of practices in PMS, there are others with very low coverage.

Case study 4

Reducing inequalities in provision

At Salford PCT, we found an area with pockets of severe deprivation and low GP numbers, but it had not used PMS as a mechanism to address these problems. As a result, primary care services were less developed than they could have been. Our review led the PCT to reconsider its approach to PMS and now a number of fifth-wave pilots are planned, which include applications for additional GPs and nurse practitioners.

Source: Audit Commission review

- 16 The commissioners who have achieved highest take-up have had board-level commitment to PMS and have actively sought to educate GPs and practices about the advantages of PMS.
- 17 We also found commissioners who did not seek to promote PMS, expecting any practices who were interested in becoming pilots to initiate proceedings. However, there has been some confusion among primary care practitioners about the benefits and implications of PMS status. As a result, we believe that commissioners should highlight the potential of PMS by, for example, using a GP from the PCT's Professional Executive Committee to champion PMS and the benefits that it can bring to patient care.

Box C

Spreading the word

Some commissioners have successfully used roadshows and presentations to introduce GPs and practice managers to the benefits of PMS. Other commissioners have used practice visits to discuss how PMS could benefit an individual practice, having targeted the practices that they thought would most benefit from PMS.

Source: Audit Commission review

Establishing a PMS pilot

Developing the proposal

- 18 The first stage of any PMS pilot is to develop a proposal that is likely to be approved by the Secretary of State. Formal responsibility for doing this rests with the PCT, who should work with the potential pilot provider so that:
- the proposal reflects the commissioner's strategic priorities;
 - targets are clear and understood by all;
 - any application for growth money is reasonable; and
 - the impact of the proposal on other services is considered.

Risk assessment

- 19 In considering pilot proposals, the commissioner should risk-assess the providers involved to ensure that they have the capability and capacity to manage PMS effectively. At most of our audit sites no formal risk assessment was carried out.

Case study 5

High-level commitment

Trafford South PCT had no pilots in the first or the second wave. Some of the Board members were familiar with PMS and encouraged staff to promote it. This resulted in nearly 30 per cent of practices moving to PMS through the third and fourth waves.

Source: Audit Commission review

Case study 6

Owning objectives

A Health authority in the north west asked pilots to choose two objectives from a list of its key priorities, and then to add a third objective of their own. This approach helped to ensure that objectives were owned both by the commissioner and the provider.

Source: Audit Commission review

- 20 In response to our audit recommendations, one PCT agreed that risk assessment would be beneficial and developed a checklist. **Box D** contains a modified version of the checklist, which should be used as an indicator of where improvement may be needed and support provided, rather than as a reason for turning down the pilot.

Box D

Checklist of potential risks to PMS pilots

Each practice should be reviewed against each statement.

- GMS Items of Service claims returns are submitted on time and completed correctly.
- Post payment verification visits provide adequate evidence for Items of Service claims.
- The practice has a relatively low turnover of staff.
- There are no serious personality or professional clashes within the practice.
- The partnership is stable.
- The practice has a generally healthy relationship with the PCT.
- The practice is financially viable and generally well-run.
- Few complaints are made about the practice.
- There have been no justified complaints about the practice.

Source: Audit Commission review

Setting objectives and targets

- 21 PMS sites are intended to pilot innovative practices, making it crucial that each pilot sets objectives for itself and targets to determine whether it has achieved them. These targets should also be linked clearly to the commissioner's priorities.
- 22 Targets should indicate whether pilot objectives have been achieved and they should be SMART, that is:
- specific;
 - measurable;
 - achievable;
 - resourced; and
 - time-based.

Setting the contract fee

- 23 PMS is intended to leave GPs no better and no worse off than if they remained in the GMS regime. This makes setting the contract fee a difficult task. The key risks associated with setting the fee are:
- ensuring that the reference year data (on which the PMS contract fee is based) is typical; and
 - taking sufficient account of exceptional items, for example, where it is known that an element of the reference year data is not representative.
- 24 It is important that contract fee negotiation is a two-way process. For example, pilots should be given the opportunity to raise any concerns about the fee being too low, but, equally, the PCT must raise cases where it feels the fee may be too high.
- 25 There are also corporate governance risks. For example, where a GP on the Professional Executive Committee or Board is negotiating a contract fee with the PCT, there is a potential for conflict of interest and undue influence. Commissioners and auditors must ensure that such risks are minimised and the key to this is having a transparent, clearly documented and evidenced process.

