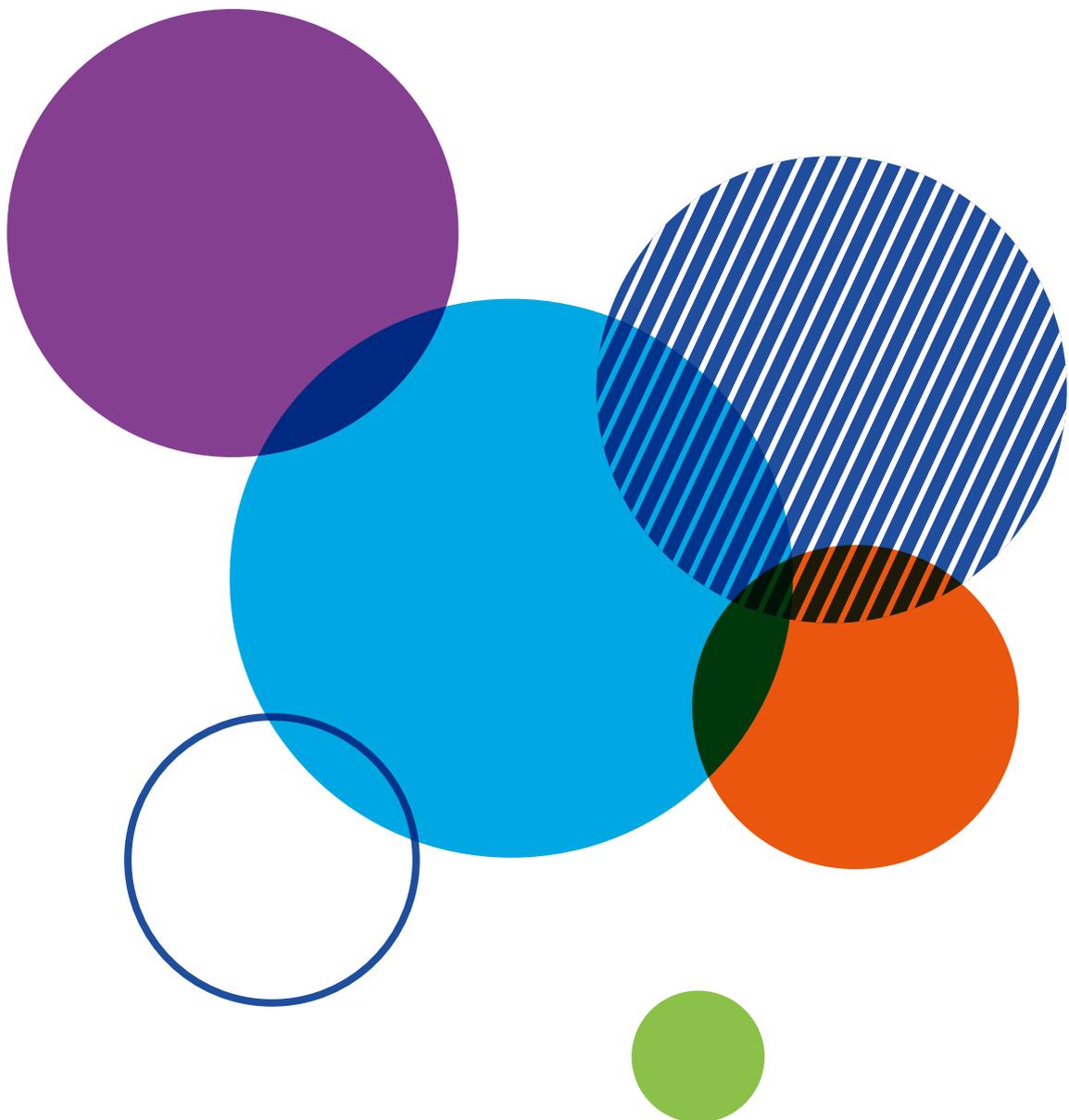




Royal College of  
General Practitioners

# The power of relationships: what is relationship-based care and why is it important?

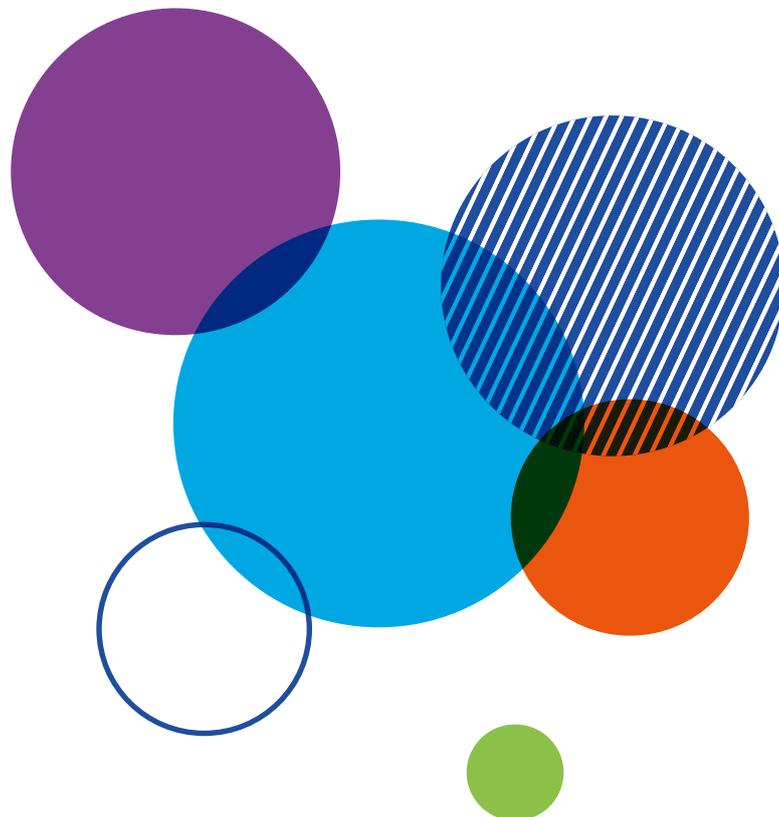
General practice COVID-19 recovery



June 2021

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# Foreword - Professor Martin Marshall, Chair RCGP



COVID-19 has radically changed the face of general practice. We have moved from a predominantly face-to-face service to one in which most consultations are delivered remotely, either by telephone or video call. Of course, during the pandemic, we had little choice. Infection control was the overriding imperative. But as lockdown restrictions are eased, we do have choices to make about what the service should look like post-pandemic. Should we retain the remote gateway to service, known as ‘total triage’? What is the right balance between remote and face-to-face appointments?

Remote consultations are certainly here to stay. For many patients, they enable quicker and more convenient access to a GP appointment, which of course is hugely important. But should speed and ease of access be our primary measures of effectiveness? They are certainly easier to quantify. But what about the quality of care? What about the relationship between doctor and patients which, to me, is the essence of general practice?

**“ the relationship between a patient and their GP is as important as a scalpel is to a surgeon.”**

For many of us, delivering one remote consultation after another has felt very transactional. The phrase ‘call-centre medicine’ springs to mind. And I fear that a predominantly remote service is ultimately to the detriment of relationship-based care - knowing

your patients, understanding their health issues in the context of their lives, forging a bond of understanding, trust and empathy. The relational dimensions of care are more challenging to measure and count but they are no less important than convenience. Yet the evidence for the benefits of trusting relationships is compelling - better patient experience, better adherence to medical advice, fewer prescriptions, better health outcomes, better job satisfaction for doctors and even fewer deaths. Indeed, the relationship between a patient and their GP is as important as a scalpel is to a surgeon. If relationships were a drug, NICE would mandate their use.

In this report we set out to define what we mean by relationship-based care, what the evidence tells us about its benefits for patients, GPs and the wider health system and why it needs to be reinvigorated. Over the coming months we will be engaging policy makers, health experts and primary care practitioners to identify what change levers are needed to strengthen relationship-based care so that it remains relevant in the modern primary care landscape.

