

Health and Social Care Committee

Oral evidence: The future of General Practice, HC 113

[Wednesday 18 May 2022](#)

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Dr Luke Evans; Laura Trott.

Questions 70 - 136

Witnesses

[I](#): Dr Jacob Lee, GP Partner, Medical Director, One Care Group; and Dr Pauline Grant, GP Partner, Clinical Director, Southampton West Primary Care Network.

[II](#): Professor Steinar Hunsb  r, Professor of Primary Care, University of Bergen; Dr Kate Sidaway-Lee, Research Fellow, St Leonard’s Medical Practice, Exeter; and Dr Rebecca Rosen, Senior Fellow and GP, Nuffield Trust.

Examination of witnesses

Witnesses: Dr Lee and Dr Grant.

Q70 Chair: Good afternoon and welcome to this evidence session, which forms part of the inquiry of the Health and Social Care Select Committee into the future of general practice. Today, we focus on an issue that is much debated and close to the hearts of many GPs, which is continuity of care, where patients have an ongoing personal relationship with the clinician who is responsible for their care.

In our second panel, we will hear from academics who have studied the clinical benefits of continuity of care. That panel includes a special guest from Norway. There was a much publicised study in Norway last year about continuity of care which had some very striking results. First, we are going to hear from two GPs who have swum against the tide in England and have continued with personal lists of patients. In doing so, I think they represent less than 10% of all practices across England, so they are very much in the minority. We invited them because we want to hear about that and whether they think it works.

I start by welcoming Dr Jacob Lee, GP partner at Horfield health centre in Bristol and medical director for the One Care group, which is the largest GP federation in England. His practice operates a personal list system which meant that between May 2020 and April 2021 55% of all GP consultations were between a patient and their usual GP.

Good afternoon, Dr Pauline Grant, a GP partner at the Cheviot Road surgery in Southampton and clinical director of the Southampton West primary care network. She also operates a list system which—I do not want to put words into her mouth—she believes is the primary reason behind the very high patient satisfaction scores she achieves in her practice. A very warm welcome to both of you.

Dr Lee, can you tell us why you have been able to continue to offer continuity of care and a patient list system when most GPs we speak to and indeed most GP representatives say that is just not possible given our shortage of GPs?

Dr Lee: As a point of clarification, I was medical director for the One Care consortium last year. I left that role recently.

Perhaps I could tell you about my experience as a GP. I have been a GP for 12 years. For a period of five years, I worked in a practice that did not have personal lists. I have worked in out of hours, and for the last three years I have worked as a GP at Horfield health centre.

My experience of working in practices that do not have personal lists was challenging. I will take you through a day of seeing patients you do not know and recognise coming to you with problems. You are trying to read their notes and get a feeling for what has been happening in the past. They have seen lots of different GPs. It makes the consultation really



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challenging when you are looking at blood test results and letters for patients you do not know because they are split between the different GPs who are in that day. It is so inefficient and difficult to try to do a good job for that individual. When you have the patient in front of you, you give them the best advice you can, but you do not know that they will ever come back to see you. Often, trying to prioritise access over continuity is a big challenge.

I saw the light, having moved to Horfield three years ago. It was a practice I had locumed at for a number of months prior to that. My days are transformed; they are very different. When I look at my list of patients I need to see that day, I recognise 70% of the names on that list. I have had conversations with them. The type of consultation we have is much more about what the patient wants and needs. I am able to understand their history and understand them in the context of their family. I provide six sessions a week and look after 1,200 patients, which is 400 families. That is a manageable number of people to know.

When a patient comes to me, my overriding feeling is a sense of responsibility to do the best for that patient. That responsibility gives me huge satisfaction in my role. It makes me want to talk about preventive care; it enables me to have conversations about difficult topics, about weight and smoking, with much more trust and a built-up sense of joint ownership of the problem with the patient.

The processing of blood test results and letters is no longer looking at the blood test result and having to look back through the notes about why it was done. I requested the test and I know what was happening. I can recognise when test results or letters are abnormal for the patient and that enables me to function much more efficiently.

For the wider practice I work with, because the administrative staff and other clinical staff know which doctor is looking after each patient, they are able to make sure that the queries and questions are directed to the right person. It makes it a much fairer system. Every GP and every doctor will consult and manage their patients in a slightly different way. This enables that while maintaining fairness between colleagues. I was talking to my work colleagues. One of the newer GPs who has joined us had locumed in a number of places. She told me this week, "I was going to take a job somewhere else and then I worked here. Suddenly, I understood what continuity and having personal lists is," so she chose to work with us. We have never had a problem recruiting because of the level of care we provide. It is still a very hard job, but as a partnership of 10 we are committed to it.

- Q71 **Chair:** Can I ask about efficiency? When we talk about continuity of care, a lot of people, particularly older GPs who remember what it was like when everyone had personal lists, say that it was lovely. They talk about all the things you talked about, but they say it is not realistic; it is not practical now. Do you think that argument holds?



Dr Lee: I very much believe that continuity is still something that can be delivered. There are challenges to delivering continuity. A lower GP workforce and funding constraints place more challenges on that. I have often heard the argument that everybody is working part time now, and nobody does more than three or four sessions. Our evidence shows that GPs who work with us and do just three sessions are able to maintain continuity of over 50%.

The frustration for me is that there is a whole cohort of new GPs who will not have experienced it and will not know what they are missing. They will be working in environments where they are seeing patients, struggling to get to grips with what has happened, trying to make the best decisions in the 10 or 15 minutes they have with the patient and not having follow-ups. They are on the hamster wheel of its feeling very difficult. For me, this is the most important thing we can do and get right to make our general practice succeed for the future.

Q72 **Chair:** Before I turn to my colleagues let me bring in Dr Grant. How has continuity of care changed during your period as a GP? Do you agree with what Dr Lee says? What is your perspective?

Dr Grant: I want to tell you a bit about myself before we carry on. I have a husband and four children. I was born in Bexleyheath. My father was a royal engineer and my mother was a dog groomer in a poodle parlour. I am related to Edith Summerskill, who was one of the first lady doctor MPs. She wrote a book on banning boxing, which still has not happened.

You are sitting there thinking, "Why on earth is she telling me all this?" You are thinking that because you will never see us again and do not really care about any of this. That is what general practice is becoming. If you see a person, you do not need to know who they are; you do not need to know anything about them. All you need to do is the tasks you have to do, tick the boxes you have to tick and then get the person out of the room.

Given what I have just told you about myself, if you ever meet me again—you probably won't—you will remember me and think, "That's the woman whose mother was a poodle clipper." Because I have told you my story and you know me, you remember me and recognise me; you know something about me. With a personal list, over time you get to know lots and lots of facts about people, not just that kind of thing. You know how they react. I know how my patients are likely to react to something I say or suggest to them. I know what their medical condition is likely to be. We have people who present symptoms all the time. I know it is anxiety, yet if they see another doctor they will get a visit, or an ambulance most likely, and end up in A&E. I have one patient who frequently ends up in A&E, but if he speaks to me he does not because I know that is what happens. That was the way it used to be here.

We are talking about career change. Over my lifetime, I trained in a hospital. Even in hospitals continuity is lost. When I trained, we had our



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own patients. We took them on intake and followed them right through to discharge, so the whole concept of continuity was there at the very beginning of our training.

I was in a training practice. Personal lists were the norm when I started. That has dwindled and dwindled. As for the reasons, recruitment is definitely a big issue, but I agree with Jacob. I am a part-time GP. I do only four sessions. That still amounts to 30 hours a week. I work three days a week. I am able to maintain my list very well on three days a week. I have 957 patients on my own list and see all my results and referrals. I know what happens when those patients come back to me.

