Letters

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Inclusion health and missingness in health care: dig where you stand

Professor Williamson rightly highlights the plight of the 'missing' within our urban conurbations,[1] so well described and championed by colleagues in 'Deep End' practices.

I wonder, however, if we may be missing some 'missing'. Previously we would have known our older housebound patients. Those who were frail and multimorbid. Those less able to access care for a variety of reasons. Those living at the 'Far End'.[2] They contacted or we remembered. But now it seems we are less aware of this vulnerable group. For a variety of reasons — the pandemic-induced hiatus, the pressure of 'on the day' demand, and the media-driven shifting expectations of health care — we are perhaps missing the 'missing' at the 'Far End'.

So, with shovel in hand, I feel inspired once more to 'dig where I stand'.[3] But the ground is hard. I need some help. I'm grateful for our local 'frailty practitioner' reviewing our older patients (at home) not seen in the last year. Such innovations unearth so much. The need for bio-psycho-social-spiritual care and the consequent supportive infrastructures.

The soil beneath our feet is fertile. There are many at the 'Far End' in need of care. But I suspect our shovels may not be enough. Perhaps we need the specified complexity of our practice clusters, health and social care partnerships, and health boards to sustain this dig. Perhaps we even need the mandate or incentive of government through contract.

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Realistic not romantic — real-world continuity in action

We are eight ordinary GPs in North East England — serving 13 000 patients. We contend that continuity of care is both achievable and necessary in 2023. We all work 3–4 days per week (providing 54 clinical sessions — plus five GP registrar sessions). We have our own personal lists, for both acute and chronic matters, and are all partners. Continuity of care is measured using the St Leonard's Index of Continuity of Care (SLICC) tool.[1] From August to October 2023, we averaged 81.9% (combined face-to-face and telephone), which is comparable with Norwegian levels.

Personal lists preserve the GP as a generalist, while creating the environment for relational care to flourish. As patients get ever more complex, knowledge of the patient's history facilitates managing multimorbidity. Patients benefit too: no need to retell their story and trust develops after a few consultations. Collusion of anonymity is avoided. Lines of responsibility are clear and simple. This aids both practice staff and patients. For the doctor, a list is both professionally rewarding and provides a boundary for responsibility. Our 5-year national survey data[2] show consistently excellent levels of patient satisfaction, access, and continuity — which is rare for a medium-sized practice. In addition, we have noted reduced hospital admissions,[3] which is akin to the findings of Sandvik *et al*.[4]

We are not alone. An estimated 10% of English GP practices run personal lists — in different settings (urban/deprived/rural) using differing models (clinical triage or traditional models) to suit their local needs. Several of these submitted evidence to the health select committee.[5]

For doctors and policymakers, forget uberisation — continuity using personal lists is the next logical step in renewing and revitalising general practice.[5] It is easily achievable for most practices (with sufficient GPs to make it work). We feel we are a happier, more cohesive practice, with low staff turnover, due to having our own lists.

With proven patient benefits (morbidity reduction,[4,6] better access,[2] and greater satisfaction[2]), we should now all be asking — why isn't my surgery running personal lists?

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Competing interests
Luke D Sayers and the practice have collaborated with St Leonard's, Exeter, to utilise the SLICC tool and share periodic SLICC data from November 2021–present.

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A seven-point manifesto for upstream training in general practice

We welcome the Royal College of General Practitioners' (RCGPs') seven-point manifesto for general practice but note that it overlooks upstream education in primary care. Upstream training is essential to inspire medical students to consider general practice as a career and prepare them for the unique challenges of practising outside hospital. We call for:

1) a significant uplift in funding for undergraduate placements in general practice to motivate inspirational role models, longitudinal clerkships, and regular opportunities for home visits;

2) funding for GP 'simulated surgeries' across undergraduate years to develop clinical skills for mild-to-moderate presentations as well as to prepare students for the organisational tasks and personal demands inherent in a career in general practice;

3) dedicated teaching on 'integrated care' for students to understand the relationships between general practice and hospital medicine as well as patient journeys through healthcare systems;

4) dedicated teaching on the contributions of general practice to tackling health inequality and promoting environmental sustainability;[1]

5) proportional representation of GPs in senior curriculum leadership roles at all medical schools and at the General Medical Council (GMC) and Medical Schools Council;[2]

6) formal GP objective structured clinical examination (OSCE) stations within the Medical Licensing Assessment (MLA; the GMC's new exit exam for all medical students). This is essential to ensure that GP teaching is prioritised within curriculums in preparation for the MLA. These scenarios must capture the 'well-judged clinical restraint' essential for general practice (in contrast with current 'hunt the diagnosis' OSCEs, which are often necessary in hospital practice);[3] and

7) a 4-month rotation in general practice for all foundation doctors.

Without prioritising these upstream, preparatory factors, the RCGP's good intentions will fall short. A 'life course approach' to general practice careers is essential to address recruitment, burnout, and retention.[4]

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Inequities in hypertension management

Blood pressure (BP) control is an important public health issue. The GP has a unique and indispensable role in BP management and primary prevention of associated diseases.

The authors report that Black ethnicity and younger people have poorer control of BP compared with White and Asian ethnicity. Despite better control of hypertension in the Asian group, cardiovascular disease was higher.[1]

Blood pressure measurement is central to this study; however, the authors fail to provide any detail on how BP was measured. We assume office BP readings were used. Current guidelines for the diagnosis and management of hypertension unanimously recommend the use of 24-hour ambulatory BP monitoring.[2]

It is well established that 24-hour ambulatory BP, and particularly night-time BP, are superior to office BP in predicting total and cardiovascular mortality and cause-specific cardiovascular complications in patients with hypertension, and in population cohorts. Ambulatory BP reveals both white-coat and masked hypertension, and has been shown to be a cost-effective intervention.[2]

Regarding ethnic variations described in the study, the lack of 24-hour ambulatory BP may explain some of the findings. Prevalence rates for masked hypertension, excessive morning BP surge and morning hypertension, and nocturnal hypertension are all higher in Asians than Westerners.[3] Furthermore, sleep