



# **How to implement and manage personal lists in General Practice**

**A Guide for GPs and Practice  
Managers**

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## Definition of a personal list system

- Patients are split into “lists” which are subgroups of the overall practice list. Each list is allocated to one named GP and patients are informed who their personal GP is.
- The personal GP takes overall responsibility for the care of the patient long-term.
- Correspondence from patients, hospitals and the results of investigations are transmitted to the personal GP.
- The practice staff and the system of organisation try as far as is possible to arrange for patients to see their personal GP, given that with many GPs not in the practice every day this is not always possible.

# 1. Improving continuity through personal lists.

Continuity of care is widely considered to be a fundamental part of general practice. There are a number of well-studied significantly associated benefits including reduced mortality. GPs who have continuity of care with patients often feel that they would struggle without it. Patients who have continuity are more satisfied and more likely to forgive minor mistakes on the part of the GP.

Continuity is currently falling in England as perceived by patients.<sup>1</sup> Many GPs would like to provide continuity but are not sure how in the current healthcare climate.

## **MYTHBUSTER: “Personal lists are old fashioned and can’t work in modern general practice”**

There are a number of myths about personal lists including that they are old fashioned and impossible in modern-day general practice. We know of a number of practices, including large inner-city practices, which are using personal lists to great effect, some winning awards and several being rated CQC Outstanding. We hope to bust these myths!

Personal lists also make it possible to measure and track continuity, for all patient appointments, on a monthly basis using our SLICC measurement tool (see measurement section for more details). We think this is important as it allows a practice to see whether continuity is improving for patients and also to potentially provide comparative feedback on the performance of individual doctors within the practice.

**“Are you fed up with looking at others GPs’ test results and letters, seeing a patient who only yesterday saw one of your colleagues? Then you need continuity, likely to reduce workload, unnecessary tests and A&E attendances. Want to have extra demand compared to a high continuity practice? Then keep going with ‘any doc will do’.”**

**Dr Will Sherlock, GP Partner**

We believe that personal lists provide the most straightforward and logical system to improve continuity in general practices. By giving each patient a designated GP, it is immediately clear which GP the patient should see, when possible, and which GP is responsible for the patient. Although originally described in 1979<sup>2</sup> a minority of practices are using personal lists to provide continuity. There are variations on how the system works, for example, some practices may have different policies about when patients need to see other GPs or change lists.

## 2. What are personal lists and how do they work?

The personal list system of general practice organisation consists of the allocation of a group of registered patients to a named/accountable GP within a group general practice. The named GP only takes overall responsibility for those patients on his or her list.

The more times a GP sees or speaks to a patient, the better they get to know each other. The better the GP knows the patient, the more they can tailor care to that patient. If a patient's appointments are spread over a number of doctors, the opportunity for a doctor to get to know the patient may be lost.

If GPs remain in a practice long enough, they will get to know some of the patients and their families, and may find that this helps them in consultations and when undertaking administration tasks for these patients. If it is a small practice with only two or three GPs, it is possible for GPs to get to know patients without any formal system for encouraging continuity- continuity will be high, just because there are only a few GPs so the chances of a patient seeing a particular GP are 1 in 2 or 1 in 3. As practices get bigger the chance of seeing the same GP decreases. At this point, GPs may find they are not getting to know patients in the same way. In a large group practice, without a system, patients can end up seeing a large number of different doctors and with no doctor really getting to know them or be responsible for them.

### Asthma deaths in children with fragmented care

A report (Levy et al)<sup>3</sup> published in 2019 described cases of children who had died of asthma. One of the themes in these tragic deaths was “failure to take an overview of their care by any one single clinician, leading to fragmentation of care both in primary and secondary care.” In one case: “TM, a girl who died just before her 14th birthday, suffered from 47 asthma attacks in her last 4.5 years of life. She was seen by 16 clinicians at her GP surgery on the 19 occasions she attended due to poor control”. In another: SH had suffered 48 asthma attacks in her 10 years of life; during this time, she was seen by 10 GPs and six different practice nurses”. If these children had been seen by the same GP most of the time, with that doctor feeling responsible for them, these deaths could perhaps have been prevented.