The other thing is that you learn. If you do something that does not work very well, you know about that because you see the outcome of your actions, and next time you change your behaviour and you learn. You are continually learning, whereas somebody who sees a patient and never finds out what happens later on is not learning.

There is less and less continuity. I would not work in a practice that does not have personal lists. I trained in one. I made sure that every practice I worked in had personal lists because that is the best way of working. I would not work anywhere else. We personally would fight tooth and nail to keep personal lists.

You have brought me along at a very interesting time because we are losing partners; they are retiring. The survey result that you had last year you probably will not get next year, because we are struggling to maintain personal lists. On my side, there were seven partners, but in two years' time there will be two. We are trying to recruit salaried GPs, but the ones we are trying to recruit want limited sessions. They are not prepared to work to take up the slack. With personal lists, you have to do the work related to your patients. If I am having a busy day and a lot of my patients are calling in, I have to stay until it is done; I cannot leave, but for a lot of doctors—they have good reasons for it—it is not easy.

Having said that, we work long hours, but our day-to-day interactions are easier. As Jacob said, it is not that difficult when you are dealing with your own patients; it is not as stressful. I see the names on the list and can pretty much say what is going to happen. I say that for so-and-so this and that will happen. That is much less stressful than seeing a whole load of names of people I have never met. When I speak to somebody on the phone I can see their face. I know them and they know me. When they are speaking to me on the phone they know my face.

- Q73 **Chair:** One of the most common responses, for example, from NHS England, if you talked to them about the Norway study would be, "Yes, we think continuity of care is a really good thing for patients with long-term conditions who are vulnerable, but young 30 or 40-somethings do not want to see the same doctor twice; they just want to see someone quickly. For them, it is access that matters more than continuity." Do you buy that argument?



Dr Grant: Personally, I do not. I like to build relationships with everybody. Say somebody rings in complaining of a sore throat. I had exactly this yesterday. Somebody rang in with a sore throat. They had just woken up with it that morning. Because of my relationship with them, I was able to say, "You could have waited three or four days; you do not need to ring me on day one complaining of a sore throat." Because they have a relationship with me, some of them, not all, do not want to upset me, so you are also educating patients and it is a way of reducing demand, so I do not mind that.

Q74 **Chair:** Let me ask Dr Lee about that argument.

Dr Lee: Everybody values and gets benefit from continuity. However, there are groups of patients who value it and get more benefit from it. The patients who get more benefit from it are those who go to the GP more often. If you go only once every couple of years for an acute illness, it probably does not matter who you see. If you have the benefit of seeing the same GP, you start to build up trust with that individual over time. Therefore, when you have a more serious illness, or an acute illness that takes more than just one or two appointments to get to the bottom of, you start to build up a foundation. They have known you over time. The other point about personal lists is that you also know their family who may have seen you as well, so you become a trusted person in the delivery of their healthcare.

However, we have to be realistic. We have a widening workforce with allied health professionals coming in to provide a lot of the care we give as a nation. They are a fantastic asset to us. We need to think about how we prioritise continuity for those who need it the most. While I am wedded to personal lists, I recognise that continuity does not only need personal lists. There are other ways of achieving continuity for those who need it the most.

Chair: Thank you.

Q75 **Laura Trott:** What you have both said is incredibly interesting. I want to ask about a particular issue related to women. There is some evidence that women go to the doctor more often, but I have a hypothesis that they would probably benefit more from personalised care just because of some of the issues around menopause, contraception, when they are pregnant and that type of thing. Is that your experience, or not, Dr Grant?

Dr Grant: I think both genders benefit equally. It is quite hard for men to open up sometimes. If you have a relationship with a man that you have developed over time, that is really helpful. Ladies tend to open up and will splurge to anybody. I think personal lists are particularly important for men as well, and for everybody, including children. The point about families is important. If I know that I am dealing with a woman with mental health problems and I see that her child is having behavioural problems, I have an inkling as to why that is.



Q76 **Laura Trott:** Dr Lee?

Dr Lee: I go back to the point that those who attend the GP more often will benefit more from continuity. We know from studies and the Carr-Hill formula that women attend more than men, as do children and elderly people. There are certain groups who attend more.

To go back to the point about telling your story once and having it heard, there is nothing more frustrating than having to tell your story time and time again, particularly for the most vulnerable in our society; people with drug and alcohol problems and those with learning disabilities find it very hard to open up and tell their story. Once you have opened up and exposed all those difficult things, which may be around a difficult maternity or ongoing concern about breast cancer, you do not want to have to tell that story again, because it is difficult. I think women would benefit from continuity, as would everybody.

Q77 **Laura Trott:** This is probably more for the second panel as it relates to empirical evidence. Dr Grant, your point about learning was interesting. Do you have evidence in your surgeries about the benefits of that side of things and the number of avoidable mistakes? I know it is difficult because this kind of data is not kept routinely, but can you talk anecdotally about the learning element a bit more?

Dr Grant: We get very few complaints. When you have had a list for a while, your complaints go right down. It is very interesting that when you have a new doctor, complaints are quite high to begin with, and then they tail off. That may be more to do with trust and learning. I am not sure I can evidence it. I know for myself that you learn. Jacob might be better on this.

Dr Lee: I think you are right. No systematic data is kept. However, as an individual practice we carry out regular audits and look at referral data and how we provide our care to our patients and whether there are differences, as there always are. In a normal distribution, there are GPs at this end and that end in the way they practise. You can look at any part of what we do, from requesting tests to prescribing. That enables us to have a conversation and talk about that.

We look at cases and follow them through. GPs are not infallible. It is about being able to say to a patient that you know well, "Actually, I didn't get that right; it isn't exactly what I was hoping," or, "It's a surprise to me that this has turned out to be something more significant than we both thought." Maintaining a relationship and building up years of trust enables you to continue working through that with that individual. We learn and the patient learns with you. They are much more open to questioning and challenging what you are doing in a non-combative way, such as, "Do you really think this is right for me?" We can have a more open dialogue about that.

Q78 **Laura Trott:** It was quite interesting to hear about your different



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experiences of recruitment. Are there any particular issues that you think are driving that in your individual practices? Dr Lee, you said there were no recruitment issues for your surgery.

Dr Lee: To date, touch wood. We are aware that over the next five years we will have five GPs coming up to retirement, so at the back of your mind is whether people will come through. We are a training practice. We have trainees and medical students coming to us. They see the way we deliver our care. We think it is attractive. A lot of our trainees want to stay on and work with us, which is great. I think we have a good reputation. For those who understand continuity and personal lists and come to see how we work, it is an attractive way of working.

If there are no GPs out there, it will be harder and our list sizes will have to increase. At the moment, I have 215 patients per session that I do. If we have to take on wider allied health professionals to provide that care, that list size will have to go up, which means that my time will be spent looking after patients who have more complicated and difficult ongoing problems and I will see fewer minor illness-type conditions. However, at the core of that, I will have oversight of their care. A personal list still enables you to do that.

Laura Trott: Thank you very much.

Q79 **Dr Evans:** I do not want to spend too much time on this, but to help contextualise it, I was a GP before I came into the House. Dr Lee, you do six sessions and your list size is 1,200. Is that the same for all 10 partners?

Dr Lee: There are nine clinical partners and one executive partner.

Q80 **Dr Evans:** How many sessions does each of them do?

Dr Lee: On average, we do five. The least that a partner does is four, and some do six.

Q81 **Dr Evans:** How big is your list size?

Dr Lee: We have 17,000 patients.

Q82 **Dr Evans:** Can I ask you the same question, Dr Grant? You do four sessions. How many partners do you have?

Dr Grant: We have 11 partners at the moment. We started off with 13. It is the same, between four and six sessions.

Q83 **Dr Evans:** How big is your list size?

Dr Grant: It is 15,500.

