

# A new environment for primary care

In this article, **Georgina Craig**, of the Company Chemists' Association, and **Steve Feast**, of the NHS Modernisation Agency, envision a new era for primary care where high street-style convenience, consumerism and competition between providers — and not policy — drive service development

The re-election of a Labour government presents the NHS and the private sector with stability in health policy, built on the concepts of patient choice, plurality of service provision and contestability (competition) through commissioning. There is recognition that traditional service providers are not the only answer to the choice challenge. The public health White Paper, "Choosing health", will engage the public in a debate around their personal responsibility for health. And the widely anticipated White Paper on primary care, due to be published in the autumn, may go as far as enabling patients — specifically those with long-term conditions — to determine their own care package; it is also likely to focus on the need to build a mixed economy in primary care and increase competition between providers.

Over the past five years, the Government has created a number of drivers for change. The new contracts in general practice and pharmacy and the introduction of payment by results facilitate the flow of money from secondary to primary care. Practice-based commissioning creates incentives for primary care — most notably GPs — to innovate and redesign services to minimise referral. Add to that patients exercising real choice over the care package they receive and it creates a highly complex new environment for primary care contractors.

How the different players — especially pharmacy and GP contractors — react to this environment is interesting to explore and may give some indication of the challenges ahead. This article extrapolates these changes in primary care to a point where high street-style convenience, consumerism and competition between providers — not policy — drive service development.

In this new world, entrepreneurial general practices enter into partnership with private sector venture capital companies to establish public limited companies, operating through alternative providers of medical services (APMS) contracts. Business managers work with high street partners on joint health promotion campaigns that achieve high brand awareness of "General Practice Plc" — brand awareness is key when patients choose where to go for their care since customer loyalty alone ensures stability of revenue. The drive

to maintain brand quality is also the key to service improvement.

Practices invest significant resources in infrastructure to enable them, in partnership with consultants, to perform complex procedures in the community. These specialists become shareholders in the Plc and so benefit financially from this arrangement. The harder they work to avoid referral into more complex expensive environments, the more they are rewarded.

In addition, the Plc is a major shareholder in an in-house pharmacy. The pharmacy is much more than a place to pick up prescriptions. It is where most monitoring of people with long-term conditions and medicines management takes place, using new technology to enable point-of-care testing and diagnosis. The Plc has also constructed a fitness suite as part of its well being and weight reduction strategy.

In a nearby regeneration area, four pharmacy contractors join forces and win an APMS contract for provision of primary care medical services, alongside their pharmacy work. To free time, they share investment in automated dispensing; the pharmacists train and register as independent prescribers, and two nurses join the new company "Community Pharmacy Plc" as partners. Pharmacists manage all minor illness — and nurses focus on long-term conditions, while working closely to ensure integration with pharmacists' medicines management work — most notably medicines utilisation reviews (MURs) and the management of repeat medication. The model is proving so successful — and so cost-effective at addressing the chronic lack of primary care capacity — that the company is considering franchising the concept to other pharmacy contractors and primary care trusts. Discussions are ongoing with three inner city PCTs that are keen to progress the idea.

There has been significant specialisation within pharmacy locally. One supermarket pharmacy, opened after a successful application under the 100-hour opening exemption, has been commissioned to provide a seven-day walk-in service, plus a number of additional and essential medical services at the weekend, using a nurse, supported by the out-of-hours home care team. Throughout its extended hours, it also has an APMS contract to

run a minor illness service. All these services are fully integrated with the local out-of-hours network. The success of these services in reducing unplanned hospital admissions has triggered further investment in the service.

Another supermarket pharmacy has developed a specialist role in health promotion. Its in house dietitian, funded by the PCT, works directly with a local team of health trainers. The dietitian shops with clients and refers them if necessary to a Sure Start scheme, supported by the supermarket, that provides cookery lessons and free cooking utensils to families with young children. Clients can also access the smoking cessation service provided at the pharmacy.

A number of neighbourhood pharmacies are also working in partnership with a one-stop centre. Since there was already adequate service provision in the area, the pharmacies joined together through a consortium to provide a limited service on site, with the on-site pharmacist working with GP practices when the pharmacy is closed. The majority of patients choose to have their repeat prescriptions dispensed closer to home — and these pharmacies monitor patients' therapy and provide targeted MURs and prescription interventions. All the pharmacies are happy to work closely in partnership with the one-stop centre pharmacist since they all have a stake in the business — and patients are delighted with the convenient service on offer. There is talk of investment in near-patient diagnostics, including automated chemical pathology, ultrasound and magnetic resonance imaging because an investment company is looking for commercial partners with potential consulting space in the hope of winning the locality's diagnostic screening contract, which is out to tender.

Surprisingly, all these services co-exist happily alongside each other. The services patients need are closer to home, and there is so much more capacity in primary care that everyone is happy. So, when the local hospital downsizes, there is no public outcry. In fact, the public does not notice at all.

The only thing we know about the future is that it is difficult to predict, but all of these scenarios could happen sooner rather than later, given the current primary care policy context. Pharmacy and general practice are bound to change in the years to come — but what will the future look like? Only patients and primary care contractors can decide. But the result will be modern services that meet the needs of 21st century people — and primary care as we know it will seem like a sepia picture from the past.

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