Relationship-based care isn't just a luxury, an anachronistic nice-to-have that is incompatible with the modern general practice landscape of multi-professional teams, portfolio careers and working at scale. I would argue that it's just as relevant today. Indeed, it's essential to delivering patient-centred care and to revitalising the profession. Trainees and newly qualified GPs consistently tell us that what attracted them to work in general practice was the connection with their patients. Whether long-term or over a shorter episode of illness, it's the relational aspects of care that makes a GP's job rewarding. This is one reason why policy makers need to start paying more attention to relationship-based care. There are record numbers of GPs in training but, despite successive retention initiatives, doctors continue to quit the profession at an alarming rate. If we can help GPs rediscover the joy of relational care, we stand a much better chance of retaining them.

## Introduction

The relationship between doctor and patient is at the heart of general practice; in many ways it is the unique selling point of the profession. The ability to foster and realise the benefits of strong, trusting relationships - what we call 'relationship-based care' - continues to be critically important within general practice.

The term 'relationship-based care' brings together a number of related and overlapping concepts - continuity of care, therapeutic relationship and person-centred care - which articulate the value of the relationships and interactions between clinicians and patients. There is a significant body of research evidence which demonstrates the benefits of these different elements of relationship-based care, for patients in terms of outcomes and satisfaction, for practitioners in terms of job satisfaction and retention, and for the whole NHS in terms of fewer A&E visits, fewer unplanned admissions and better adherence to medication.

Growing workload and workforce pressures on general practice, and the changes in the way primary care is delivered in the 21st Century, have made it more challenging to develop and maintain strong relationships. Nonetheless, the evolution of the primary care landscape presents fresh opportunities to reinvigorate relationship-based care. It's vital, therefore, that the value of the relational aspects of care are not only recognised but consciously designed in as new models of care and policy frameworks are developed. We need to cultivate an environment in which GPs and their teams are enabled and supported to deliver relationship-based care.

## What is relationship-based care?

Drawing on their 2020 article in the BMJ,<sup>1</sup> Pereira Gray et al have defined relationship-based care as 'care in which the process and outcomes of care are enhanced by a high quality relationship between doctor and patient'.<sup>2</sup> This requires that clinicians possess the knowledge, skills and attitudes to build and maintain strong relationships. While relationships can be built in a short timeframe, long-term therapeutic relationships have been a core characteristic of the long-established model of general practice. What connects both short-term and longer-term relationships is the ability to establish rapport, trust and empathy - knowing patients and their families, seeing the whole person and understanding their back story. The relational nexus better enables GPs to get to the heart of a patient's health issues and means that patients are more likely to feel ownership of treatment plans and trust their doctor's advice.

**'Relationship-based care describes care in which the process and outcomes of care are enhanced by a high-quality relationship between doctor and patient.'**

**The relationship will often, though not always, have developed over time and is characterised by trust, mutual respect and sharing of power between doctor and patient. It leads to better understanding of the patient's ideas and expectations, a better understanding of the family and community in which the patient is living and the opportunity for a therapeutic relationship to develop'**

Pereira Gray D. et al (2020) What are the benefits of relationship-based care and how can they be maintained when an increasing number of patient contacts will use alternatives to face to face consultation? unpublished.

The importance of relationships between clinicians and patients has been conceptualised in various ways, each of which has a significant evidence base. The concept of relationship-based care draws together the commonalities and complementary elements of some of these concepts.

## Continuity of care

Continuity of care is a broad concept which encompasses both long-term relationships between clinicians and patients - 'relational continuity' - as well as the processes which enable care to be joined up between different healthcare professionals or across organisation boundaries - 'informational and management continuity'. Relational continuity - patients seeing the same GP over a long period of time - has always been a core element of general practice. However, although the terms 'continuity of care' and 'relationship-based care' are closely connected and often used interchangeably, they are not the same thing. It is possible, and often necessary, to build rapport, trust and empathy within a single consultation - all doctors use their expertise in psychology and sociology to do so. Equally, multiple interactions between a patient and clinician will not necessarily guarantee a strong, trusting relationship. Even where longitudinal continuity exists, it is possible for patients not to feel listened to or able to participate in decisions about their health, or else for clinicians not to learn enough about the patient to deliver the best care.