Q84 **Dr Evans:** One thing that struck me listening to this is that list size is such an important thing. I think the average list is 1,800 to 2,000. Are you on the lower side that allows you to deliver that care, because one of the biggest issues between access and continuity is list size? Is that a fair characterisation, Dr Lee?



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Dr Lee: As well as the partners, we have a similar number of salaried doctors who also hold a personal list. Full time, if you call that eight sessions, is 1,600 to 1,700, so it is at the lower end of other practices.

Q85 **Dr Evans:** Do you have complaints or concerns about access? Routinely, how long would be the wait to see a GP at your practice?

Dr Lee: We monitor access to the surgery. Our target is 80% of patients being able to see their own GP within two weeks, for 80% of the year. We always have on-the-day availability. We run a duty doctor system. For urgent problems, patients are seen. If your own GP is not in on that day you will be seen by another GP, and that is absolutely fine.

We have a culture of asking patients whether they can wait. We train our teams to have that dialogue and to understand the benefits of continuity, trying to encourage patients—a sort of nudge theory—to wait until tomorrow when their doctor is in. Patients are often very receptive to that.

Q86 **Dr Evans:** How does that access compare with your PCN as a board? Where do you sit? Are you somewhere in the middle for speed of access, because regionally it can vary a little bit? I am just trying to get the basics right.

Dr Lee: Our PCN is two surgeries together. I don't have the exact figures. I think our access is pretty good.

Q87 **Dr Evans:** I was struck by your points about younger doctors boxing off what their working life is like. My father is a GP. He is turning 70 and still working. He talks about the different ethos between those who came through in that era and my era. I see that for myself in the negotiations people have. They say, "I will only do two visits; I will only see 15 patients and do three phone calls," or something like that. How much of a problem do you think there is in relation to working to your contract, or not working to your contract? The question I am getting to is whether we should be saying in the NHS that everyone should work to their contract.

Dr Grant: I do not think you would be able to afford that. I think we are very good value for money as partnerships. We do all the work that is there. We soak up everything; we are the elastic in the system. If you wanted a salaried service and you wanted to pay everybody to do a set number of hours, you would probably need 50% more doctors, as a rough estimate, which would cost you 50% more.

Can I say something about access? My patients see me within two or three days, but usually on the day. We have excellent access. Even with a personal list, I have heard doctors say, when I have asked around, "You cannot have access and continuity," but you very much can.

Q88 **Dr Evans:** That is what I am trying to get at. How we do that and what is it in policy terms? My approach would naturally be, "Should we be limiting the number of consultations or contacts we have?" Should we put



in a legal statute that you should only have 30 contacts a day, or do we do it via list size, by saying we can maintain list sizes that are 1,500 patients per full-time equivalent doctor? Do you think that is right? The danger is that there is a lot of good will in the NHS that is frittering away. How do we navigate that? If I was in the Health Secretary's position, my worry would be that, if you said that, suddenly there would be massive gaps in the NHS, with patients being left out. What are your thoughts, Dr Lee?

Dr Lee: The aspiration of having 1,500 patients for every full-time equivalent GP would be fantastic.

Dr Grant: It would be brilliant.

Dr Lee: I would fully support that. If you can support that with funding and staffing, yes, please. The reality is that personal lists are the gold standard of continuity. There is a lot of very good continuity that happens for patients outside the personal list system. You can be very restrictive in your patient list size. If you have a patient population that is much younger, with more minor self-limiting illnesses, their needs are different. They need nurse practitioners and physiotherapists to help solve the majority of their cases. Limiting the number of GPs to 1,500 would not work in that situation. You need some trust and flexibility that the GP practice knows its patient population the best. For me, it is about bringing continuity up the agenda.

Q89 **Dr Evans:** We have talked a lot about continuity for patients and yourselves in primary care. How is your continuity with secondary care? We hear a lot about GPs having interactions on inappropriate tests, and chasing that side of things. It is also just knowing, when you refer someone to a diabetologist, how good they are, what they are doing, what their likely approach will be and the complexity of dealing with it, if it is a nephrologist. Dr Lee, can you talk a little bit about the emphasis you see in the way you are running your practice with primary and secondary care and the relationships you have in that interface?

Dr Lee: I have an aspirational vision of how it should be. For our patch of local surgeries, we have named diabetologists, endocrine specialists and cardiologists we can have a closer dialogue with. I think we are moving in that direction, but we are not there yet. There have been periods when you send a referral off into the ether and get back a generic letter with a name you do not recognise. It is about building trust between primary and secondary care and building continuity in links and relationships.

Continuity, knowing who you are referring to, has huge benefits in being able to hold risk in the community. We are starting to do that in the mental health sector. We have a named psychiatrist who looks after a number of practices. That enables us to hold and manage the risk to patients who are having more difficult times and need more intervention. I can pick up the phone and ring them and say, "What should we do here?", rather than following a very circuitous route by paper trail. I



would love to see that in all specialties. Hospitals are very stretched, but that is what we should be aiming for.

Q90 **Dr Evans:** Dr Grant, do you have any comment on that?

Dr Grant: I think the PCN is a good opportunity. We are starting to come together as Southampton City PCN clinical directors. We have started to have meetings with the local hospital. We are able to say what we think is not going well from a general practice point of view and the hospital is starting to listen to us. That is a really good opportunity.

Chair: Thank you.

Q91 **Lucy Allan:** Thank you both very much for really persuasive testimony this afternoon. You have converted me to continuity.

Dr Lee, I know that you have experience of protecting continuity in a large GP federation. In my constituency, I have a practice with a 60,000 patient list. You access that GP practice by telephone and then you get allocated to any surgery, whoever is available, because access is a massive problem. The argument has always been, "We can't do personal lists here because of the size of our practice." You have evidence of it working in a large-scale practice. How would a practice operate in that way, where people can come only through a call centre and get allocated to any surgery or doctor? What would they need to do? What are the obstacles preventing them from doing what you so eloquently described?

Dr Lee: That is a good question. As a practice, we have the benefit of 17,000 patients over one site, but at the call centre we have our patient co-ordinators who are at the frontline on our phones, so they do the same job. I think it is about making it important and something that you want to do.

As part of my medical director role with One Care, I was very lucky to be involved in the Health Foundation's continuity of care piece of work. Within that, I had the benefit of working with 23 different practices with varying list size. Some had very small surgeries and some had multiple sites and big practice list sizes of 30,000 or 35,000. It is about co-ordinating the care you are giving. If you need to see a GP, you may as well make it a GP that the patient knows. There are simple things you can do. Using the usual list name at the top of the computer system, you can say, "That's your doctor, so let's look at when that doctor is in." You can try to encourage the patient to wait to see that doctor. If it is an appointment with one doctor and another doctor, you may as well try to corral it into the same site.

This is where access versus continuity comes in. It is about having a dialogue with the patient: "If you want to be seen today you can be seen, but you will be going to X practice over there, but if you could wait, your named doctor is this person and we could fit you in here. How would that sound?" We went through a whole lot of learning in that programme. It works. You start to build multi-sites; you build mini or micro-teams of nurses and doctors working at the same site. You try to go to your local



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site, unless it is something urgent, in which case you go somewhere else. By urgent, I mean that the patient needs to be seen on the same day and that site does not have capacity. It is about enabling the practice to have headspace.

Q92 **Lucy Allan:** It can be done at scale and that is not an obstacle in itself; it is more to do with lack of will.

Dr Lee: Scale is about creating networks where patients go and maintaining that conversation about where your doctor is: "This person is next available here. Let's try to fit you in there." If they are not available and it is urgent, that is okay; you see somebody else, but they then signpost you go back to your own doctor for follow-up. It is a different mindset, but it is achievable.

Q93 **Lucy Allan:** It requires the will of somebody in the organisation.