For the GP in a large practice, the number of patients can make it hard to build up relationships with individual patients or take responsibility for their care as the doctor may not see the same patient again. Some practices try to promote continuity of care for episodes of illness but it can be difficult for administrative staff to keep track of which doctor a patient should see. During episodes of illness, patients may divulge important personal information, not all of which can be captured clearly in a record. If the patient then

goes back to seeing a number of other doctors, they won't have this information. Another problem is that if the doctor did not know the patient before the episode, their understanding of the normal state for that patient will be reduced.

A personal list system can help with continuity. It does **not** mean that all appointments will be with that one GP. With part-time working, same-day appointments and GP annual leave, this is not possible or expected. The list defines with whom the patient should be having continuity so that the practice can work towards this. It also clarifies who is responsible GP and conversely means that GPs are not so responsible for patients who are not theirs, potentially reducing burnout and enabling delegation of responsibility across the practice.

Personal lists mean everyone working at the practice can quickly see (through the Usual Carer or Usual doctor field in clinical systems) who is the responsible GP to whom the patient should be directed to see whenever possible.

## MYTHBUSTER: “Personal lists mean that patients **ALWAYS** have to see their own GP.”

No practice can hope to achieve this as GPs have holidays, training and often work part time. However, this doesn't mean personal lists have failed.

Personal lists are the system which is most likely to provide continuity.

Patients will sometimes specifically choose to see another GP for certain problems- for example if it requires an intimate examination and their GP is of the opposite gender. This is not a problem unless the patient is always choosing to see another GP, in which case continuity of GP care will be better if they change to the list of the GP they actually see.

We consider that if a practice is managing to get patients to see their own GP for more than half their consultations, they are doing well.

Under this system a doctor is responsible for a defined list of patients and this should be proportional to their working hours. This means that GPs will have to deal only with their own more complex patients and, if the system is working correctly, not everyone else's.

*“I had been seeing so many other GPs’ patients, I didn’t have free slots for my own. The partners put in place a policy that if we happen to see other GPs’ patients, we should send them back to their own GP for follow-up. The admin staff even telephoned patients who had booked in with me to ask if they would mind seeing their own GP instead and most were fine with this. It was a liberation!”*

**Salaried GP, rural dispensing practice**

Using personal lists to increase continuity is not a quick fix. In practices with personal lists in place, it may take a new GP around two years before they start to see the benefits. After about five years with a personal list, most GPs feel very comfortable with their patients and in control of their work.

The more strongly a practice encourages patients to see their own GP, the quicker this will happen. Knowing the patient makes checking test results and paperwork easier as their own GP has a better idea of what is expected for each patient. They find that they are not having to start from scratch each time and so consultations are quicker or can cover more ground.

As this process continues, for some of the more complex patients GPs can also start to use the prior knowledge of patients, as well as the relationship that has built up, to really get to grips with the underlying issues for the particular patient. Another possibility is that GPs who have built up this kind of relationship can use that to influence the patient's health-seeking behaviours and to help the patient seek other outlets and to agree boundaries.

**"There is always give-and-take in a modern personal list group practice with some judgements being taken on the day so that if for example a GP is not feeling well or is under special pressure it is perfectly reasonable for other GPs to see the patient. GPs in group personal list practices have six**

**weeks holiday a year and will inevitably miss some other time for training, compassionate leave or illness. So that on average 7/52 weeks of the year (say 15%) of the time patients are inevitably seen by other GPs, even before you take into account that many GPs don't work 5 days per week."**

**Professor Sir Denis Pereira Gray**

**"We are a personal list practice and also recruit for research studies with the NIHR Clinical Research Network. As part of my job, I ask GPs to check lists of their own patients for research studies. One fairly new GP was quite stressed at having to check one of these lists. Two years later, she had got to know her own patients so well that she was able to just zip down a longer list in a few minutes!"**

**Administrative staff member, city centre practice.**

Under this kind of system, even with part time doctors, over 50% of appointments can be with the patient's own doctor and this proportion is higher for those most likely to need continuity- older patients, more frequent attenders and more disadvantaged patients.