**“ While for a minor complaint I'll usually see the first available GP at my practice, when it came to a more complex problem, I had no hesitation in choosing to wait longer in order to see the GP who I had found to be the most open, supportive and non-judgemental.”**

Emma, Patient, Cumbria

Continuity of care is often considered to be incompatible with speed of access to a GP appointment, with waiting times seen as a higher political priority. Accessibility is a defining feature of primary care<sup>3</sup> and a pre-requisite for the delivery of good care but continuity and access do not have to be mutually exclusive. It is unavoidable that it may take longer for patients to be able to see their named or preferred GP than to see any available clinician. However, good access is as much about being able to see one's preferred clinician, as it is about how quickly

an appointment can be made. Emerging evidence from the Health Foundation's *Increasing Continuity of Care in General Practice* programme, for which the RCGP is a learning partner, suggests that some patients are willing to wait longer in order to see a clinician they know. In balancing continuity with speed of access, we also know that some patients value continuity more than others and certain groups of patients or types of consultation benefit from relationships more than others. The important task for general practice is to identify who would most benefit from continuity and when, and to ensure that patients are able to make informed choices about the different access options available to them.

## Case Study: Improving self-management through relationships

“ I’m in my 70s, was born with asthma and, as with many older people, I’ve also developed a number of other health conditions. Throughout my life I’ve been fortunate in having mostly good GPs but my recent GP was by any standard simply fantastic. A combination of bigger and smaller things added up to shape my view of him as someone I had the highest respect for, someone I really trusted and a GP I truly valued. He was cautious and thorough, always with great warmth and more than a touch of good humour.

We always talked openly and honestly about things like test results, in language I could understand and I felt he did all he could to level up the power dynamics in our relationship. This enabled us to explore various treatment or health options, as well as lifestyle changes that could support a reduction in my medication. He would josh, challenge and cajole but always encourage me on my journey to better self-management of my health. And slowly, notwithstanding occasional lapses, I did change my lifestyle. And together he celebrated both my little and sometimes bigger successes. Through it all, he was there for me.”

Dave, Patient, North Yorkshire

## The therapeutic relationship

Another way in which the relational dimension of care has been conceptualised is ‘the therapeutic relationship’, a psychoanalytical term which encompasses “friendship, respect ... empathy, trust, alignment between the doctor’s agenda and that of the patient’s lifeworld, ... and an ongoing focus on care that embraces prevention, illness management, and rehabilitation”.<sup>4</sup> Psychoanalyst Michael Balint played a pioneering role in understanding the therapeutic potential of doctor-patient relationship in general practice.<sup>5</sup> The importance of consulting skills which can enable doctors to realise the benefits of therapeutic relationships is reflected in the GP curriculum itself, which includes learning outcomes on establishing an effective partnership with patients, and maintaining a continuing relationship with patients, carers and families.<sup>6</sup>

## Person-centred care and shared decision making

The concept of ‘person-centred care’ describes an approach which puts the needs, wants and interests of an individual patient at the centre of all healthcare interactions and decisions. One element of person-centred care is ‘shared decision making’ whereby patients are actively involved in decisions about their healthcare. A person-centred approach is complementary to relationship-based care but is conceptually distinct. Where patients have strong, trusting relationships with their clinicians, this facilitates person-centred care and shared decision making.

### Case Study: Building relationships

“ For the last 7 years I’ve looked after a patient who I will call Mohammed, a 40-year-old immigrant from Iran who was obese and had poorly controlled type 2 diabetes. I’d been seeing him for more than a year before he opened up to me about the reasons for his health problems. I learnt that he and his family lived in a grossly overcrowded apartment with no kitchen. He used to eat all of his meals in one of East London’s many fried chicken shops. Mohammed found the food enjoyable, cheap and filling and didn’t initially show much inclination to change his lifestyle.

Over 2-3 years I worked with other members of our team and with social workers to get him rehoused, to join a job club, to start exercising in the local gym and to attend a cooking course with his wife. He confided to me that he wouldn’t have done any of this if I hadn’t suggested that he might benefit, if he hadn’t trusted me and if I hadn’t supported him. There have been ups and downs along the way and I’m not claiming any miracles, but 7 years down the line he’s in a much better place.”