Dr Lee: It requires headspace. A local practice made up of five different sites came to us this week to say, "We are going to start doing personal lists of micro-teams. Can we come and look at how you manage your list? Can we come and do it?" I was thrilled to receive that email this week.

Q94 **Lucy Allan:** Dr Grant, you have set out the case very articulately. Could you talk us through some of the challenges that you must have had to overcome to do what you do? I think too many practices say that it cannot be done and there are too many obstacles in the way. Obviously, you have had to deal with the same challenges they face and you have overcome them.

Dr Grant: Because we have always done it. This is a very interesting question. If you take a practice that has already disbanded the model and does not have personal lists or continuity and is run with lots of different bits of salaried GPs, how do you get that practice back to a system where they can do it? The challenges we face will be in the future when we lose our partners. We are already bringing in some salaried GPs. The way we are going to run it is to try to have them manage personal lists between them. We will have a salaried GP doing two sessions and another doing three sessions and they will hold a list. Where you really believe in the system you can definitely make it work.

If you come from the point, as we do, that this is the priority and we will do anything we can to maintain it as a priority, you can make it work. You can roll it out to other practices, but they need to want to do it; they need to see the benefits. That comes back to training. At the moment, young GPs have not seen continuity of care and do not know the benefits; they have not seen it work. How do you get them to want it when they have not even seen it?

Q95 **Lucy Allan:** You have outlined that it can be more efficient to have a personal list. I think the perception is, "We can't do that because it is too inefficient. We've got to deliver because we've got so much demand."



Dr Grant: I think that is about filling rotas, isn't it? It is the same in hospitals with junior doctors. We got rid of the horrible system that I grew up in where you worked all weekend and all night, hours and hours on end. To do that you had to make 12-hour shifts. To have 12-shifts, you had to fill the rota. That was difficult. To put another restriction in the rota and say, "We're going to fill this rota, but we need three of you to be on that ward at that time because they are your patients," means it is much harder to fill the rota. I think that is what practices are saying: "We have to move where our doctors go in order to have a personal list or to have continuity, and we can't do that because we are so stretched for GPs that we have to slot them in wherever a GP says they will work." You say, "Okay; work there," even if it doesn't fit in with continuity. I think that is what they are saying.

Q96 **Lucy Allan:** What is the one thing the NHS could do to improve continuity?

Dr Grant: The NHS is a complex system; everything is very complex. I don't envy you. You pull at one end of it and it unravels at the other end. How you do that I do not know, but I think training is very important. Just thinking outside the box, maybe trainee GPs should work mainly in partnerships that have personal lists, because then they will be indoctrinated and they will want to do it. Training is really important.

If you want to support this model in practices, you first need to sort out whether you want a partner service or a salaried service, because at the moment we are in total uncertainty. What is happening is that you are pulling the rug from under the partnership model and it is collapsing bit by bit. At the moment, we are like a Jenga stack. There are holes everywhere. If you pull out the last one it will collapse, but you do not know when that will be.

Mr Javid signed his Policy Exchange document that said that partnerships would be gone by 2030, so who will buy into a partnership if it will not be there in 2030? Nobody. We have partners leaving at the top and none coming in at the bottom. Whenever anybody leaves at the top, I have to buy their share. I brought £60,000 into the practice. Each time a partner leaves I have to put in another £10,000, another £12,000 or another £20,000. In the end, there will be three partners who own a third of everything, but Mr Javid has put his name to a document which says that they will buy out all partners. They will buy up our premises. Nobody will want to be a partner.

Q97 **Lucy Allan:** Does that spell the end of personal lists?

Dr Grant: Not necessarily the end of personal lists, because you can have a salaried service with a personal list, if you like. It is just a system of working. You could be salaried and have a personal list, but at the moment the system is so destabilised that it is hard to plan. If you want to bring in personal lists, it is another initiative. General practice has too many initiatives at the moment. You are telling us to do this, that and the



other; jump through this, that and the other hoop to get money. You are giving us more and more things to do when at the moment we are barely functioning—not barely functioning; we are doing a good job but in difficult circumstances. From my point of view, first you need to decide what model you want and then you can build continuity into that model, but at the moment there is too much uncertainty.

Q98 Lucy Allan: Dr Lee, do you want to add anything?

Dr Lee: It is important to disaggregate continuity and personal lists. Personal lists are the gold standard of continuity. You can provide continuity to groups of individuals. You can have all palliative patients, or all patients who are frequent attenders. You can start to provide continuity for specific groups if you need to.

In what we can do nationally to try to support continuity, you can make continuity and trust in your GP, which is a more understandable way of explaining it, part of the national agenda, and a priority area. We have done that very successfully with access, so we can do the same with continuity. We can start measuring continuity. It is easily done. Our practice produces these figures every day. Nationally, you could start to measure continuity. Even if you have 10 appointments with nurse practitioners and other allied health professionals but one or two appointments with a GP, if it is the same GP that counts, and you measure GP continuity.

You can promote the value and benefits, on which there is huge research, which you are going to hear about, of continuity to patients through media and health promotion campaigns. You can provide operational and financial incentives to support and encourage practices to want to move to that way of working. It is not always the money, but having the headspace. One thing the Health Foundation did really well was to provide headspace and project management support to help practices move in the direction they wanted to go. You can provide training on the benefits of continuity in the GP training scheme and try to ensure that all trainees have access to work in a practice that works with personal lists or values continuity. Those are things that will take us a long way.

Q99 Chair: I have a couple of final questions. Thank you very much for your fascinating evidence. I tried to introduce continuity of care when I was Health Secretary. I changed the GP contract so that every patient had a named GP. It failed and I do not think much changed for most patients, so where did I go wrong? If you wanted to answer that question you could be here for a long time, but in that specific respect why did the things I tried to do not work?

Dr Lee: Having a named accountable GP in itself does not change who the patient sees. It is about supporting the practice to have the processes at its front door that enable the patient to get to the right clinician. You have to restructure how your frontline staff work and how you as a practice think. It is a fantastic start. Having a named accountable GP is



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absolutely the right thing. The next step is to say, "How do we measure how much of our GP contact is with that person?" GPs love a target. We're very good at them. If you start to measure it, we will start to move towards it and you will see change. We are very adaptable and we can mould the systems we work within to make those changes. It is just about bringing it up the agenda.

Q100 **Chair:** Pauline?

Dr Grant: Having a named GP does not change what happens on the ground; there has to be will on the ground to change the way people work. If you give GPs a target and put some money behind it—it would have to be serious money—they will possibly reorganise themselves, if you can measure it in an easy way, not in an onerous way. I had the idea that, if you supported it by funding, it would have to be aspirational. These are just off-the-wall ideas. Jacob has done a lot of research on this.

You could say, "We'll give you a certain amount of money at this point as an aspirational payment if you say that you are going to do continuity of care. We'll come back in a year and see where you have got to. If you implement it, every year after that, you will be paid that money to carry on with that system."

Q101 **Chair:** Do the principles you have talked about for continuity of care apply also to secondary care? I am not talking about your relationship with secondary care; I am talking about somebody who goes to hospital with three things wrong with them. I used to hear some horror stories where people would go to hospital, or indeed be shuffled between hospital and the social care system, and there was never one person in charge of that patient's care, even if it was for an acute period of illness. They were out of their GP's hands, as it were. Do you think the same principles apply in a different context?

Dr Lee: I think that for an acute admission having an accountable named clinician overseeing that patient's care from start to finish brings benefits. That person knows they have to look after the patient through that journey. When you are looking at longer-term chronic disease management and care, where you have multiple outpatient appointments over many years, ideally you see the same consultant, who knows you and knows your story. It is more challenging because the number of contacts in that timescale is much fewer. If you see a cardiologist annually, that is 10 appointments over 10 years, while they are also trying to train registrars and other junior doctors to learn the skills of the job. I am sure it would be beneficial, but I think it is more difficult.