The most important aspect is that everyone knows who is the patient's doctor and that the patient is referred back to them (perhaps only to check test results or perhaps for a follow-up phone call) when possible.

Patients should be able to change doctors at their request or at the request of another doctor. Patient should however not be encouraged to "doctor shop" and some practices discuss patient transfers on an individual basis in partnership meetings to ensure this doesn't occur.

**"We are a digital first personal list practice managing to get around 60% of appointments with the named/personal GP. All eConsults are responded to within 48hrs but if the named GP isn't available then a holding reply is sent and a slot booked with the named GP when next available. This does incur double handling but is more efficient than a reply from the non-personal GP."**

**Dr Will Sherlock, GP Partner**

The NHS GMS contract in England for general practitioners requires GPs to provide every registered patient, including children, with a named GP who is accountable for their care. The personal list system is the simplest way of integrating this requirement of the contract into day-to-day general practice organisation.

### **Key extracts from the Standard Medical Services (GMS) Contract, October 2020 , NHS England**

#### **7.7B. Accountable GP**

7.7B.1. A Contractor must ensure that for each of its registered patients (including those patients under the age of 16) there is assigned an accountable GP.

7.7B.2. The accountable GP must take lead responsibility for ensuring that any services which the Contractor is required to provide under the Contract are, to the extent that their provision is considered necessary to meet the needs of the patient, coordinated and delivered to the patient.

...

7.7B.8. The Contractor must include information about the requirement to assign an accountable GP to each of its new and existing registered patients:

- (a) on the Contractor's practice website or online practice profile; and
- (b) in the Contractor's practice leaflet.

### 3. Creating and managing lists

If a practice wishes to use a personal list system, the first step is to set up the lists!

1. Each GP (partner or salaried) who works 4 sessions or more should ideally have a list. This list should be proportional to the number of regular sessions, with list sizes ideally around 200-250 patients or fewer per session worked each week. The size of the practice list may mean that this number is larger but it will work best if patients are equally distributed in proportion to GP clinical sessions as no one GP will feel unfairly treated. It might be useful for new GPs to start in the practice with smaller lists which then grow as they get used to having a list. Use the “usual carer” or “usual doctor” field in your clinical system so that it is easy to see who each patient’s GP is.
2. There may be some GPs in the practice who already have continuity with certain patients. The GPs may be able to list these. Make sure that these patients have the right GP as their named doctor and in the “usual carer” or “usual doctor” field in your clinical system.
3. Ask patients when they contact the practice for an appointment whether they have a regular doctor and make sure they are on the list of that doctor.
4. Try running a search of appointments to see which doctor each patient has seen the most over the past year.
5. Ideally, unless the patients would like it to be otherwise, keep families together on one list, as information about one member of a family or household often helps in understanding the others.
6. Then for patients who do not attend frequently or have any family already assigned to a list, try to balance the lists up evenly by age so that no GP ends with a large proportion of older or younger people. This can also be done by ensuring that doctors with less than the required list size are preferentially open for new registrations which allows balancing of lists.
7. If possible, once the lists have been worked out, contact patients to let them know who their GP is. According to section 7.7B of the GP contract, all patients should be informed of who their named accountable GP is. The same letter could also request that patients try to book with this doctor whenever possible and that the practice will try to assist with this.
8. Encourage the reception team to ask who is the patient’s the personal doctor and if the patient doesn’t know, to look it up. Suggest some stock phrases to use to try to get patients to book in with the personal GP even if it is a few more days to wait. Possibly use the Continuity Counts leaflets to help explain this to patients (available to download from [www.continuitycounts.com](http://www.continuitycounts.com))
9. Ideally, set up systems so that correspondence and tasks such as test results, hospital letters and prescriptions go to the personal GP, being mindful that patient safety should not be compromised if there were to be a significant wait for their personal doctor to action. Some practices agree these timelines in a partnership meeting.

## Some variations and tweaks:

Practices where all GPs work at least 4 days per week can go further and have a system of all appointments with the personal GP except when they are away and it is an emergency.

