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PRIMARY COLOUR

Helen Salisbury: Everyone benefits from continuity of care

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Triage, signposting, and care navigation are buzz words that crop up frequently in discussions about the future of general practice. They form part of NHS England's vision of a leaner, cheaper service, in which simple health problems are attended to by someone with just enough skills and training for that task, leaving doctors free to concentrate on complicated cases that definitely need all that expensive training and professional expertise.

The concept isn't new. Years ago, as a GP registrar, for a few weeks I had to fill in a form after each consultation about whether the patient's problem could have been managed by a nurse rather than a doctor. Even then I was aware that this wouldn't produce useful answers. After all, judging in hindsight that the patient hadn't really needed a doctor is very different from making that decision in advance on the basis of the presenting complaint. Before you've seen the breathless patient you can't know whether their problem is anxiety, infection, or a pulmonary embolus.

Even if patients who are diverted from seeing a doctor receive safe and adequate responses to their main problem, they'll miss out on all the other parts of care that characterise an ongoing patient-doctor relationship. (What did you decide about the statins? How's your mum doing now? Did you get that reminder about your blood tests?)

Alongside the move to greater triage—sometimes with online forms to flesh out that presenting complaint—comes the concept that continuity of care is a luxury needed by only a subset of complex patients, while everyone else will be fine seeing any doctor, taxi rank style, in a centralised urgent care facility. This direction of travel was set out in the 2022 Fuller stocktake report,[1] badged as a vision for integrated primary care.

However, we don't always know at the outset who or what will be complex. We can guess that older patients or those with multiple diagnoses will be in this group, but I'm concerned that patients with mental health problems or families with safeguarding needs may slip through the net and receive only anonymous urgent care. Even with physical diagnoses, complexity isn't always obvious at first glance: the vomiting teenager may have a self-limiting gastroenteritis, or it may be the first presentation of diabetes or an eating disorder. Night sweats and sleeplessness may be the menopause, but they could be symptoms of lymphoma. If I already know my patients I'm more likely to recognise when they're ill, but in the brave new world of urgent care centres this opportunity will be missed.

Overwhelming evidence shows that continuity of care benefits health, longevity, cost efficiency, and both patient and doctor satisfaction.[2] The House of Commons Health and Care Select Committee recognised this in its report on the future of general practice and recommended a series of measures to restore the patient-doctor relationship, including capping list sizes. These recommendations have been rejected by the government.[3-5]

I'm strongly persuaded that the right person to see the patient—for a whole range of minor, major, new, or long term conditions—is usually their own GP. We need to train more GPs, and retain the ones we have, to provide this gold standard for all patients. If we continue down the current route of breaking up, reorganising, and down-skilling general practice it will be an increasingly unattractive career option, and the quality of care we can offer patients will deteriorate further.

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