Dr Grant: I think the same thing. There should be more continuity in general. It is not easy.

Chair: Thank you both very much for joining us. If the Hunt family ever moves to Bristol or Southampton, please make space for us in your

surgery on your personal lists, because you have made a very powerful case. We appreciate you joining us, so thank you very much.

Examination of witnesses

Witnesses: Professor Hunsb r, Dr Sidaway-Lee and Dr Rosen.

Q102 **Chair:** A very warm welcome, first of all, to Professor Steinar Hunsb r from the Department of Global Public Health and Primary Care at the University of Bergen. We are very grateful to you for travelling over to see us; you are most welcome. You were part of the research team that published the major study on continuity of care, which was published in the *British Journal of General Practice* last year.

Dr Kate Sidaway-Lee is a research fellow at the University of Exeter and St Leonard's medical practice, which is a leader in the study and promotion of continuity of care. Thank you very much for joining us.

Dr Rebecca Rosen is a GP and senior fellow at the Nuffield Trust where she leads on new organisational models for general practice.

Thank you all very much for sparing your time this afternoon. I would like to start with Professor Hunsb r. Could you talk us through what your study found in terms of the clinical benefits of continuity of care?

Professor Hunsb r: Thank you for the invitation and yes, I will. To start with, when doing science in a field like this, many of these kinds of studies are observational studies. It is often said that something is only an observational study, but this is the gold standard of our health service's research. I pinpoint that these are good-quality studies if they are done properly. We cannot do experiments; we cannot do randomised control trials in such huge healthcare. Observational studies are the gold standard and mine is one of those. The discussion about quality is not about the science; it is about how it is done, sample size, validity of the variables and so on.

We have investigated the association between having the same doctor over time and what we call hard end points: mortality, risk of death, hospitalisation for emergency reasons and issues for EDs or out-of-hours care. This is rather unusual because, when we measure continuity of care, we usually do it much more simply. We do it by the fraction of appointments that you have with a personal doctor divided by the total number of appointments. If you go to your surgery six times and you see your personal doctor four times, the continuity is four into six: two thirds. That is the usual way and that is the way you should measure it in practical life.

In Norway, we introduced a new personal list system in 2001. That means that we now have 21 years of experience and we have had a lot of doctors in that system for all those 21 years. All appointments are in the national register; we have all the doctors, all the consultations, national mortality figures and admittances to hospitals. We have all those data



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and we can combine them. We chose to use 2018 as the end point year. Up to 2018, it was possible to have several years of continuity, and up to 18 years of continuity.

What we found was the same as other studies have shown; there is a clear association between continuity and hard end points. Eleven of 11 studies show reduced mortality. There is an association with reduced emergency admittance to hospitals. There is a clear association between less use of emergency services like out-of-hours services.

What is new in our study is the size of the study; it is a national database. Also, we used national continuity, which is the length of the relationship, not the fraction of appointments or consultations last year, but the length. We have good and bad doctors in health; we have very sick people, and people who are not sick at all. Over time, it shows a reduction of roughly 25% to 30% in all hard measures.

Q103 **Chair:** In all hard measures.

Professor Hunskår: Hard end points, yes.

Q104 **Chair:** Including?

Professor Hunskår: Mortality—what we call the real hard end point.

Q105 **Chair:** You are 25% less likely to die if you see the same doctor over a long period of time.

Professor Hunskår: Yes. Further research should search for the particulars in that. What are they? But that is the main result and the rationale for why we should aim at continuity in general practice.

Q106 **Chair:** Did you do any research, or is there any other research in Norway, about the benefits to GPs? We heard in the earlier session how it is more motivating and less stressful for GPs.

Professor Hunskår: Yes. I was astonished when preparing for this meeting to learn how you have left the principles, so to say, because Britain is the father of general practice in the world. We looked up to Britain for 50 years, until the last 10 or 15 years. I brought a quotation from the first professor of general practice in the world, Richard Scott, who was in Edinburgh. In, I think, 1964, he said that there are two characteristics of general practice which distinguish the GP from every other professional: first, access and, secondly, continuity of care. That is all there is and everything else supports that. It is a very good example that we have left what I, as a professor in the field, would call evidence-based health policy; we have left those principles.

Q107 **Chair:** Thank you. We are going to come back to you, but I want to bring in your fellow panellists, if I may. Dr Kate Sidaway-Lee, how would you characterise the continuity of care that we have in general practice in England at the moment? Does your evidence show that it has been going in the right direction or the wrong direction and what are your



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observations about what you have heard so far?

Dr Sidaway-Lee: Yes. Unfortunately, continuity is thought to be falling in British general practice at the moment. There are a few studies that have used the general practice patient survey, which has two questions that ask whether a patient has a preferred GP and whether they see that preferred GP. Over the last two decades, that has been falling overall.

As we have already heard, there are a small fraction of practices which use personal lists where continuity has not been falling. We have been looking into how many personal list practices there are in the country, using a randomised sample of practice websites. We have looked at the websites of 350 practices, and we found just under 10%, as you said, personal list practices in England, based on our representative sample. In those practices there is likely to be better continuity, so there are some practices bucking the trend, but, overall, unfortunately, it is going down.

I agree with a lot of what Jake and Pauline said. Recently, we have been taking part in a Health Foundation project, with Jake and Rebecca as well. That has meant that we have been to other practices around Exeter and around the country. We have spoken to lots of GPs who work in personal list practices and other practices. So much of what they say is echoed in all the other practices. The other thing we hear from personal list practices is that they cannot imagine how people do the job without personal lists.

Q108 **Chair:** Can I ask you about two arguments? Then I will bring in Dr Rosen and throw it open to my colleagues. The two arguments that you often hear are: "It is not possible to have continuity of care until we have the 6,000 more GPs that the Government have promised us—a lovely aspiration but it is just not realistic now." The second argument is, "It only matters for more vulnerable patients with long-term conditions, not for younger, healthier patients." What is your view on those two arguments?

Dr Sidaway-Lee: While I agree that we need more GPs, and that is fairly well established, I would argue that if we have a shortage of GPs it makes more sense to use them as efficiently as possible. That would be with patients they know well; it means they can work better and more efficiently.

Can you repeat the second question, please?

Q109 **Chair:** Yes. Should we use them just for people with long-term conditions as opposed to younger, healthier patients?

Dr Sidaway-Lee: Yes. There is an issue with that in that it is quite hard to predict who is going to have a long-term condition in the future. Ideally, you would have continuity of care established before they had that condition. If you had the chance for the doctor to get to know the patient before they started to have the long-term health condition, it



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would be much better. That would be through a list and continuity, essentially.

Q110 **Chair:** Thank you. Dr Rosen?

Dr Rosen: On the very specific point about whether we should target continuity particularly on people with long-term conditions and frailty, that kind of thing, those are groups of patients for whom there is evidence that continuity produces better outcomes, but they are not the only groups by any means. For people who are living with drug and alcohol problems or people who are living in a context of domestic violence, it is extremely important that their primary care practitioner knows that is their context, so that when they come in with backache, you think it is probably more likely to be something about their domestic abuse than pulling a muscle, for example.

However, if you look at the very large group of a general practice list that is mainly healthy adults, it is a huge number. Within that, although the prevalence of complex illness is low, it amounts to quite a lot of people because they are a big proportion of the list size and they develop significant problems. That has been a real blind spot of policy, partly because they create the medico-legal catastrophes where they go around six or seven different doctors and nobody notices that they have gone from being normally fit and well to being quite unwell. Many months will have gone by before the penny can drop and therein you have missed and delayed diagnoses—catastrophe at times for the patient but also medico-legal problems.