Prof Martin Marshall, GP in East London and Chair, RCGP

## Benefits of relationship-based care

Benefits to patients 	Benefits to GPs 	Benefits to the NHS 
<ul style="list-style-type: none"> <li>• Improved experience and satisfaction</li> <li>• Better health outcomes</li> <li>• Lower mortality rates</li> <li>• Increased engagement with medical advice</li> </ul>	<ul style="list-style-type: none"> <li>• Greater job satisfaction</li> <li>• Improved recruitment and retention</li> </ul>	<ul style="list-style-type: none"> <li>• Fewer A&amp;E attendances</li> <li>• Fewer unplanned admissions to hospital</li> <li>• Better adherence to medical advice</li> </ul>

Relationship-based care is not just a ‘nice to have’, there is substantial evidence that the relational aspects of care - continuity, therapeutic relationships and person-centred care - offer tangible benefits to patients, GPs and to the wider health system. The research literature shows that continuity is strongly associated with increased patient satisfaction and experience,<sup>7</sup> while a person-centred care approach also appears to have positive effects on patient satisfaction.<sup>8</sup> Shared decision making is associated with improved patient satisfaction and experience in 54% of studies.<sup>9</sup> Patients’ perceptions of their GP’s ability to empathise have also been shown to be important,<sup>10</sup> in particular their ability to respond to their patient’s health related concerns, and to demonstrate that they understand the patient’s problem, regard it as valid and that they are committed to finding a solution. Patients want to know that clinicians will engage emotionally – research has found that they look for clues to reassure themselves of their care-givers’ competence and caring.<sup>11</sup>

Continuity of care, person-centred care and empathy are also linked to increased adherence to medical advice,<sup>12 13</sup> while shared decision making is shown to be associated with positive changes in patient behaviours in 37% of studies.<sup>14</sup> Continuity of care is shown to support better health outcomes generally<sup>15</sup> while personal continuity is associated with lower mortality rates.<sup>16</sup> Person-centred care also has positive effects on clinical outcomes.<sup>17</sup>

Relationship-based care is also linked to job satisfaction. We know from the College's survey of GPs in September 2020 that the rise in transactional remote interactions necessitated by the COVID-19 pandemic reduced job satisfaction for 63% of respondents<sup>18</sup> while published research has linked continuity of care specifically to higher GP job satisfaction.<sup>19</sup>

In addition, continuity is linked to lower costs, lower use of emergency departments and reduced likelihood of being admitted to hospital.<sup>20</sup> While the evidence is still emerging, person-centred care also appears to reduce litigation.<sup>21</sup>

### Case Study: The value of trust

“One case that sticks in my mind was a woman in her late 50s. She had consulted several other doctors in the surgery, and it was only on her second or third visit to me that she felt comfortable enough to disclose her situation.

She and her husband were going to have their home repossessed and be rehoused by the council. As a couple with no other dependents living with them, they were offered a one bedroomed flat. She disclosed to me that she had been sexually abused as a child and as a result she insisted on sleeping alone, wearing a dressing gown to bed and sleeping with the light on.

Disclosing this and requesting that I provide medical evidence to the council for a 2 bedroomed dwelling had been the hidden agenda in all those previous consultations for 'minor' problems. Building trust and rapport enabled me to address the underlying issue.”

Dr Mair Hopkin, Joint Chair, RCGP Wales

## Relationship-based care in a changing health landscape

A combination of societal shifts and new models of care have made doctor-patient contacts more transactional - focused on issues which are narrow in scope and time-limited - and weakened the relational aspects of care. The relationship between doctor and patient must evolve in order to reflect this changing context. For example while continuity of care should be encouraged, it is not always achievable or essential. We need to understand and articulate how relationship-based care fits within the emerging health landscape, and how it can be protected and rejuvenated to ensure its benefits for patient care, clinicians and the NHS can be realised.

### Societal changes

Cultural and demographic changes in society have affected the wider environment in which general practice operates. It is increasingly uncommon for people to have a personal relationship with their bank manager, greengrocer or solicitor, and a growing number of public services have an impersonal front end. In addition, changing demographics have led to a more mobile population, meaning that people, both as staff and patients, are less likely to stay in one area or practice. This reduces the ability to build relationships over a long period of time.

