Written evidence submitted by Dr Timothy Kimber (FGP0378)

I have been a GP for 35 years, I have been a trainer, an LMC vice chair, a founder and medical director of a GP federation, IPC Ltd. , a CCG clinical director, and a CCG primary care lead. I am senior partner in an 11,000 patient practice in Coastal West Sussex

My key messages are:

Retain the partnership model

Incentivise the formation of merged practices of at least 30k patients

Incentivise the introduction of Allied health professionals into primary care

Reward GPs based on outcome, not process

Make public expectation realistic, i.e. be honest about what we can do

Make regulation more about outcomes, and more facilitative

Barriers to access

The slow progress in creating multidisciplinary teams in primary care is one of the main barriers, combined with the inflexibility of many practices in adopting such teams, i.e. an expectation that 'The GP does everything'. This is exacerbated by lack of trust in Allied Health professionals' ability both by GPs and patients.

The capacity problem in primary care can only be solved by increasing numbers of clinicians (by increased training capacity) and multidisciplinary working.

Practices need to divide work into three categories.

1 – on-the-day/urgent care, which can be done mainly by AHPs under the supervision of a GP. An ideal team consists of Prescribing nurse practitioners, Paramedic practitioners, physiotherapists, and mental health practitioners. There should be access to social prescribing

2 – complex patients – to be done by GPs

3 – LTCs, to be done by nurse specialists and pharmacists

All of this streamlines the workflow.

Key players in all of this are those who manage the interface, our reception and front office staff. Much more emphasis should be placed on support and training for them, and something that I have developed in my practice is a signposting algorithm which works within the clinical system.

Current Policy

Current policy largely fails to address the problems above because mechanisms for moving AHPs into primary care teams are too cumbersome, and confusion still reigns over the status of PCNs and the mechanisms for employment. Policy should move swiftly towards incentivising practices to merge into super practices of at least 30,000 patients.

This will provide the basis for a new partnership model where the actual number of partners may be relatively smaller than we are used to, but provides a more stable basis for partnership, with more assured business continuity. It also provides a new career structure for primary care, and whereby we could see AHPs and managers all becoming partners in such a model (as in my practice).

These super practices should become the umbrella organisations for community nurses and tier one mental health workers, moving these AHPs from community trusts, which have largely failed to deliver good services in the last decade.

These efficient integrated primary care teams will greatly reduce the need for patients to seek help from providers who are less qualified and able efficiently to deal with their problems, eg A&E, OOH services

We favour the personal list system. The 'Named GP' system stands or fails depending on whether this is an administrative exercise or a true reflection of a personal list system. A true personal list system ensures continuity but does not necessarily mean that the GP does everything (see above). A personal list system can be combined with an 'on-the-day' service for more minor and immediate problems

Challenges for primary care

General practice needs to offer an attractive career structure to aspiring new GPs. Flexibility and variety will be key to this.

If the government is truly willing to consider a revised partnership model, there needs to be a sustained campaign to portray General practice in a positive light.

Patient expectation is a huge problem. In a service that is free at the point of use, without responsible use of the service, it is almost inevitable that with changing societal attitudes, the NHS will collapse. Something has to be done to educate service users that the NHS is not an unlimited resource and waiting for treatment is inevitable. My staff start to feel guilty when routine appointments are not available for 2 weeks.

Rural practice presents a particular challenge, and we must ensure that the benefits that can easily be brought about by economies of scale in urban practice can also be facilitated in rural areas.

Incentivisation pf practices in future should focus much more on outcome than process. Currently, QOF, CQC, and all regulation is perceived as a threat rather than a facilitation. As far as I am aware, CQC has singularly failed to demonstrate that it has ANY positive effect on outcomes, i.e. improving our patients health. This must change.

If integrated care systems are to succeed, super practices (rather than PCNs) which encompass all of what is currently 'community care' and tier 1 mental health services, must be seen as key players,

and these super practices will be much better able to work in a federated way than multiple small practices.

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