Case study 7

A cautionary tale – when things go wrong

The salaried GP in this first-wave PMS scheme had not always complied with information requests in the past, his GMS claims history had been questioned, and the commissioner had concerns over his professional ability. He had little experience of managing a budget and was a single-handed GP lacking good-quality administrative support. Despite this, the pilot scheme did not address these issues and did not arrange for any specific monitoring linked to these potential problems. The pilot failed, leaving serious financial shortfalls that had to be met by the health authority. Effective performance management linked to a risk assessment could have provided early warning of problems, enabling appropriate early action to be taken.

Source: Audit Commission review

Management and monitoring

Performance management

- 26 There are basic performance management principles that many NHS workers will be familiar with. These apply to PMS just as they would other areas.
- 27 Firstly, performance monitoring should take place against objectives and targets as set out in the pilot provider's proposal and contract. The extent and frequency of monitoring should take account of the level of risk identified during the risk assessment process. In **Case study 7**, the lack of performance management and risk assessment processes led to serious difficulties for one provider.
- 28 The contract should contain clear monitoring arrangements, agreed with the pilot provider, that demonstrate clearly whether the pilot is meeting its objectives.
- 29 The key to good performance management is that it provides early warning of any problems that may occur so that corrective action can be taken. It is also a way in which practices can demonstrate their achievements. When done well, performance management benefits everyone.
- 30 Unfortunately, we found that when management capacity is stretched, performance management of pilots is often overlooked. For many commissioners, a lack of management capacity has led to little or no performance management of pilots.

- 31 The example below demonstrates how one PCT has linked performance management to clinical outcomes.

Case study 8

A clinical outcomes monitoring system

Halton PCT has put a great deal of effort into developing a clinical outcomes monitoring system.

A data set was agreed by local practices and the PCT based on PMS targets, NSF targets and on good clinical care. Where targets in contracts were not SMART, indicators were sought that would be more specific and measurable.

The PCT asked its informatics service to work with the primary care team to develop a way of capturing the data and analysing it. The PCT's vision for the future is that data recording will be from the electronic patient record, currently under development.

The database is then downloaded from each practice to the PCT, who collate the data and provide it to a PMS monitoring group made up of GPs from each practice and PCT managers. The GPs agreed that the data should be shared openly, which has helped the steering group to compare statistics across practices, identify practices that may require additional support and to encourage GPs to learn from each other and share good practice.

The PMS monitoring group is a sub-group of the PMS steering group. The purpose of the monitoring group was to establish the monitoring framework and to evolve to become responsible for the ongoing monitoring of the pilots, reporting back to the main PMS steering group.

Source: Audit Commission review

Financial monitoring

- 32 Financial monitoring of PMS pilots by PCTs has proved to be a controversial subject. One school of thought has it that once commissioners and providers have agreed a contract fee and key performance measures, provided that these measures are met, there is no need for any further financial monitoring. Key to this approach is ensuring robust performance indicators and appropriate monitoring of their achievement.
- 33 Some commissioners have taken an opposing view, and tried to obtain a full breakdown of pilots' income and expenditure. This approach that would not be required under GMS and may be perceived as an intrusion into GPs' personal finances.
- 34 However, it is clear that there is some requirement for financial monitoring. This arises because PMS is partially funded by an annual transfer from the GMS non-discretionary fund. As a result, money from this source not spent by PCTs on PMS should be returned to the Department of Health. Of particular importance is the position of PMS growth funds, which are intended to pay for additional GPs and nurse practitioners. PCTs need to ensure that such growth funds are spent by pilots in this

way. PCTs may also wish to monitor how pilots spend discretionary elements of their budget, including those for practice staff, computers and premises, although there is no specific requirement to do so.

Management capacity

- 35 The overwhelming message from our audits was that if commissioners want PMS schemes to be successful, then they must invest in management capacity and expertise. Where PMS was neither utilised nor implemented effectively, lack of management capacity was the most common reason.
- 36 A critical part of developing expertise is to take a team approach. PMS involves input from a number of functions, including finance, human resources, clinical governance, strategic commissioning and information management & technology. Commissioners that embrace a team approach have derived most benefit from the PMS regime. Such an approach encourages different specialties to contribute to the process and also ensures that, should any one individual involved move on, not all of the expertise leaves the organisation.
- 37 Another reason for investing in PMS management capacity is that PCT staff who have developed expertise in PMS will, in our view, be well placed to manage the implementation of the new GMS contract once detailed agreement has been reached.

What should PCTs do?

- 38 We have developed the checklist below **[Box E]** for you to assess your organisation's readiness to set up and manage PMS pilots. The list is not exhaustive, but it covers what we see as the main points.