### Changes in medicine

Policy shifts over the past decade have also had a significant impact on the healthcare environment. Within general practice this has been particularly evident in the move away from personal lists meaning patients are less likely to be registered with, or regularly see, the same GP. This change can be traced to the introduction of practice, rather than personal, registration in 2004. The subsequent introduction of the 'named doctor' in England, Scotland and Wales, meant patients are allocated a specific GP but this is effectively a purely administrative process which does little to increase continuity of care.<sup>22</sup>

There has also been an increasing protocolisation and standardisation of care as a result of initiatives such as the Quality and Outcomes Framework (QOF) in England and Northern Ireland and the Quality Assurance and Improvement Framework (QAIF) in Wales which link payment to specific process and outcome measures.<sup>23</sup> These initiatives incentivise practices to focus attention on managing single diseases and undertaking discrete tasks, such as diabetes or asthma reviews, rather than considering the whole person. As a consequence, there is a risk of depersonalising care and reducing the quality of care, for example for those with multiple complex conditions.<sup>24</sup>

### Workload

Workload pressures have been growing in general practice for many years. Intolerable workloads are perhaps the largest obstacle to relationship-based care within general practice. The standard 10-minute appointment, which is a consequence of rising demand, does not allow GPs sufficient time in a single consultation to develop relationships or properly understand the problems and life circumstances of their patients, especially those with complex or multiple issues.

## Changes in general practice

In recent years, we have seen the growth of multi-disciplinary practice teams and the development of ‘at scale’ working through mergers and ‘super partnerships’ as well as collaborative working between practices, in form of federations, primary care networks and clusters. NHS England has committed to recruiting 26,000 additional practice team roles attached to primary care networks and there are similar initiatives to expand the practice workforce in the Scotland, Wales and Northern Ireland. There has also been a shift in the working patterns of GPs with an increase in portfolio careers and part-time working. These are all positive developments which have enabled practices to tackle workforce pressures and become more family-friendly, but have particular implications for the ability to deliver relational continuity, and necessitate a rethink in how to maintain relational care in the new landscape.

## New forms of consultation

The COVID-19 pandemic compelled general practice to adopt a radically different operating model, with remote consultations becoming the default mode across much of the UK.<sup>25,26,27</sup> As we look to a future post-COVID, it is clear that remote consultations will have a part to play. In July 2020, the Secretary of State for Health and Social Care, Matt Hancock, said that ‘from now on all consultations should be tele-consultations unless there’s a compelling clinical reason not to’.<sup>28</sup> Similarly in September 2020, the Scottish government set out a vision for a “digital first” approach to healthcare.<sup>29</sup>

There is evidence to suggest that, overall, remote consultations may be less effective at gathering information than face-to-face, even when the length and number of problems handled are the same.<sup>30</sup> There is also evidence that telephone consultations may be less good at building rapport than face-to-face because they tend to be shorter, cover fewer problems, and are perceived to be less safe. However, research also indicates that relationship building can be stronger by video than by telephone, possibly because doctors tend to give more attention by video and because of the benefits of seeing facial expressions.<sup>31</sup>

In response to a College survey in September 2020, just over half (51%) of GPs did not think that remote consultations enabled them to build the relationships for effective care, and a similar proportion (52%) said remote consultations made them anxious about delivering a good patient experience and health outcome.<sup>32</sup> When asked about different methods of consultation, GPs consistently said that they are more likely to ‘always’ or ‘most of the time’ deliver elements of quality using face-to-face appointments, compared to other types (see Table 1). These findings are particularly stark in relation to building and maintaining trusting relationships. The College’s findings are echoed by research undertaken by the Health Foundation for their report ‘Securing a positive health care technology legacy from COVID-19’<sup>33</sup> which found that, while most patients and healthcare staff had positive experiences of technology, 42% of the public and 33% of NHS staff said that technology-enabled approaches were ‘worse’ than traditional models of care.

