**Article for PMS Publication**

**Salaried Personal Medical Services in a Small Rural Practice.**

**Cuminstown** is a small village in the very heart of Grampian in north-east Scotland. I have worked there as a General Practitioner for 25 years. It is very much a family concern with my wife working as Practice Nurse and Practice Manager. Up until 1990 the practice was single-handed. This is a personal account of becoming a Personal Medical Services Practice based on my own experience and the opinions expressed by the practice team.

Like many small rural practices in Scotland the practice was in receipt of an Inducement Payment. Although regarded as an essential practice for the area, the practice was too small to be economically viable and the practice income had to be ‘topped up’. Single handed practice was particularly wearing and isolating and the Associate Practitioner scheme allowed the practice to acquire an Associate GP. This revolutionised the working conditions.

It was becoming increasingly difficult to work under the Inducement Payment System. Accounting was expensive and complex. Payments could be slow. It was not really geared up for modern General Practice, which was changing at an alarming rate. Payments for Associate Practitioners were falling behind what could be earned elsewhere and the increasing number of practice vacancies in the area made Associates hard to find. When the last Associate left at the beginning of 2001 and recruitment of a replacement was proving impossible it became clear that an alternative arrangement was necessary to allow the practice to continue.

Personal Medical Services (PMS) was an option. It was clear that the practice could not continue as a single-handed practice. The stress and isolation would be too great. The practice was performing well and this was borne out by comparative audits of chronic disease management throughout the Local Health Care Co-operative. At the time the situation came to a head, the practice team had worked hard to achieve RCGP Practice Accreditation. We were functioning well as a practice but in danger of falling apart under an outdated Inducement System that was too inflexible to meet our needs to develop the practice.

The Associate Medical Director was approached to find out about PMS. The main problems were the recruitment and retention of a second GP and it was proving impossible to increase the level of clerical staffing under the inducement arrangements. A PMS contract allowed the employment of additional part time clerical staff and enabled the practice to advertise for a salaried general practitioner.

It took nearly a year to recruit a second doctor but we were lucky to recruit an experienced GP. There is a serious recruitment problem in this area and we were fortunate to attract a doctor to this salaried post.

Due to the rural nature of the practice, the patient list is comparatively small at 1,300. As this is too small a practice for two whole time practitioners, and agreement was made with the Primary Care Trust that both doctors would work three quarters time in the practice and undertake other duties for the Trust and the Local Health Care Co-operative (LHCC). I now have a part time post with the Trust in the field of Clinical Governance and my colleague is working as a Lead Practitioner for the roll out of new chronic disease management programmes throughout the LHCC.

The change over period required adaptability and a change of philosophy for the practice team. It immediately felt different in that we all became Trust employees. We were a locally managed unit within a massive organisation and no longer independent contractors. It was no longer ‘us and them.’ We were now part of the Trust. The practice no longer had a bank account or chequebook. New methods of accounting had to be quickly acquired by the Practice Manager. We had to adapt to the fact that as part of a large organisation, it takes longer for bills to be paid or equipment to arrive form Central Stores.

It is safe to say that everyone that we had contact with in the Trust was supportive and helpful. There were a few minor hitches but none that could not be overcome by patience and perseverance. We suddenly had the support of the Trust infrastructure. We had access to Human Resources, Accountants, Line Managers, Health & Safety Officers etc and the GP’s had Crown Indemnity.
The practice now had a budget. This was a new concept but we found it a reasonable way to operate. Our fears that we might become dominated by the might of the trust were unfounded. We were very much allowed to continue with our practice operation and development in an autonomous way.

However, we were not allowed to rest on our laurels. A QUID plan had to be developed (Quality Improvement Developments). The Inducement System had really offered no inducement to develop as a practice. As part of a PMS pilot we had to state our objectives and demonstrate improvement on a number of issues pertaining to practice organisation and disease management. This turned out to be less daunting a task than we had feared. The practice was developing along the lines we had chosen anyway. All we had to do was audit our activity and organise our thoughts appropriately. Practice Accreditation had already made us jump through hoops and prepared us very well for the monitoring requirements of a PMS pilot. It has actually placed us in a very good position for coping with the new General Medical Services (GMS) contract. Indications at the present time are that PMS practices will have to develop along similar lines.

