



Royal College of  
General Practitioners

## Continuity of care in modern day general practice



## Introduction

Patients who receive continuity of care in general practice have better health outcomes, higher satisfaction rates and the healthcare they receive is more cost effective<sup>1,2</sup>. The College has previously produced research demonstrating why continuity of care is important to general practice (see *Promoting Continuity of Care in General Practice*, 2011) and this paper will not duplicate that work, but will expand on it further. We know that continuity can be beneficial, but this paper will ask whether it is still important in modern day practice, and assess how it can be delivered in the context of changing demographics, work patterns and models of care.

Modern day general practice consists of an increasing number of GPs who work part time, in addition to more GPs broadening their role - for example, by taking on management or leadership positions, or conducting academic research. Even GPs who work full time will not be available to provide continuity at all times. Furthermore, modern general practice is now increasingly working in collaboration with other parts of the health and social care system, and many practices have formed federations and networks, to provide a range of healthcare services for patients. This paper looks at how this will affect continuity of care.

Despite the fact that 80% of UK GPs have stated that continuity of care is one of the most essential components of general practice<sup>3</sup>, modern day general practice is faced with policy developments and socio-demographic changes that are making it harder to deliver. College analysis of the GP Patient Survey has shown that the number of patients seeing their preferred GP only "some of the time, never, or almost never" is at an all time high in England at 40.3%.

Percentage of patients that have a preferred GP that only see them some of the time, never, or almost never

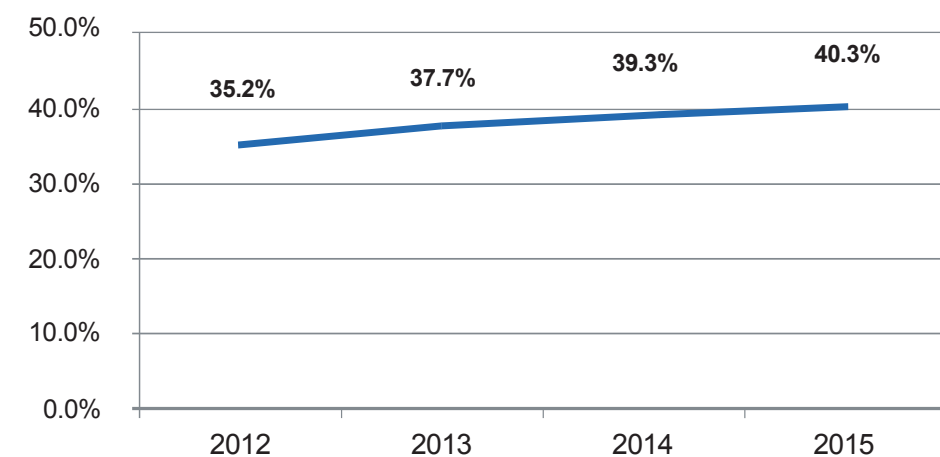


Figure 1: Percentage of patients in England that have a preferred GP and only see them some of the time, never, or almost never

As patients' ability to see their preferred GP continues to fall, general practice faces a significant challenge if it wishes to continue to prioritise continuity of patient care. New methods of working, including multidisciplinary teams, telephone triage and micro-teams, may provide solutions to falling levels of continuity for those who need it most. However, these require successful implementation, as well as significant investment to produce more GPs.

As well as exploring how continuity can be delivered in modern day general practice, this paper will also establish key principles that general practice should adhere to, if continuity is to remain at the core of the primary care as it continues to evolve.



## Why is continuity important in modern day general practice?

### Defining continuity

Continuity can be defined as “the extent to which a person experiences an ongoing relationship with a clinician, and the coordinated clinical care that progresses smoothly as the patient moves between different parts of the health service”<sup>4</sup>. It can consist of relationship continuity, management continuity and informational continuity.

“Relationship continuity is longitudinal, personal, continuing and caring: it implies knowledge of each other within the context of the therapeutic relationship, with commitment and trust. Both doctor and patient contribute to its creation and maintenance. It can involve more than one clinician and it should be flexible over time, responding to the patient’s changing needs and social context”<sup>5</sup>.

“Management continuity can be thought of as the ‘seamlessness’ of care: perhaps better thought of as tailored care where the seams are strong and invisible – and fit the wearer. It involves co-ordination and teamwork between care-givers and across organisational boundaries. It helps the patient navigate the healthcare system as smoothly as possible. It depends on good communication and in the timely and accurate sharing of information. Such informational continuity is an essential part of good care; the completeness, readability and availability of clinical records is very important”<sup>6</sup>.

Informational continuity ensures that clinicians have access to accurate, up to date, patient records during patient consultations. New, more complex, models of care, will only work if they link up with innovative I.T. systems. Patients dislike having to explain their symptoms and history to different GPs and informational continuity is a method of tackling this, especially when they cannot see their preferred doctor. Furthermore, informational continuity acts as the backbone for both relational and management continuity.

As a result, continuity can mean different things to different people. This paper focuses mainly on relationship continuity, but recognises the role of other forms of continuity and the increasingly important role they play in modern day general practice.