You have patterns of illness that are perhaps less severe, where a patient who has not been into the practice for three years suddenly comes once, twice, four or five times. If you can spot that, catch that person and give them continuity for their symptoms until you have found what is wrong with them, they may then be treated, live with their condition perfectly well, and not come into the practice for another two years. It is the concept of episodic continuity.

I really enjoyed listening to the two GPs before us; I would love to work in their practices, and hats off to them. They demonstrate that, if you are committed to the culture and to setting up the processes, they are not rocket science at all, but it requires passion and some organisational design. Technology really helps, and you can do it. The three of us have been part of a Health Foundation-funded cohort where we demonstrated it in our own practices.

One other thing that I would add about this is that I am a pragmatist. It is fantastic if you can run a personal list size, but in a big urban community like the one I live in, you have massive list turnover, you have lots of staff turnover, and it is harder. It is not impossible, but it is harder. There is a pragmatic approach that you can take, which is that if you cannot give continuity to everybody, you target it. You find the people who need it and will benefit from it, some of whom have long-



term conditions but by no means all. You target your continuity towards them.

- Q111 **Chair:** Can I ask a final thing and then I will bring in my colleagues? There was a big debate last year about people not being able to get face-to-face consultations with their GP. Do you think there is a connection between the fact that people were not going to be seeing the same GP, because 90% of practices do not offer continuity of care, and the worry the public felt about a virtual consultation as opposed to a face-to-face one? If you had more continuity of care, people would be more relaxed about virtual consultations.

Dr Rosen: Probably you need to start off at a different point, because some people absolutely love them. Patients have quite a sophisticated set of instincts about when face to face is needed and when it is not. It is not always appropriate, but I think the biggest frustration was access—No. 1—and then it was having a pretty good sense that you needed to be examined and being told you could not be.

I do research at the moment about the sudden switch to digital consulting in general practice. Going around practices and looking at how they are emerging from the pandemic, the most thoughtful of them are saying, "Look, if somebody comes in with tummy pain, with pelvic pain, with an earache, you can't do it over the telephone." They are saying to their receptionist, "Don't even try. Book them in. Forget the telephone." Once we get to that kind of situation, it will all become a bit more sensible, so I think it is a bit nuanced.

Chair: Thank you.

- Q112 **Laura Trott:** The evidence we have heard today about continuity of care has been overwhelming. What I am really interested in is, if the NHS were to make this change, what should we as a Committee recommend that they actually do? We heard very generously from the Chair about the fact that this has been tried before and it actually has not worked. What are the changes that the NHS should make to ensure this happens, Dr Sidaway-Lee?

Dr Sidaway-Lee: My first priority would be to get practices measuring continuity. I would want that in the GP record systems so that practices could just do it with a click of a button. We have our own measure of continuity, called SLICC, which uses personal lists or a named GP system. It is very simple; it just looks at the percentage of appointments that are with a patient's own GP for a whole list. It is particularly useful because you can look at it in chunks of a month, so you can see how it is changing over the course of a year by looking at it every month. Having that in GP systems would be very helpful.

I would probably suggest something along the lines of PCNs having chunks of money that they could devote to continuity improvement projects, which would give them the headspace that was talked about before and, hopefully, allow them to find their own ways to promote



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continuity. There are now far more resources available to practices to find their own way towards continuity. Those are probably the main two I would suggest.

Q113 **Laura Trott:** Thank you. Dr Rosen, same question.

Dr Rosen: I agree. We should be measuring it, and I think we are at a really critical point in health policy. We are where we are because we have had two decades of very, very relentless focus on rapid access. It goes right back to advanced access, as it was called, in the early 2000s. We have been relentlessly pushing on rapid access rather than the right access for your needs. Because of the post-pandemic recovery, and things like the British social attitude survey showing that dissatisfaction with access is such a big problem, we are on the cusp of pushing for some solutions that are sensible. There is an emerging vision of delivering access at larger scale than a single practice by a professional skill-mixed team using the ARRS roles, the new multi-professional paramedics and pharmacists, but at a scale where they are not working in isolation; they can work as an effective team, overseen by GPs and supported by technology in access hubs. It started with David Cameron's access challenge. It is fairly widespread across the country. People are looking to extend it in order to create more access and make better use of the ARRS roles.

I would go right back to what we heard in the previous session. If you just push that for access, you will just get rapid access. If you push it with a dual lens that is partly about rapid access but absolutely rooted in a commitment to also giving continuity to the people who really need it, you could encourage those organisations to look both ways—to work at scale for rapid access but have the same people working in micro-teams for continuity. I would argue that, if you use data and data analytics of the kind that they have been using in America for two decades, you can work out which way to steer patients.

The risk we are running at the moment is that people are talking about producing access hubs at 100,000, 200,000 people. That is too big to be connected back to micro-teams. It just becomes remote and detached. In the last couple of days, we have uploaded to the Nuffield Trust website a few case studies of organisations—completely different types: one big chain, a couple of small networks, one federation of 14 practices—that are organising for access and continuity, and are committed to both.

That is what you have to do; you have to have a pair of objectives, measured, and not just go for rapidity because that is where the political pressure is and that is what the *Daily Mail* is saying. Stand your ground and say, "Continuity is important." You have to do both.

Q114 **Laura Trott:** That is incredibly helpful, thank you. Finally, Professor Hunsbør, what should we learn from the Norwegian model? If we were implementing it here today, what do you think we should do?



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Professor Hunskår: First, the most important thing is to accept that it is important, and that it has nothing to do with seeing your GP all the time. It is about knowing that you have one and it is realistic that you can see him or her.

Can I talk a little about what is high or good continuity? In principle, it is 100%. In principle, it is 100%, but that isn't necessary. Everyone knows that GPs are not there 24/7. They have holidays, they are sick, they are on courses. Then we are down to 90%, and everyone will accept that. Also, there are instances when you just need a doctor, a quick fix. It is a UTI, sore throat, whatever. You go to your practice and, hopefully, it is the GP you know, but it does not matter if it is not, as long as you know that he or she will get the report. The data about that incident can be put on two important hard disks; the hard disk of the practice and the hard disk of the GP, who can read that report and can connect. They see the report and say, "Oh, this is nothing, forget it." Or they can say, "Hmm, have I thought about that? This lady I must see." That is continuity of information.

In Norway, we are at about 70%. That is high compared with Britain, even in the practices that have continuity. Our practices are smaller, maximum 20,000, 25,000 people, with often between three and seven doctors. The largest practice in Norway today is around 20 doctors. We have split into much smaller entities but it also has to do with the principle. There is a crisis in Norwegian general practice, but it is not about that. Everyone is struggling to keep up continuity. What we are arguing over with the Cabinet and so on is not about that, but how to do it better. The main issue is how many patients you can cope with. How many can you cope with?

When we started out in 2001, the standard agreed by everyone was 300 patients per day, five days a week: 1,500. It differed from 1,200 to 2,500, and you were not allowed by regulation to have more than 2,500. Now, we agree that the correct answer is about 1,100 or 1,200. Why? Because there has been a huge transfer of tasks from hospitals to GPs, taking over things that were impossible to do in general practice 10 years ago and are now daily practice: treatments, investigations, whatever. But with 1,500—

Q115 **Chair:** Sorry to interrupt, but do you think the emphasis on continuity of care is why Norway got the top ranking in the Commonwealth Fund comparison of different healthcare systems?

Professor Hunskår: One of the reasons, of course.

It is not possible to secure a follow-up to your GP. There are some dirty tricks there. Now I am going to be personal. I did, as an academic, one and a half shifts a week, through Monday and every second Friday. I had continuity of 0.75, which you say is not possible. All follow-ups were given the follow-up appointment by me at the end of the consultation, even the annual check-up: "Today, it is 18 May. You are here for your



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diabetes. You are coming back in one year. Shall we say 18 May 2023 at 10 o'clock?" That meant that, when I started on my list each Monday, about 60% of those were put there by me, and they had continuity of 100%. That is just a dirty trick.