Practice policies such as when to send a patient back to their own GP and when to suggest a patient **switches list** (e.g. if a new patient sees another doctor several times) should be worked out. Some practices have a rule that if there are three consultations in a row with a particular GP who is not the personal doctor, there is a discussion about whether the patient transfers.

For GPs who work 4 sessions per week or fewer, it might work to have a **micro-team** with two doctors sharing a list. Ideally these doctors should work different days, covering the week, but also have some protected meeting time when they can discuss patients together.

Some personal list practices also have a **buddy system** where if the main GP is not available, patients are directed to the buddy GP. Here there is still one primarily responsible GP but the buddy has a greater chance of also getting to know the patient. This works best when the buddy works on different days from the lead GP.

If possible, a **wider family** group should all be registered with the same GP, including over multiple generations and separate households where possible. This increases the knowledge the GP has about all of these individuals as knowing each family member adds to the picture. This can improve clinical decisions.<sup>4</sup> The relationship built up by repeated consultations with one family member can also improve relations with other members of the family,

*“Last year a parent of a child that I’d seen a few times divulged that she (the parent) had been sexually abused as a child. I attribute this to the relationship that had built up seeing her child.”*

*GP Partner, rural practice*

There are no significant additional costs in running personal lists compared with a way of working which doesn't use lists, sometimes known as a pooled list system. Extra training and guidance sheets for receptionists may be needed. There are, potential cost and time savings with a reduction in potential for "the collusion of anonymity"<sup>5</sup> as patients are less likely to get "lost" between different doctors. When this happens, additional costs are incurred through repeated consultations and through repetitive investigations and hospital referrals. Without continuity, GPs often find themselves dealing with unresolved problems.

*“I'd say that there are significant costs to not running a personal list system, for example extra HCA appointments, extra blood tests.”*

*Dr Will Sherlock, GP Partner*

## 4. Overcoming potential problems.

Some “solutions” which can be applied to general practice appointment systems claim to be quick fixes for GP overload and patient access. Often switching to triage systems or other ways of controlling patient access to GPs does briefly reduce workload. However, generally as patients get used to any new system, the frequent attenders learn how to play the system and demand increases again, often above initial levels.

Under the personal list system GPs do need to work with their own more challenging patients (although not everyone else’s, which can be a relief). This might be hard at first for some GPs as they will have to cope with repeated consultations with their own complex patients, rather than hoping these patients will go to someone else next time. In time, continuity of care with these patients usually helps GPs to deal with underlying problems or agree limits, which are easier and may only be possible between a GP and patient who have got to know and trust each other.

*“The longer I had my list, the fewer heartsink feelings I had. As I got to know and understand patients, I was better able to work with them, particularly with patients with a mix of social, physical and mental health problems.”*

**Retired GP Partner**

At first, the patients with whom GPs will feel they have continuity may be the frequent attenders, including some patients who GPs find more of a challenge to consult with. When a practice is at this stage continuity may feel like a disadvantage. This is particularly true if some GPs are more invested than others. The GPs working hard on continuity may find they are having to deal with all their own difficult patients as well as other GPs. This is why it needs to be a **whole practice** decision and all GPs need to “buy in”. Complex patients and those who attend frequently need to be split fairly across lists to prevent any one GP from being overburdened.

### Pooled/Combined list system of practice organisation

- All the patients registered with the practice are seen as one group or “pool”. Patients can see any doctor they choose, so continuity is in effect delegated to patients.
- Patients seeing a succession of different GPs is accepted.
- GPs provide appointments across the whole list and usually do not know if a patient will come back to them or not.
- Named GPs do not usually take long-term responsibility for a patient.

## 5. Why practices don't use personal lists.

Given that personal lists are the oldest system of practice organisation and the system shown to be most often associated with the provision of continuity of GP care, the question arises why are they not used more often?

The first reason is that historically, when practices went from a singlehanded GP to a group practice, the default and easiest option would have been to let patients see any GP. To implement any kind of system to guide patients towards particular doctors would have taken thought and effort.

Secondly, general practices tend to keep using the same system of practice organisation over many years. New GPs entering practices accept the existing system and rarely review whether it is still the optimal way of working. As pooled list practices are the majority they continue because of inertia. Similarly, many of the personal list practices which we have studied have often used this approach for 50 years or more; much longer than any one GP's career.