**Table 1: GP perceptions of their ability to delivery on quality criteria through different types of consultations ‘always/most of the time’**

Quality measure	Mode of consultation			
	Face-to-face	Telephone	Video	Online
Be effective in delivering the best health outcome for my patients	90%	75%	46%	18%
Be efficient and deliver appointments without unnecessary subsequent follow-up	81%	61%	46%	16%
Be sure that my patients are safe	96%	79%	67%	28%
Ensure that no patient is excluded from care	84%	77%	35%	19%
<b>Build and maintain trusting relationships with my patients</b>	<b>95%</b>	<b>69%</b>	<b>58%</b>	<b>16%</b>
Provide accessible appointments for patients	66%	90%	49%	42%

[RCGP online survey of 622 GPs in the UK, in field 10th to 21st September 2020](#)

While the research literature suggests that remote consultations have limitations compared to face-to-face care, remote consultations are not inevitably a threat to relationship-based care. It is important to recognise that the experiences and skills in delivering care remotely which have been gained over the past year are still evolving and have not yet been properly evaluated. It is possible that current telephone and video consultations are, in part due to necessity, becoming different and more substantive than those evaluated in the past. The ability to build relationships remotely may increase as clinicians and patients gain experience and skills which allow remote consulting to be used more and more effectively. It may also be better to target and use remote consultations more for established relationships than new ones. Six in ten GPs whom we surveyed thought that remote consultations were more effective in treating existing than new patients.

Remote consultations will never be appropriate for all patients or all types of consultations or conditions, but they are here to stay so we need to consider how best to ensure that they enable rather than hinder the delivery of relationship-based care. We have explored the issue of remote care in greater detail in our recent report, ‘The future role of remote consultations & patient ‘triage’’.<sup>34</sup>

## Reinvigorating relationship-based care

Relationship-based care is a huge asset to general practice, but we need to rethink how strong, trusting relationships can be fostered and sustained in the new primary care landscape of multidisciplinary teams, working at scale and portfolio careers. We know that for many GPs, traditional models of general practice, which prioritise long-term one-to-one relationships, do not feel relevant or achievable. Over the coming months, the College will be doing more work to understand what changes in policy and practice are needed to ensure that relationship-based care can be protected and reinvigorated in ways that work for general practice today. Our work to date suggests a number of avenues which we will continue to explore:

### Metrics

The development of metrics for the quality of relationships could be used to track and incentivise relationship-based care. These metrics could draw on elements of existing measures for the therapeutic relationship and continuity of care. The therapeutic relationship has been measured using patient satisfaction and relationship surveys, for example *The Patient Perception of Physician Responsiveness Scale*<sup>35</sup> which has 8 dimensions:

- Sometimes my doctor seems indifferent to my needs
- My thoughts and feelings are important to my doctor
- My doctor often really doesn't 'hear' what I am saying
- Often, my doctor does not accept my feelings and concerns
- My doctor dismisses my concerns too easily
- My doctor is responsive to my needs and concerns
- My doctor is concerned about me as a person
- My doctor knows me as a person

Similarly, the annual NHS GP Patient Survey (England) contains questions about some aspects of relational care, such as seeing a preferred GP and patient involvement in treatment decisions. Staff surveys could also provide measures of relational care. Currently the NHS Staff Survey does not cover primary care but it could be expanded to do so.

There are also several established measures of continuity of care which use GP data to track which clinicians or care providers patients have had consultations with across a certain period of time. These measures include Usual Provider of Care (UPC), which describes how often a patient has seen the same GP,<sup>36</sup> Continuity of Care Index (COCi) which assess continuity across micro-teams,<sup>37</sup> and St Leonard's Index of Continuity of Care (SLICC) which monitors continuity across a group of patients.<sup>38</sup>

### Policy levers

In addition to metrics, we need to assess which policy levers could help to embed the relational dimensions of care. Reviewing schemes, such as QOF, which may inadvertently erode relational continuity, will be a crucial step. New policies in primary care could also be risk assessed for their impact on relationship-based care and reconsidered or redesigned if the impact is potentially detrimental.

## Larger workforce and longer consultations

A key enabler of change is longer average consultation lengths which would enable GPs to spend more time building relationships and exploring patients' health issues. In order to free up GPs' time to deliver longer consultations, we need to equip practices with the tools and knowhow to redesign workflows as well as tackling the underlying workforce challenges. Workforce shortages, with workforce supply not keeping up with rising demand in general practice, must be addressed so that GPs are able to dedicate time to their relationships with their patients.