Lucy Allan: A clever trick.

Q116 **Dr Evans:** Professor, you talked about hard points and you talked about mortality, a very important point. What about morbidity? Were there any hard points about that? Does continuity of care improve morbidity? Like cancer, early diagnosis is great if you are going to do something about it.

Professor Hunsbår: Are you asking what is happening?

Q117 **Dr Evans:** You said a 25% reduction in mortality if you have continuity. That is one measure we have. What about all the morbidity? Are you better handled for your COPD? Is your heart failure better handled? What about your renal failure or your diabetes? Did you have hard points to show that, actually, people living with their disease are having a better quality of life?

Professor Hunsbår: Not in this study. I would say that, for everything on the soft side in terms of patient satisfaction, there is overwhelming evidence that having a personal GP is popular. On the other side, we have mortality, hospitalisation and so on. In the middle, we have quality of care for specific diseases, where I would say that the evidence is a little more mixed. That has to do with the role of GPs. You know this very well; we are a bit more pragmatic if we have a totality to fix. Coming back to efficiency, there is no doubt that it can be very efficient to see new doctors all the time, but what is missing is that in 10 appointments—10 consultations—the personal GP can do a lot more in 10 than 10 single doctors.

Q118 **Dr Evans:** That is really helpful. Thank you. Moving that on, Dr Rosen, you talked about the models that we have here. Is the model of general practice broken? I do not mean the partnerships. I mean the difference between patients. They often come with two things: "What is wrong with me?", or "What is next?" One is acute and one is chronic. Should we be thinking about the way the model has worked for the types of patients we are looking at? We heard a little bit about doing continuity for elderly patients or for younger patients or mental health patients. Can you talk a little bit about whether the model is right? We are happy to be radical on this Committee. How do we get there?

Dr Rosen: It depends on whether you are talking about the organisational model or the conceptual model of first-contact primary care delivered by a team that knows you. I would argue that form should follow function. I would stay agnostic about the form. We are already evolving into many different types of GP organisation. I would argue, and we have just produced some stuff on the Nuffield website arguing this specifically, that you need to be conscious about the components that make up a service that is able to see you as a whole individual.



They are the preventive bits, the early screening checks, the smears and the immunisations. They are rapid access for acute illness. They are the opportunity to deliver intuitive interpretation of symptoms, knowing a person and where they come from—what I said to you about understanding somebody's back pain requiring you to know a bit about them. They are the functions of co-ordination for people at the end of life, frailty; working with all the other agencies co-ordinating with specialism. The model is rightly evolving. I used to do smears, and I do not need to do a smear. To be honest, any well-trained, recently qualified nurse, or maybe even a healthcare assistant, could do a smear.

We have probably been containing too much in the hands of professionals. We recognise that now, and that is where the multi-professional team is emerging from. We have learnt. There was a very good report from the King's Fund recently about the new roles that have come out, where if they are individuals working in isolation—if a pharmacist is just stuck in a practice on their own—they are isolated, under-supported, and many of them are leaving.

We are beginning to learn that you need to have multi-professional teams with peer support, supervision and education. That is why scale is emerging. That is why PCNs are valuable. I really think, as you heard from the GPs we heard from before, that the continuity bit is about smallness. It is about balancing small and big, and there are very interesting models emerging around that.

Q119 Dr Evans: Thank you. Kate, could I come to you for my last set of questions? I have two points—one functional and one the reality we live in. As an MP, of all the complaints I get No. 1 is about access. They have elements of continuity within them, usually when things are going wrong, but the No. 1 complaint—I do not know if I speak for the panel—is, “I can't get in to see someone. I can't get my test. I can't get to be seen.” How do we as policymakers take that into account, considering that continuity, as we have heard, is so clinically important?

Dr Sidaway-Lee: One of the things that would be quite useful would be a public information campaign. We know that continuity has all these benefits, but if patients have not experienced continuity they do not understand all those things. When patients do, it is far more about seeing “my GP” and less about seeing “a GP”. It is the kind of thing that was said before. If they are waiting for a specific GP who knows them well and knows their problem and can help them more, they prefer to wait a bit longer, and that immediate access—

Q120 Dr Evans: Do you have any data on how long people will wait? In my clinical experience, people would be prepared to wait for two or three weeks, but in the practice where I worked, when it started to get to four or five weeks it became quite difficult and patients started to shop around. Even the most patient ones would shop around. Is there any data to suggest where the sweet spot is for that?



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Dr Sidaway-Lee: Yes, I do not know it off the top of my head, I am afraid.

Q121 **Dr Evans:** Could you write to us with that? Is that all right?

Dr Sidaway-Lee: Yes, I can try to find that.

Q122 **Dr Evans:** Thank you. To put continuity into practice, do you have a vehicle that would be useful? Is it a DES? Is it a LES? Should it be a Government fund that comes down from—

Laura Trott: What is a DES or a LES?

Dr Evans: Sorry, they are enhanced services. They are local enhanced services, and they are a way of getting GPs to provide a certain type of service—smears, for example, or something you want to concentrate on. If continuity of care was going to be something we really wanted to push, should it be a top-down NHS England fund? Is it something that PCNs and CCGs could be providing? Dr Rosen, you are smiling at this. Would you like to come in instead?

Dr Rosen: I had a conversation with a GP last week who described himself as being on the hamster wheel of doom, which I thought was a great phrase, because he is micro-incentivised for so many different things. In general, we are inundated by micro-incentives. We need whole-scale transformation of the way we are willing to work. Paying for another extra thing is probably not the way to do it, but rather building a vision for the kind of range of functions that have to be delivered by whatever kind of organisation can deliver them that has GPs in it and probably some other staff.

Q123 **Dr Evans:** We need to build again rather than use QOF or any of the other scales.

Dr Rosen: Yes. If you want him off the hamster wheel of doom, you probably need to.

Q124 **Lucy Allan:** Professor Hunsbør, what are the obstacles and resistance that you encountered in making the transition from the one system to the preferred GP practice? Were GPs resistant to the idea initially?

Professor Hunsbør: The GPs were not resistant to the idea, but there were definitely tough negotiations on the contracts and what should be expected. We had a new regulation saying that the maximum waiting time for an appointment is five days, which is rather tough, and not all can do that. We also have in regulations that you have to see a certain percentage of your patients as emergency appointments. You should have access to your GP every day, or his or her locum. That has meant that we can organise the practice so that you see someone else.

In many practices, if you have five doctors, you can say that doctor 1 has emergencies on Monday, doctor 2 has emergencies on Tuesday, and put half of the appointments aside for that, and that will be enough. I had



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four to six slots a day for emergencies. That was enough for me. The rest of the week my colleagues took over for me, one or two each day, with my small list. People accept that.

We have a slogan for out-of-hours services in Norway: "It is for everyone but not for everything." That may be a good idea for British general practice for the campaign that you mentioned. People should know that, yes, you have a personal GP, but you do not need to see him or her every time for everything. If you can accept that, it means that you can have space for good continuity for the rest of the things. Your lists are too long.

Q125 **Lucy Allan:** When you were doing those tough negotiations, were you able to sell the idea that morale and retention would be improved, or was that not something you knew at that stage? Subsequently, have you identified that as an effect?

Professor Hunsbår: We were in a situation where almost all GPs at the time really wanted the personal list because we had lived in a world where people went from practice to practice and we did not have a digital system that we could read across practices. It was news stories, news stories. Some doctors over there did that and another one had referred for this and another for that. It was so clear that doctors wanted to have their lists so that they could control, overlook, know and handle their patients.

Q126 **Lucy Allan:** Dr Rosen, do you think that it is viable for every single practice to operate a personal list?

