# Patient choice of GP practices

Since 2015, all GP practices in England have been free to register new patients who live outside their practice boundary area.

This means you can **register with a GP practice** (https://www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/) somewhere that's more convenient for you, such as a practice near your work or closer to your children's schools. This will give you greater choice and aims to improve the quality of access to GP services. Use the **Services near you facility** (https://www.nhs.uk/Service-Search/GP/LocationSearch/4) to find out what people say about a GP practice.

These arrangements are voluntary for GP practices. If the practice has no capacity at the time, or feels it is not clinically appropriate or practical for you to be registered so far away from home, they can still refuse registration. The practice should explain to you their reason for refusing your registration.

## How to register with a GP practice further away

You may wish to join a GP near work or re-register with your old GP following a move. The new arrangements make this possible; however, there are a few things to consider:

- Research your options in the area you want to register with, so you choose a practice that is right for you.
- Compare GP surgeries according to facilities, services or performance before you decide. Ask friends, relatives and others you trust for their thoughts and recommendations.
- Contact the practice and ask if it is accepting registrations from out-of-area patients.

- If the practice is accepting registrations, ask for a registration form.
- The practice will decide, following a review of your completed registration form, whether to accept you as a regular patient or accept you without home visiting duties (if it is clinically appropriate and practical for you to be registered away from home).

Because of the greater distance to your home, the GP you register with is under no obligation to offer you a home visit. If you are not well enough to go to the practice yourself, then other arrangements will be made. NHS England (the body responsible for buying GP services) ensures there is access to a service either near your home or at home (if needed). When you register with a practice further away from home, you will be given information about what you should do in those circumstances.

Additionally, if you're worried about an urgent medical concern, you can call the **NHS 111** (https://www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/nhs-111/) service to speak to a fully trained adviser. This service is available 24 hours a day.

- **Patient information leaflet – Patient choice of GP practice (PDF, 28kb)**

  (https://assets.nhs.uk/prod/documents/141230-patient-information-choice-of-gp-practice.pdf)

Registering with a practice further away from home can affect decisions about **referrals for hospital tests and treatment** (https://www.nhs.uk/using-the-nhs/nhs-services/gps/referrals-for-specialist-care/), or access to **community health services** (https://www.gov.uk/government/publications/the-nhs-choice-framework). Speak to the GP about your options.

## Outer practice boundaries

In 2012, all GP practices were asked to agree an outer practice boundary. Outer practice boundaries are an expansion of a GP's original catchment area. Whereas in the past you may have had to register with a new GP even after only moving a

few streets away, these outer boundaries can be a way to stay registered with your old GP.

You'll still have to speak with your GP first and, if appropriate, the GP may keep you on the register. For example, a GP may refuse to keep you on the register if you need frequent home visits but don't live close to the GP practice. If the GP covers a large area and the travel distance to your home is too long to justify regular home visits, then the GP can suggest that you register with a practice closer to your home.

However, if the GP decides you can stay registered, then you will continue to receive the full range of services, including clinically necessary home visits.

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Next review due: 26/11/2021

# Seeing same doctor every time 'reduces risk of death'

Friday June 29 2018

"Seeing the same doctor each time you need medical care might reduce your risk of death, research suggests," The Guardian reports.

The story was prompted by a review of data gathered by 22 previous studies to see whether continuity of care – seeing the same doctor – had any link with premature death (mortality risk).

The majority of these studies found reductions in mortality with increased continuity of care. But the findings of a review are only as good as the studies it includes.

These studies came from different countries with highly diverse health systems – most were from North America, with only 3 from the UK.

The studies were so different in their methods and how they measured continuity of care that it wasn't possible for the researchers to pool study results together.

And only around half of the doctors assessed were GPs or family doctors. It's not known how many of the doctors were treating long-term conditions such as diabetes or heart disease, or whether they were treating people in hospital.

This is the first review to look into the question of whether seeing the same doctor can reduce your risk of death, so it adds valuable insight that needs to be explored further.

But because of the differences in countries, methods and types of doctors across the studies, it's hard to draw any firm conclusions.

And on a practical note, in England it's not always possible for people to see the same GP.

## Where did the study come from?

The study was conducted by researchers from the University of Exeter and the University of Manchester.

No sources of funding were received and the authors declared no conflicts of interest.

The study was published in the **peer-reviewed** (https://www.nhs.uk/news/health-news-glossary#peer-review) journal BMJ Open, which is **free to access online** (https://bmjopen.bmj.com/content/8/6/e021161).

The Guardian's and BBC News' reporting of the study was accurate.

The Mail Online took a more alarmist approach with the headline: "Seeing the same doctor every time could save your life".

Because of the limitations of the study, this dramatic suggestion is unproven.