Many GPs have no experience or contact with practices using personal lists and so don't realise how well they can work.

Some practices have tried arrangements which involve targeting continuity at particular groups such as frequent attenders, older patients, or those with particular health conditions.

This may be more difficult to achieve, because:

1. Efforts need to be made to identify and flag these patients. All practice staff need to know how to do this and then which doctor the patient should see. This can become complicated and can lead to confusion.
2. It is not really possible to know who will be in need of continuity in the future. If continuity is needed, it is better to have it already in place, so that the GP-Patient relationship already exists, before the patient actually needs it.
3. By targeting one group such as frequent attenders, GPs may find they are having to deal with more difficult patients alone, while missing out on building relationships with other patients.

Targeting a subgroup of patients can be an interim step but, the great majority of patients miss out on continuity. The policy that **every patient counts** takes into account the growing amount of research that shows that continuity of GP care is significantly associated with benefits for young people, the mentally ill and disabled people and indeed all groups. A decision to prioritise continuity for one group of patients always risks reducing continuity for most other patients.

However, many practices feel that providing continuity for everyone is too difficult and therefore shouldn't be attempted. This puts them off personal list systems.

## **MYTHBUSTER: “some patients don’t want or need continuity so we should only offer it to a subset of patients.”**

There are some patients who may not want or need continuity, however, identifying those who do can be difficult. Additionally, continuity works best when it is in place *before* a serious health problem arises- these are rarely predictable.

An administratively straight-forward way to offer continuity to all patients is through a personal list system applied to all.

A personal list system may enable more disadvantaged patients to get continuity as it is the default pathway. This was found in an audit in one personal list practice.<sup>6</sup> If it is left up to patients to ask to see the same doctor, it is more likely to be those who are able to work the system who will get continuity.

GP trainees do not learn about how personal lists work in modern general practices. Most GP trainees complete vocational training without learning about personal lists, without knowing their advantages and disadvantages, and few have visited a practice which uses them. The biggest single obstacle is that many GPs do not know about personal list systems or understand how they work.

General practice differs from many of the specialties in that its vocational training scheme has become separated from the basic research on general practice itself. This leads to two different problems. First many general practitioner trainees do not learn how powerful the associations are with continuity of doctor, and specifically GP, care. For example, two systematic reviews have now shown that continuity of doctor (Pereira Gray et al 2018)<sup>7</sup> and GP care specifically (Baker et al 2020)<sup>8</sup> are associated with reduced mortality

Worse still, there are a worrying number of GPs who have myths about personal lists. Many of these are countered in our Mythbusters boxes.

St Leonard's Practice in Exeter has been hosting visits from other general practitioner colleagues for 50 years. These have led to many rich discussions and have provided many colleagues who have never seen a personal list practice before with an opportunity to understand how they work and see the figures measuring the amount of GP continuity that happens.

Visiting other general practices and discussing with colleagues the way they organise their practice is usually a very pleasant and educational process and could usefully be done more

often. We believe for example that every GP training should have the opportunity to visit and study the workings of both pooled list and personal list general practices.

## Published facts about personal lists

The facts about personal lists are public and have been published in general practice medical journals for over 40 years. They are easily accessed by anyone who is interested in them.

Pereira Gray (1979)<sup>2</sup> first coined the term personal lists and reported in one practice how the change from combined list to personal lists increase the amount of provision of personal preventive care and the proportion of patients with chronic disease (diabetes) seeing their own doctor.

Roland et al (1986)<sup>9</sup> showed that patients in general practices using personal lists received more GP continuity than did patients in practices using pooled list systems.

Baker and Streatfield (1995)<sup>10</sup> found that patients were more satisfied than practices using pooled lists.

Sidaway-Lee et al (2019)<sup>6</sup> measured the amount of continuity of GP care being provided in over 35,000 appointments over two years in a general practice with over 9000 registered patients. They found that 52% of all face-to-face appointments were with the personal GP over the two years. For all appointments for patients aged 65 or more 65% were with the patients' personal GP.