Box E

How well does your organisation manage PMS?

Use this checklist as a starting point for checking whether your PCT needs to take action.

	Yes	No
The PCT's Board has made a clear statement on how PMS can support its overall strategic intentions.	<input type="checkbox"/>	<input type="checkbox"/>
The PCT actively informs GPs and primary care professionals about the benefits of PMS and targets practices with populations that could benefit most.	<input type="checkbox"/>	<input type="checkbox"/>
The PCT works in partnership with potential providers to formulate effective proposals.	<input type="checkbox"/>	<input type="checkbox"/>
The PCT has a formal risk assessment process to ensure that PMS pilots have the maximum chance of achieving their objectives.	<input type="checkbox"/>	<input type="checkbox"/>
PMS pilots' objectives and targets are clear and consistent with the PCT's key priorities. Targets are SMART.	<input type="checkbox"/>	<input type="checkbox"/>
The contract fee setting process is transparent, documented and based on evidence.	<input type="checkbox"/>	<input type="checkbox"/>
A performance management framework is in place for PMS pilots and is appropriately utilised.	<input type="checkbox"/>	<input type="checkbox"/>
Financial monitoring of pilots is aimed at ensuring that badged monies are spent on the things that they are intended for.	<input type="checkbox"/>	<input type="checkbox"/>
Different functions within the PCT contribute to a team approach to managing PMS.	<input type="checkbox"/>	<input type="checkbox"/>
The PCT encourages regular feedback from pilots and enables examples of good practice to be shared.	<input type="checkbox"/>	<input type="checkbox"/>

What should health authorities do?

- 39 The Strategic Health Authority (StHA) has a number of different functions in PMS. Where the PCT intends to act as the provider of a PMS pilot, the StHA must formally act as the commissioner, although it can use the PCT as its agent in a number of respects, such as preparing financial details and pilot agreements. In addition, StHAs are directly responsible for other aspects of PMS, including approval of growth monies and the performance management of PCTs' role in PMS.
- 40 We have not yet carried out any StHA audits, but would expect, in terms of PMS, that StHAs:
- identify PMS leads within the authority and take a team approach, particularly involving finance;
 - consider which PCTs are particularly likely to struggle on PMS and put in place arrangements to assist them;
 - ensure that there is a local support network in place for PCT officers engaged in PMS work so that problems can be resolved as they arise; and
 - consider how the application of growth money can assist their own strategic objectives.

Department of Health assistance with PMS

- 41 National guidance has been produced for PMS from the third wave onwards. It is important that commissioners use it to ensure that they make best use of the flexibilities and options that PMS offers. The guidance is available from the Department of Health's website at www.doh.gov.uk/pricare/pca.htm.
- 42 In addition, a PMS National Development Team has been set up (now part of the National Primary Care Development Team) and has worked to ensure that a network of PMS facilitators is in place, as well as a peer support network for individuals in general practice. In collaboration with the National Primary and Care Trusts Development Team, the PMS Team has also produced a competency framework for PCTs, available on their website (see below). Also available on the website is an Organisational Toolkit for the Evaluation of PMS pilots, which contains primary care clinical indicators and performance review frameworks. The Development team also runs a national telephone helpline.

The future of GMS and PMS

- 43 The lessons learnt from PMS pilots have directly informed the formulation of the framework for the new GMS contract. This recently agreed framework aims to be less bureaucratic than the current GMS contract and is based on delivering high-quality healthcare. This reinforces the need for PCTs to performance manage all (PMS and GMS) practices.
- 44 Health ministers have stated publicly that 'PMS is here to stay' (highlighted by the recent announcement of a fifth wave). The issue now is for the Department of Health to clarify how PMS arrangements will continue alongside the new GMS contract.

Useful websites

Department of Health PMS website – www.doh.gov.uk/pricare/pca.htm

PMS National Development Team website – www.doh.gov.uk/pmsdevelopment

Further work in this area

- 45 The Audit Commission is currently developing a study on general practice. This should provide comparative information and other resources in 2003 to help PCTs to monitor and shape general practice. It will draw on the findings of the Audit Commission's report, *A Focus on General Practice*¹, published in July 2002 (which can be downloaded from www.audit-commission.gov.uk), as well as on the lessons from monitoring and managing PMS pilots.
- 46 If you would like more information, or are interested in knowing more about anything you have read in this bulletin, please contact your District Auditor or local audit manager, or ring our Business development Directorate on 0121 224 1114.

¹ *A Focus on General Practice*, Department of Health, 2002.

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