## What kind of research was this?

This **systematic review** (https://www.nhs.uk/news/health-news-glossary#systematic-review) aimed to explore whether there's a link between continuity of care with doctors and mortality.

As the researchers say, while there's been much research into the effects of improved treatment and diagnosis, the value of the doctor-patient relationship hasn't really been looked into.

Continuity of care is defined as repeated contact between an individual patient and a doctor.

This should in theory allow for a stronger relationship and better mutual understanding, and result in improved health outcomes.

Because of the differing methods used in the individual studies, the researchers were unable to carry out a **meta-analysis** (https://www.nhs.uk/news/health-news-glossary#meta-analysis) (where the results of individual studies are pooled) that you'd normally expect to see after the review.

## What did the research involve?

The researchers searched medical literature databases for studies published between 1996 and 2017 that included the

words "continuity" or "continuity of care" together with terms relating to doctor, patient and mortality.

Studies had to have directly assessed some measure of continuity of care by any doctor (such as a GP or hospital doctor) and any measure of mortality. All studies were assessed for quality and risk of bias.

In total, 22 studies met the inclusion criteria. Two-thirds were retrospective studies using data provided by health insurance companies.

Only 3 studies came from the UK (England only). The others were mostly from the US and Canada, with a few from France, Israel, The Netherlands, Taiwan and South Korea.

Around half of the studies, including the UK ones, looked at contact with GPs or family doctors.

The other studies looked at any physician or hospital doctor, with even a surgeon and psychiatrist in 1 study each, and 8 of the studies looked at specific groups of patients, like those with diabetes or older adults.

Continuity of care was measured over different periods of time, from 1 month to 17 years: "Mortality was measured within different timeframes – for example, 1 study measured death rates during the length of a hospital stay, and another measured them from hospital discharge to 21 years later."

The researchers took into account **confounders** (https://www.nhs.uk/news/health-news-glossary#confounding-factor-confounder) that could have influenced the results, such as age, gender, ethnicity and socioeconomic status.

## What were the basic results?

The studies were too diverse to pool the results in a meta-analysis. Overall, 18 of the 22 studies (82%) generally found that increased continuity of care was associated with significantly reduced risk of early death.

Most of this was related to all-cause mortality (death from any cause). Of the remaining studies, 3 found no link and 1 showed mixed results.

The size of the risk reduction across the studies was variable, but most often it was a fairly modest reduction in the range of about a 15 to 25% reduced mortality risk.

It's not possible to know what this meant in terms of **absolute risk reduction** (https://www.nhs.uk/news/health-news-glossary#absolute-risk) – in other words, how much of a reduction in risk a 15 to 25% drop would represent.

## How did the researchers interpret the results?

The researchers concluded that, "This first systematic review reveals that increased continuity of care by doctors is associated with lower mortality rates."

They acknowledged that the evidence is observational (so it can't prove cause and effect), but say that patients appear to benefit from continuity of care with both generalist and specialist doctors.

They said: "Despite substantial successive technical advances in medicine, interpersonal factors remain important".

## Conclusion

This study provides a valuable initial insight into the value of continuity of care.

The importance of good relationships between healthcare professionals and patients – with good understanding of the patient's needs, views and concerns – shouldn't be underestimated.

It seems plausible, therefore, that continuity of care could have a direct effect on improving patient outcomes and reducing mortality.

But as evidence, systematic reviews are only as good as the studies they combine, and the limitations of these studies do need to be acknowledged.

These were highly diverse studies with widely variable healthcare systems, patients, doctors, and methods of assessment. This is why the results couldn't be pooled.

And without absolute figures, it isn't possible to know how great a difference this could make.

For example, if only 4% of people died during study follow-up, a 15% reduction with better continuity of care could reduce this to 3.4%, which doesn't seem so large.

This is nevertheless an interesting review that highlights the importance of good doctor-patient relationships.

It would be useful if a similar study focusing on the UK perspective and GP care was carried out in the future.

Analysis by Bazian
Edited by NHS Website

## Links to the headlines

**Keeping the same doctor reduces death risk, study finds** (https://www.theguardian.com/science/2018/jun/29/keeping-the-same-doctor-reduces-death-risk-study-finds)

The Guardian, June 29 2018

**Seeing the same doctor over time 'lowers death rates'** (https://www.bbc.co.uk/news/health-44643607)

BBC News, June 29 2018

**Why seeing the same doctor every time could save your life: Patients are open about symptoms, trusting of medical advice and inclined prescriptions from familiar GP** (http://www.dailymail.co.uk/health/article-5898735/Why-seeing-doctor-time-save-life.html)

Mail Online, June 29 2018

## Links to the science

Gray DJP, Sidaway-Lee K, White E, et al. **Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality** (https://bmjopen.bmj.com/content/8/6/e021161)BMJ Open/ Published online June 28 2018

Digital health

# High-profile health app under scrutiny after doctors' complaints

Babylon advice service faces warnings it can miss symptoms of serious illness

Babylon is one of a number of new tech products being adopted by overburdened health services

Aliya Ram and Sarah Neville JULY 13, 2018

An app that uses artificial intelligence to assess medical symptoms and boasts more than 2.5m users faces regulatory scrutiny after complaints from doctors, who warn it can miss signs of serious illness.