Dr Rosen: To some extent we do because, as you heard, we all have a name at the top of the computer. That is our personal list. We do not necessarily pay enough attention to it, but we have one. The question is how to get us to pay more attention to it in a way that will improve outcomes and patient experience.

To step back a little bit and pick up on various comments that have been made, Dr Evans was right to say that some younger GPs do not particularly care much about continuity. Maybe they will as they progress through their careers. One of the ways you can organise care if you have a balance between access and continuity is that if you love continuity you can spend a bit more time doing it and less in the acute clinics, and if you are not so interested you can put all your locums into the acute clinics where it does not matter if they do not know the people who are there.

There is another component that is essential and helps to target it, in so far as you can. We have not talked much about patients, but in the project that we did in my practice to improve continuity, we had a big focus on patients. We had slides in the waiting room. They are not very full now. We could send out texts and messages. We gave scripts to GPs, and we gave them visiting cards to give to patients that said, "I am in on Monday and Wednesday. In your situation now, you will really benefit



from continuity." You help them to know when it is important and when it is not, if they are less interested. There are ways of targeting it.

Q127 **Lucy Allan:** Dr Sidaway-Lee, do you share the view that younger GPs are less enthusiastic about this model of care?

Dr Sidaway-Lee: Some can be. As has been said, the problem is that a lot of them do not see continuity of care. When they do, they tend to be quite keen. We often hear about registrars who train in a personalised practice and then go on to join that practice because they like the model and they want to have a list. One of the things that we would recommend would be exposing trainees to personalised practices as much as possible. That is something we are working on at the moment.

Q128 **Lucy Allan:** What do they perceive the disadvantages to be? Do they feel that it is more onerous or too much of a burden? Why is there resistance to it?

Dr Sidaway-Lee: That is part of it. They perceive it as more work because, if they have a list, they have to see those patients on the list and their test results and things like that, and they feel that is extra work, although they are probably doing the same amount of work, just for different patients, so I am not sure that is accurate. The other issue is that some of them are concerned about having the responsibility. If they have only just finished their training, it is quite daunting to be told, "These are your patients. Go off and deal with them," without even the chance that an older GP—as they perceive it anyway—will see the patient the next time. There is perhaps some scope for support for newer GPs.

Q129 **Lucy Allan:** That is a very good point. Professor Hunsbår?

Professor Hunsbår: Young colleagues do not see it as less work in the long term. Some of the fault is on us as educators, and specialist training and so on. It is about the perspective. Working in a continuity perspective, I know which of my patients are smokers. I do not need to ask them every time and then tick that I have asked them. My task is to prevent them from getting lung cancer in 20 years' time. I can find the right time to have that discussion. For high blood pressure, I do not care so much what the pressure is today. My real task is to prevent them from having renal failure or myocardial infarction in 10 or 15 years.

That is the perspective when you have continuity. If they are just shopping around, no one will have that perspective. As policymakers, that is the perspective you should have; you can be part of a system sparing the hospital sector from 25% of the emergencies.

Lucy Allan: Yes.

Q130 **Dr Evans:** Kate, can I pick up another point? In a previous session, we heard two GPs who were talking about burnout, and they said they had moved to being either locums or sessional GPs on the basis that it would allow them to protect their own practice. They were able to deliver to



those patients in that timescale without going home worried sick that they had done something wrong. There is self-management by turning towards being a locum or a salaried GP—a work/life balance, in essence, given that it is so stressful. How much do you think that is playing out in the reality of particularly younger GPs who have not seen the benefits of what it is like to have holistic GP? Is that a reality that you are seeing?

Dr Sidaway-Lee: Because most of my experience is with personalised practices, that is not something I see so much, possibly for the reason that the personal list is somewhat protective against burnout. It puts a limit around the patients you have to deal with, essentially, as long as the lists are balanced correctly. That goes to the list size argument.

Q131 **Dr Evans:** Dr Rosen, do you have any thoughts on that from your research?

Dr Rosen: I have probably misrepresented how younger GPs think about their jobs. If you choose general practice, you choose it for many reasons, but one of them is about being part of a holistic approach to healthcare. Particularly through Covid, there has been a catastrophic loss of exposure, and that is coming up in our research interviews. They have had zero exposure to home visits. It has all been transactional for a small cohort of people. They might be worth researching to see how they progress.

If we rebalance the way that a typical practice—not one of the 10%—is asked to deliver its service between acute and a commitment to some element of continuity, just as we have been hearing, you will know that it is very rewarding and people will get that reward. They may not know that they are not getting it now. There are some situations with people who are particularly complex when it can get very difficult, and as a younger doctor you absolutely need support to deal with that. The surveys we have done in our practice show that people get satisfaction when you build continuity.

Q132 **Dr Evans:** I have a final point about continuity. We do not talk enough about care homes, and they are a hugely important part of GP services. There has been a move to have named GPs going in. There has been a move to have ARRS nurses in some areas. Is there evidence to suggest what is the best way to look after often acutely unwell people, and the chronically unwell, who are a big demand on GPs' time? Are there models that you think seem to be beneficial one over the other? Clearly, there has to be a range, but is that something Government should be looking at more closely in continuity of care for our most vulnerable?

Dr Rosen: Care homes were one of the areas that came out most positively from the whole vanguard initiative. The evidence from the vanguards was strongest for the care home initiatives. It is about having one or two GPs in any practice that serves a care home who are dedicated to that care home, get to know the staff and can work with them, with training initiatives for the staff as well. There are all kinds of



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things. The evidence lies in the vanguard experiences, which demonstrate several different approaches.

- Q133 **Chair:** Thank you. We are going to wrap up at 4 o'clock, but I have a final question. We have had very good discussion in both our panels about the clinical impact on patients and the motivational impact on GPs, but I want to ask you something slightly different, if I may. It is a question we do not normally ask at these Committees. To what extent do you think continuity of care speaks to your values as a GP and to the values of the system that you are part of? Let me start with you, Steinar.

Professor Hunskår: For me, the professional journey has been starting out with continuity as an ideology and a good idea, and through my professional life seeing that it is not only ideology and a good idea, but that the proof in the pudding is there. Now, as a scientist, my approach is that this is the way to do it, not because it is a good idea but because it is the best.

- Q134 **Chair:** You started off with the values and you have become scientific.

Professor Hunskår: Yes.

- Q135 **Chair:** Let me ask Rebecca.

Dr Rosen: It plays absolutely to my values. I see my role as a professional working with individuals and contributing to the effective running of the system. Continuity is a critical element of my belief in what general practice can do for patients, avoidable admissions and things like that, as the evidence shows. It is also a central part of my job satisfaction, and when I do not have it I get increasingly grumpy. We know that it is one of the major dissatisfiers for a lot of GPs that is showing up in the Manchester survey. There are pros and cons.

- Q136 **Chair:** Thank you. Kate?

Dr Sidaway-Lee: I am not a GP. I am a researcher who works in general practice. I have only worked in this field for eight years, but it has been very interesting and my ideas have developed over time. When I first came to it, I was not a believer in continuity. The research has convinced me, as has working alongside many GPs. They are very keen on continuity, and it is seen to be one of the key things for their job and very important for their job satisfaction as well.

Chair: Thank you. Before we wrap up, I want to do something that we do not normally do in these Committees, which is to acknowledge someone who has come along to listen as a guest of our Committee. Professor Hunskår talked about Britain being the father of general practice. Professor Sir Denis Pereira Gray is the father of continuity of care. He has been championing it his whole life, and he is one of the absolute greats in this area.

We are very privileged, Sir Denis, that you have come to listen and very grateful for the fact that you have been talking about it for much longer



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than anyone else here. I want to say a particular welcome, and thank you very much for joining us.

Thank you very much to our second panel, Kate and Rebecca, and Steinar, who has come all the way from Norway. It is enormously appreciated. It has been a very important session.