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Cite this as: *BMJ* 2025;389:r833
http://doi.org/10.1136/bmj.r833
Published: 29 April 2025

TAKING STOCK

Rammya Mathew: The illusion of continuity in general practice

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Continuity of care is one of the great strengths of general practice. The evidence for its value is clear: better outcomes, fewer hospital admissions, more efficient use of healthcare resources.[1] But delivering true continuity relies on one essential ingredient—a stable, available workforce. And right now, in UK general practice, that's in short supply.

Fewer than 25% of qualified GPs now work full time,[2] which compares with more than 75% of hospital consultants.[3] While general practice has long appealed to doctors seeking flexible working patterns, the reality is that rising workloads, mounting administrative burdens, and a lack of protected non-clinical time have driven many GPs to reduce their clinical commitments—not by choice but by necessity.[4]

Policy efforts to improve continuity have largely focused on assigning named GPs to the patients identified as most likely to benefit. But what's the value of a named GP if that clinician is unlikely to be available? The GP Patient Survey indicates that we're failing to achieve continuity as defined by patients: in 2018, 26% of patients reported that they usually got to see their preferred GP. By 2023 that had fallen to just 16%.[4]

In response, some practices have adopted "micro-teams"—small groups of clinicians delivering care to a defined patient cohort. A systematic review suggests that this can enhance continuity, but it's still not clear whether team based models can replicate the depth, trust, and clinical insight built through a long term, one-to-one GP-patient relationship.[5]

Rather than continuing to rely on workarounds we should ask a more fundamental question: how do we make general practice a job that doctors can sustainably commit to? If we're serious about restoring meaningful continuity we need to make full time (or near full time) work a more attractive and viable option. That doesn't mean expecting GPs to work nine or 10 clinical sessions a week—an approach that's neither healthy nor realistic. But it means designing roles with balance: manageable clinical workloads, protected time for professional activities, and space for teaching, training, leadership, or portfolio work.

We also need to consider whether a simple uplift to the global sum (core funding for general practice) goes far enough—or whether more meaningful reform is required. Consultant-style contracts—with structured job planning, protected non-clinical time, and support for portfolio careers—may better reflect what the next generation of GPs are looking for, particularly as many now turn away from the traditional partnership model.[6]

For the first time, more salaried GPs than partners now work in UK general practice. And yet the model salaried GP contract has remained unchanged since its introduction in 2004, more than two decades ago. The health secretary, Wes Streeting, has pledged to prioritise continuity of care—but these promises will fall flat without structural reform to truly support the workforce.

Continuity doesn't just need policy: it needs presence. That means creating working conditions where GPs are not just surviving but are thriving. If we fail to act we risk watching general practice drift further into unsustainability, with fewer GPs, fewer clinical sessions, and patients left with only the illusion of continuity in place of the real, relationship based care they deserve.

Competing interests: I am a salaried GP working less than full time in general practice.

Provenance: Commissioned; not externally peer reviewed.

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