Babylon Health has formed partnerships with the English National Health Service as well as tech giants Samsung and Tencent, expanding rapidly since it was founded four years ago. Investors include the founders of Google's DeepMind AI unit while users include Matt Hancock, the UK's new health secretary and former culture secretary.

The UK medicines regulator asked questions about the app after one doctor complained it had failed to identify symptoms of a heart attack or deep vein thrombosis. Two other doctors told the FT they had complained about wording on the website, which has since changed, that could confuse patients.

Babylon, one of a number of new technology products being adopted by overburdened health services eager to cut costs, has two significant partnerships with the NHS. Some patients in London can register to use the app's video consultations to communicate with a doctor instead of registering with a traditional GP's surgery. Babylon also delivers a telephone advice service called NHS 111 in north London.

The complaints have shone a spotlight on a regulatory system that seems to lag far behind new innovations and classes Babylon's service alongside items such as spectacles and sticking

plasters. Uber was criticised last month for using a different health app, PushDoctor, to verify drivers' vision with video calls, a length of string and home-delivered eye charts.

Babylon said it had responded to questions from the Medicines and Healthcare products Regulatory Agency, which had confirmed the company was not under formal investigation. The MHRA said it could not comment on specific companies but added that it "regularly carries out post-market surveillance and maintains dialogue with manufacturers".

The Financial Times tested Babylon's symptom checker to understand its response to the two conditions at the centre of the first complaint. When told a 66-year-old obese male smoker was experiencing sudden chest pain and excessive sweating, Babylon suggested 9 out of 10 people with similar symptoms were likely to be having a panic attack and made no mention of the risk of a heart attack.

By contrast, the NHS website's advice page for "chest pain" contains an alert box warning people to seek medical advice and call an ambulance if the pain begins with symptoms such as sweating. "You could be having a heart attack," the box says.

Babylon said: "Variable outcomes are still possible if a different symptom is selected, as each symptom could suggest an increase or decrease in the probability of a larger number of potential diseases." Disclaimers on Babylon's symptom checker and terms and conditions say that the chatbot's responses are not diagnoses and do not constitute medical advice.

Dr Richard Body, a cardiologist and professor of emergency medicine at Manchester University, and Dr Annette Neary, a former consultant with the NHS, both expressed concerns about the results when contacted for their views. "Laypeople don't realise that 90 per cent of diagnosis is based on history," Dr Neary said.

A rheumatologist from north London, who spoke to the FT on condition of anonymity, said he had been incorrectly referred three patients through Babylon: "With standard NHS GPs, the quality is variable, but on average the quality is higher," he said.

Babylon said: "Statistically your 'consultant rheumatologist' would only expect to see one or two of these referrals, so we don't think this gives his/her perspective much credence beyond blatant self-interest . . . We regularly conduct clinical audits of our referrals, which consistently demonstrate they are of high quality and are clinically appropriate."

Another doctor, GP and medical writer Margaret McCartney, has complained to the MHRA as well as the Care Quality Commission and Advertising Standards Authority about wording on Babylon's support website. According to a screenshot she shared with the FT, the page about the NHS 111 non-emergency service "Is it safe?" used to read: "a study examining the app's safety and accuracy found that it gave safe advice in 100 per cent of the cases used in the test". "I was concerned that the app was unsafe and was being oversold," she said.

The page no longer exists in the same form. Hugo Farne, a respiratory doctor, also told the FT he had complained to the ASA about language on Babylon's website. According to screenshots shared with the FT, the website used to say Babylon's technology was certified as a medical device with the MHRA and that its video consultation service had been "comprehensively inspected by the Care Quality Commission".

Correspondence from the MHRA, seen by the FT, said Babylon would be asked to amend the wording. The ASA's website indicates that five complaints about advertising by Babylon have been informally resolved.

Babylon told the FT it constantly updates the content of its websites. "As an innovative company working at the forefront of technology and operating in an industry with many vested interests, Babylon operates under very close scrutiny," it said. It added that the complaints about its chest pain and deep vein thrombosis responses had been made by an individual with "potentially vested interests". The doctor, whose identity is known to the Financial Times, rejected the allegation.

"We go far further than traditional GPs when it comes to safety measures, as every patient interaction is recorded, encrypted and can be played back for later review," the company said.