**So what are the advantages?**

From a doctors point of view the practice seems much more stable. Our recruitment problem had been addressed. A doctor can now be recruited to a supported post with a definite salary. The contents of the pay packet are yours to keep (apart form the Tax) – quite different from the Inducement System where over or under payment was quite common. There was always an uneasy feeling that you were asking for money you weren’t quite entitled to. It’s a difficult feeling to explain but I’m certain any Inducement Practitioner will understand. As I am now in the final decade of my professional life I had never expected to develop a role out with the practice. This has been stimulating and has brought me out of a fairly isolated position into the very heart of the Health Service in this area.

I feel less isolated. I am now part of the Organisation. I feel more supported and better understood. The practice is working more effectively as a team and it is easier to incorporate trust employed community staff into the practice activities. Staff employment, the complexities of employment regulations and payroll responsibilities are now dealt with by the Trust. We have the co-operation of the trust in that we have been able to incorporate other trust employees such as Community Nurses into our practice development.

The practice does its own dispensing. This is a particularly labour intensive activity and requires particular care, as there is no Pharmacist input to reduce the risk of error. Our PMS development has allowed a small increase in practice staff. This has meant that we now have one of our team in charge of the dispensary. Apart from the obvious benefit of making the whole process more safe for our patients there has been an unanticipated benefit in that the dispensing side of the practice has become more efficient and more profitable. Good news for the Trust. Our budget benefits even if we do not benefit directly.

**The disadvantages?**

I am now working harder than ever before. However it is more enjoyable and seems to be more productive. In fact the workload has increased for every member of the practice team. My Practice Manager has had to adapt to a completely new way of working. This has been achieved without too much difficulty. There are problems with the payment of accounts by the Trust on behalf of the practice. The Practice manager has often to chase up outstanding bills and payments. PMS was promoted as a contract that reduced paperwork. In reality there is just as much paperwork but it is different from what was previously required to run a small business.

**Advantages for the patients.**

With an extra permanent doctor we have increased the time spent consulting. Accessibility is improved and the vast majority of patients receive a same day appointment. Our chronic disease management programmes have increased in both number and the quality of care we provide. Patient safety has improved, particularly as regard to the dispensing side of the practice. Locum doctors do not have to be employed for holiday or study relief. Although they generally do a good job, in a single-handed practice the are left to work unsupervised and cannot be expected to know all the systems that operate in a practice.
What could we have done differently?

We underestimated the Practice Management time required to run a PMS practice. We have eight hours per week, which is not really enough time to manage a practice that does its own dispensing and tries to operate at a high standard.

In our PMS proposal we had hoped to work towards the Quality Practice Award. Is such a small practice with so much development going on, the documentation required for this award was actually getting in the way of developing our service for patients. We have now abandoned our work towards this award but use the standards as a guide to the quality of service we try to provide.

The future.

General Practice is about to change with the introduction of a new contract. Much of this new contract is quality based and very similar to PMS ideology. We will probably become a permanent PMS practice as we see PMS as a way of operating a practice that has special difficulties such as a small rural practice, a practice with a special practice population e.g. homeless patients or a practice with recruitment difficulties.

We are concerned that PMS developments will be overshadowed by Primary Care Organisations having to cope with the complexities of implementing the new contract for our GMS colleagues. It is just as important that PMS practices and their patients are not disadvantaged in any way. We require the same preparation funding so that we can make any staffing increases necessary to fulfil the quality requirements of the new GMS contract. The salary of a PMS practitioner should reflect the performance of the practice against the quality criteria of the GMS contract. We fully expect to have to demonstrate that we are achieving but it is only fair that the practice receives the same rewards if we achieve a high level of quality points.

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