## Micro teams

A number of practices have trialled the use of micro-teams operating with personal lists shared between multi-disciplinary team members. This model facilitates the relationship between a patient and a small team within the practice and allows for patients to see the appropriate team member according to what they need at a particular time. Practice staff share information about the patient within the micro-team in order to enable personalised care.

### Case Study: Continuity and micro-teams

Between January 2019 and June 2020, the Valentine Health Partnership, a GP practice in South East London, undertook a project to identify patients who might benefit from continuity of care and to test whether continuity would result in improved patient experience and outcomes. This was inspired by a review of missed and delayed diagnoses which found that some of these occurred among those who consulted repeatedly but saw multiple different GPs.

The project analysed and flagged those whom it was thought would benefit most from increased continuity and developed processes to deliver continuity for these patients with their usual GP or their micro-team.

- 1** 416 patients were flagged for continuity and the majority experienced improved continuity with their named GP and even more so with that GP's micro team.
- 2** Patients who received continuity for over 50% of their appointments had a lower use of A&E and urgent care.
- 3** 93% of staff said that the project made them more likely to promote continuity.
- 4** 70% of patients who responded to a feedback survey said they found it easier to see their preferred GP

Source: "Relational continuity for general practice patients with new and changing symptoms - Final Report" July 2020, Valentine Health Partnership

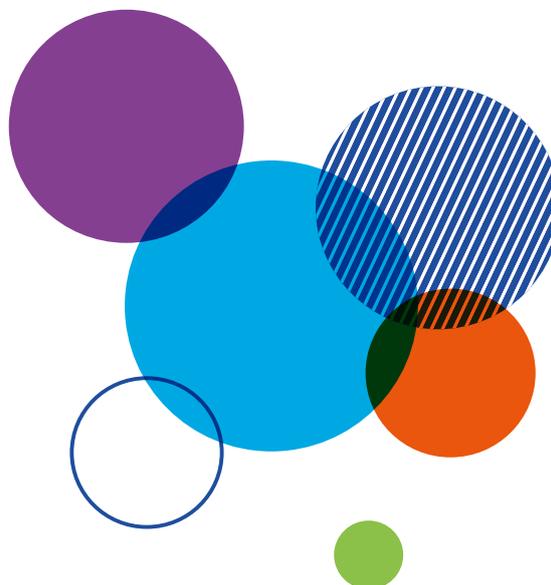
## New practice team roles

Expanded practice teams can also particularly enhance relationship-based care where a social prescriber or care planner is able to spend more time with a patient and fully understand their experience, problems and preferences. This holistic approach means insights can be shared within micro-teams. For these models to work, time and resources are needed to integrate these new roles into practice teams.

## Skills, knowledge and attitudes

Equipping and encouraging the development of the necessary skills, knowledge and attitudes is likely to be critical to embedding relationship-based care within a changing general practice landscape. The GP curriculum focuses explicitly on relationships but this should begin at undergraduate level - the profession needs to attract trainees who are as interested in people as they are in diseases. It also needs to be hardwired throughout career pathways from medical education and professional development to appraisal and revalidation. Skills development needs to encompass remote consulting skills to ensure that clinicians are confident and able to establish rapport and trust through tele-consultations. There is increasing recognition that consulting remotely requires a different skillset from face-to-face and these skills are particularly important in relation to building strong relationships.<sup>39</sup>

In summary, relationship-based care is an evidence-based intervention which improves patient experience and outcomes, enhances GP job satisfaction and reduces pressures on other parts of the NHS. These benefits demonstrate that the relationship between clinicians and patients is not a 'nice-to-have' but an essential intervention which allows for the most effective identification and treatment of the patients' health concerns. The ability to build trust, empathy and rapport enables GPs to manage undifferentiated illness more effectively - in other words to be better general practitioners. This is why policy makers need to recognise, value and, above all, invest in the relational aspects of care. Doing so will improve the quality of care and, by helping doctors rediscover the joy of being a GP through the connections they forge with patients, it will enable the NHS to retain talented and experienced doctors.



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