Andrew Haldenby, director of think-tank Reform, said technologies such as Babylon had huge and widely recognised potential to speed up access to health services and enable quicker diagnoses: "The potential is so great that it is easy to get carried away . . . it's important to remember that the technology is still in its early days."

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# Life & Times
# Books

**Challenging Perspectives on Organizational Change in Health Care**
**Louise Fitzgerald and Aoife M McDermott**
*Routledge/Taylor & Francis Group, 2017, HB, 220pp, £84.00, 978-1138914490*

## CHANGE IN THE RIGHT WAY

Innovation (as disruptive as possible) and change (radical, transformational, breakthrough) are the buzzwords of the decade. You want better health care? Then make something new and different happen. If you work in the NHS you will know that it funds a mushrooming industry of change agents, change programmes, change frameworks, and whole-system change events hosted by indefatigably smiling change facilitators. An embarrassing amount of money is passed to management consultants in the process.

Some of us make a living studying the successes and failures (of which the latter probably outnumber the former) of this transformational change industry. The statistics are apocryphal but perhaps not wildly out: it is said that around 60% of all healthcare change efforts, and 80% of those involving a new IT system, fail (with or without the input of said consultancies). Why? If I can make over my living room, why can't I introduce a new, evidence-based, and NICE-endorsed care pathway in the clinical specialty of which I am the designated lead — even when my entire team knows it is going to be performance-managed against the change and the patients and staff are already on side?

The answer, according to a new book by management academics Louise Fitzgerald and Aoife McDermott, is that achieving the kind of top-down 'transformational' change envisaged by policymakers (and promised by fast-talking consultants) is nigh-on impossible, for two main reasons. For one thing, this kind of change is inherently impossible in complex public-sector organisations (in such settings, there are mathematical and ecological reasons why incremental and adaptive change has a far better chance of succeeding). For another, the health system lacks the capacity (in terms of what Pettigrew long ago called the *'receptive context for change'*:[1] the necessary resources, knowledge, leadership, relationships, and vision within healthcare organisations and the supportive political and economic environment beyond them) to implement major transformational changes. It was ever thus, but, because of the progressive downward squeeze on budgets and the triple pressures of technological progress, rising patient expectations, and demographic shifts, it's all getting worse.

Take, for example, the repeated restructuring of healthcare commissioning in recent years (a topic dear to the hearts of the *BJGP*'s readers). Describing commissioning as *'a prime example of a complex subject where knowledge and skilled change implementation are crucial'*, Fitzgerald presents empirical evidence that a succession of governments in recent years have mandated the 'transformation' of commissioning with a view to improving efficiency, value, the patient experience, etcetera, etcetera (you can fill in the blanks). But study after study has shown that the policy vision of smooth, focused service transformation never seems to materialise — and, what is more, policymakers fail to learn from their mistakes. As Fitzgerald sums up in Chapter 5:

*'Restructuring is frequently based on simplistic notions of organizational change, which do not incorporate the effects of dynamic contexts, individual responses and agency. It is therefore unlikely to produce system transformation. Empirical research on mandated change and restructuring has indicated that effective, radical organizational change requires high levels of knowledge, skill and commitment throughout the organization* [...] *The disruptive, negative effects of restructuring appear to have been dismissed by policymakers or become lost through government changes. The role of civil servants in preserving institutional memory and learning is important. Restructuring distracts attention from ongoing priorities and delays improvements in patient care. It also causes dislocation of relationships and the loss of organizational memory and potentially some workforce skills with each restructuring. However, the history of restructuring featured here indicates limited learning from experience and significant re-making of errors.'*

Perhaps it's heartening to hear from an international expert in public-sector management that the treacle you felt you were wading through the last time you tried to help solve a local commissioning restructuring problem had a robust theoretical explanation. And the same goes for disruptive innovations more generally.

Those who know the way critical management scholars' brains work will not expect simple or universal solutions to such deep-seated problems. But the authors do offer some important recommendations (Chapter 10). First, those who trumpet the need for 'transformational' and 'disruptive' change should familiarise themselves with the substantial evidence base against this approach and learn the advantages of what they call *'accumulative change processes'* — humbler, less radical efforts that aim not to disrupt or destroy the complex infrastructure that forms the fabric of our healthcare organisations.

Second, policymakers who seek change should put substantially more effort into supporting healthcare organisations to build the capacity for change, including the ability of individual staff to seek out new knowledge and apply it adaptively to changing situations (something Sarah Fraser and I argued for 16 years ago).[2] Third, accumulative change is more likely when there is space and support for interprofessional dialogue, sensemaking, and collaborative problem-solving. And, finally, more attention needs to be paid to 'the relationship between actors and contexts' (which is academic speak for *'I'd love to have politician X shadow me for a day'*).

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