## 6. Measurement- how much continuity are your patients getting?

Practices might find it useful to know the levels of continuity delivered by the practice as a whole and by individual GPs, and whether these are improving or deteriorating. Sometimes, measuring and comparing continuity rates for individual doctors leads to overall improvements.

**“Good professionals (in all walks of life) need to know how they are doing and need to have measures that inform them of what is happening in their organization. Ideally, we want a situation where multiple internal audits in general practice are organised, are private, internal and used for continuing professional development”**

**Professor Sir Denis Pereira Gray**

We have developed a practical method for measuring continuity of care monthly in a general practice, using personal lists. This was first used with paper records at the practice in 1974 and has since been used and refined. It now uses data extracted from the clinical system into an Excel file which is set up to automatically calculate continuity measures. This is available as a measuring toolkit consisting of Excel templates and instructions which works with either SystmOne or EMIS.

The first measure we use is the **St Leonard's Index of Continuity of Care (SLICC)** which is the percentage of patient appointments that are with the named/usual/list-holding GP. This measure has some major advantages for GPs. It is a simple measure, it is applicable to short periods of time and includes patients who only have one appointment, unlike the other measures used in research which require patients to have more appointments to be included. This means the SLICC can be used for monthly monitoring of continuity measures.

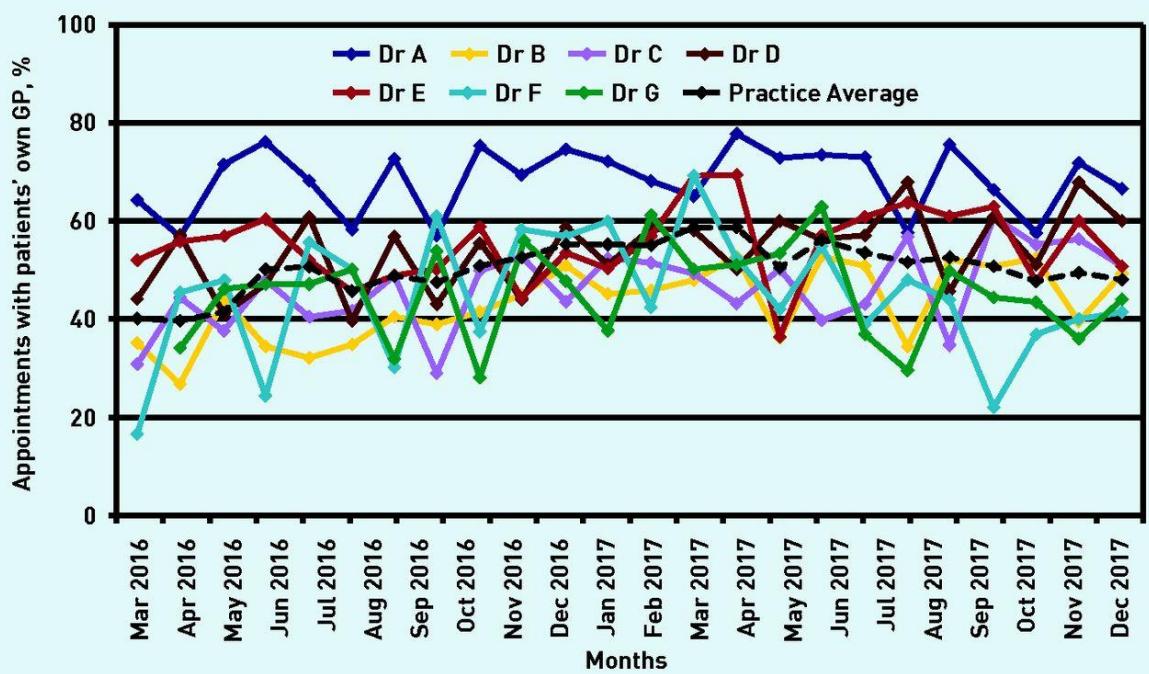
The SLICC reflects the own-GP continuity that patients are receiving, so the patient perspective on continuity. If this is 50% or more, we would usually consider that the practice is doing well, as, half the time they consult a GP, patients are consulting with their own GP. If the practice is achieving this for all patients, they are very likely to be providing better continuity of care for older people and those with long term conditions, who value continuity the most.

Any non-list holding doctor seeing patients in the practice will reduce the SLICC score. This includes registrars, so GP trainers who ask their registrars to see patients from the trainer's list (which is good practice for a trainer) will usually have lower SLICC scores. When comparing results within the practice, allowances will need to be made for this and other factors which may be dependent on your particular practice e.g. Same day and emergency arrangements, partners absent on other work such as organisational work, working in branch surgery or undertaking specific roles within the practice.

Practice size will also make a difference, as, with a larger practice, there are more doctors available to see. If a practice has only two GPs there is a 50% chance of a patient seeing their own GP (assuming they work equally and barring locum cover and registrars), even if it is an on-the-day emergency appointment. If there are 10 GPs (all with lists for this example), then the chance of seeing your own GP at random is only 10%. Again, this doesn't mean that large practices will not achieve high SLICC scores but it means having a planned policy and may take more concerted effort. This should be considered when comparing SLICC scores between practices.

The second measure that can be used is the **Own Patient Ratio (OPR)** which is the proportion of patients a GP sees who are their own patients. This is calculated by dividing the number of GP appointments with their own patients by the total number of consultations provided by that GP. This measure looks at the GP perspective on continuity and could be considered in some ways easier for GPs to influence. It may be easier to not see other GPs' patients than it is to stop your own patients from seeing other GPs! This measure is often used alongside the SLICC to monitor continuity on a monthly basis.

### An example of the results of SLICC measurements for a single practice for two years



Reproduced from: Sidaway-Lee K, Pereira Gray D and Evans P. A method for measuring continuity of care in day-to-day general practice: a quantitative analysis of appointment data. *BJGP* 2019; 69 (682): e356-e362

## 7. Looking after your own patients.

“Patients even get to know you so well they comment on your own health. I sought help (finally listened to my wife) for my insidious weight loss after 2 patients on the same day asked if I was ok as I was looking thinner and had I been running more. I was diagnosed with Diabetes within a week. So, continuity can be pretty good for your own health.”

Dr Luke Sayers, GP Partner

Having a list means knowing which patients are “your” patients. This can increase the responsibility that GPs feel for patients as well as increasing continuity. GPs often find that having their own defined group of patients makes the job more satisfying and is clinically useful. It has been shown that the more a patient sees a doctor, the more they trust that doctor. This can lead patients to disclose difficult personal information which is sometime invaluable for the GP in looking after the patient. Knowing and being known to the whole family is also often key.

“This week I saw a 14 yr old 'X' who had had a panic attack after being at a party where a friend of hers had become extremely intoxicated. X had had to look after her friend while she vomited in the toilet. I immediately understood the significance of this for X as I know her mother is an alcoholic and X has had to care for her many times in the past. I also know the father has a chronic headache problem, likely linked to the stresses caused by his wife's drinking. Her younger brother also has behavioural difficulties and possible ADHD. This knowledge of the family was invaluable when consulting with X”

GP partner, suburban practice

“Last month a patient I'd seen regarding poorly controlled asthma and frequent exacerbations disclosed a history of sexual abuse and neglect as a child. When she'd needed to be seen for exacerbations of her asthma, I'd always made myself available.”

GP Partner, rural practice

“I was discussing with a colleague who has worked in a group practice without personal lists for 5-7 years and has now run her own list for around 11 years. She reports she now sees a far more diverse group of patients and medical conditions.

Having a personal list give more diversity to the patients you see and the conditions presenting. She finds the variety much more satisfying.”

GP Partner

"As a young GP I was called on a home visit to a baby. When I got there the baby was obviously desperately ill with severe gastroenteritis and I thought it was so bad that I did not call an ambulance and simply swept the mother and baby up and drove them straight to the hospital. Sadly, the baby died of fulminating gastroenteritis.

25 years later in a surgery a receptionist said to me that she had a woman on the phone who was very bothered about a baby with diarrhoea but who did not sound to be too bad.

She thought the woman was fussing. I asked the name and I remembered at once that it was the mother who had lost the baby a generation before. I asked the receptionist to tell her to bring the baby straight in.

When the woman arrived, she explained this was now her grandchild and she looked frightened and was near tears. Diarrhoea in her experience in a baby could be lethal. I examined the baby and in doing so said gently: "I understand why you are so worried" I found little wrong and gave the usual advice. The Granny went out smiling saying: "I'm so glad it was you as I knew you would remember AB" (her dead baby son)."

**Retired GP Partner**

It can also make it easier to consult with patients. Many GPs find this particularly important when it comes to remote consulting.

"One of the more recent reminders to me of how valuable that knowledge of the patient is came at the beginning of the pandemic. We never really did anything other than face to face consulting before, and suddenly switching to telephone first for everything was a huge change. I feel that the success of this was mainly down to already having established that rapport, relationship and understanding with the patient which enabled telephone consulting to work well. It has been much harder in those patients who have joined us since the pandemic." **Dr Francesca Frame, GP Partner**

Knowing the patient can also mean doing less not more, which is often better for the patient than unnecessary treatments and tests and potential iatrogenic harm.

"With my own patients, I am more likely to try things, including watchful waiting, and monitor the situation closely. My patients are more likely to accept this from me as they know that I will provide follow-up appointments, sometimes by telephone. I also find I learn more from this kind of practice."

**GP Partner, urban practice**

"I feel my knowledge of that patient allowed me to "do" less - fewer antibiotic prescriptions, fewer referrals etc. I cannot back this up with statistics, but surely this results in less iatrogenic harm?"

**GP Partner**

## 8. Why it is really worth it!

Personal lists have been shown to increase continuity of care and continuity of GP care has been linked in numerous research studies to a range of positive outcomes for patients. For more information and a further selection of some of these studies see [www.continuitycounts.com](http://www.continuitycounts.com) or the Health Foundation RCGP Continuity of Care Toolkit.

GPs are often surprised to learn that a whole raft of benefits have now been found by research to be associated with better continuity of GP care. These include benefits for patients, benefits for the GPs themselves, and benefits for the NHS as a whole.

Benefits which have been shown to be significantly associated with higher continuity include:

Better patient satisfaction. <sup>11</sup>
Patients adhering more to prescribed medication. <sup>12</sup>
Patients more accepting of personal preventive medicine. <sup>13</sup>
GPs being able to provide better quality of care. <sup>14</sup>
Lower use of A&E departments. <sup>15</sup>
Fewer hospital admissions. <sup>16,17</sup>
Lower mortality. <sup>7,8,18</sup>
Lower healthcare costs. <sup>19</sup>

For each of these there are multiple references. Here we have included only more recent or more relevant references.

Research has found that GPs report gaining the greatest job satisfaction from tailoring medical care to fit the needs of individual patients.<sup>20</sup> This means getting to know patients as individual people which is much easier with continuity of care and is usually associated with better quality of general practitioner care. With the best will in the world it is not possible for a GP to get to know the important social determinants of health within a single consultation, but it is perfectly possible to gain knowledge of these social determinants over a series of consultations over time.

GPs often mention that continuity helps them to save time. Time can be saved during consultations as patients have less need to repeat their story and GPs do not have to keep asking background details as they may have to do with strangers. Time can be saved during administrative tasks as knowing the patient well reduces the need to check through records. Time might be saved on appointments as established personal list practices seem to have fewer consultations with frequent attenders.

There is a real danger in modern general practice of GPs spending an increasing amount of time on triage and seeing patients who are strangers to them. While sensitive generalist-orientated consulting with empathy can do much for such patients the greatest rewards for GPs themselves and the patient come from building good long-term relationships over time.

The improved knowledge and understanding from knowing patients can improve quality of care. This applies both in acute serious conditions such as the diagnosis of meningitis before the diagnostic rash has appeared,<sup>4</sup> or to the care of common chronic diseases like diabetes.<sup>21</sup>

Many GPs write that they do not want general practice to become like an impersonal call centre. Recent research justifies this view and makes seeking continuity of GP care professionally logical.

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