There is an abundance of evidence demonstrating that continuity is the key element of what makes general practice effective. Much of this reasoning has been collated in the Colleges 2011 paper, *Promoting Continuity of Care in General Practice*.

Evidence suggests that patients experiencing continuity are more likely to have positive health outcomes, with continuity even being shown to impact on patient mortality<sup>7</sup>. Relationship continuity is closely linked with patients who feel able to cope with their condition, and those who experience continuity are more likely to adhere to medicine regimes in the long term<sup>8</sup>. Continuity will therefore prove vital for a health system that will have to deal with an increasing number of patients living with multi-morbidity in the future. Diabetes patients especially benefit from continuity, gaining better understanding of their illness<sup>9</sup>, and better quality of diabetes management<sup>10</sup>.

Furthermore, when patients receive continuity of care, the number of preventative procedures, including health screenings and immunisations increases, which results in savings at a later date<sup>11</sup>. Higher rates of continuity within general practice can also have an effect on other parts of the healthcare system, producing savings in prescribing, hospital referral, admissions and the use of A & E<sup>12,13</sup>. This could prove essential as we integrate our health care system. Investing in general practice could save vast amounts of money for the NHS, with the average cost of a general practice consultation being £21, compared to an A&E visit which costs around £124<sup>14</sup>.

There is; however, other evidence to suggest that continuity can have adverse effects. Late diagnosis, especially in relation to cancer<sup>15</sup>, contradictory evidence that it potentially leads to less rigorous control of chronic diseases such as diabetes<sup>16</sup>, and patient dependency on their doctor, are some possible knock on effects of patients receiving relational continuity.

Despite this, it appears that the benefits of continuity of care outweigh any adverse effects, but this needs to be monitored in the current constantly evolving landscape. It is important that we find ways to robustly evaluate the effects of any new policy initiatives on continuity of care.

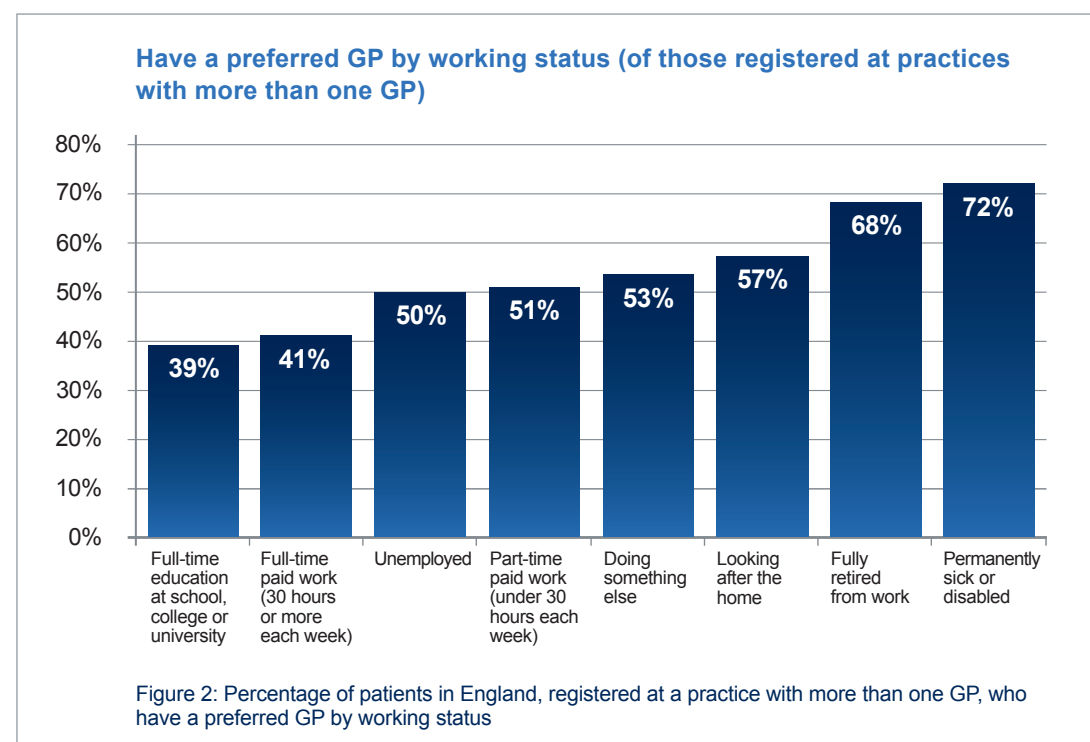


## Who is continuity important to?

Continuity is valued by a wide variety of patients and their carers. College analysis of the GP Patient Survey has shown that 51% of patients in England, who were registered at a practice with more than one GP, had a preferred GP in 2015. However, we know that continuity is particularly important to certain patient groups. People living with multiple long term conditions, elderly people and those with mental health difficulties, who may struggle to establish trusting relationships, have all been shown to benefit greatly from continuity in their care. Modern day general practice should develop to provide continuity for these patients in particular.

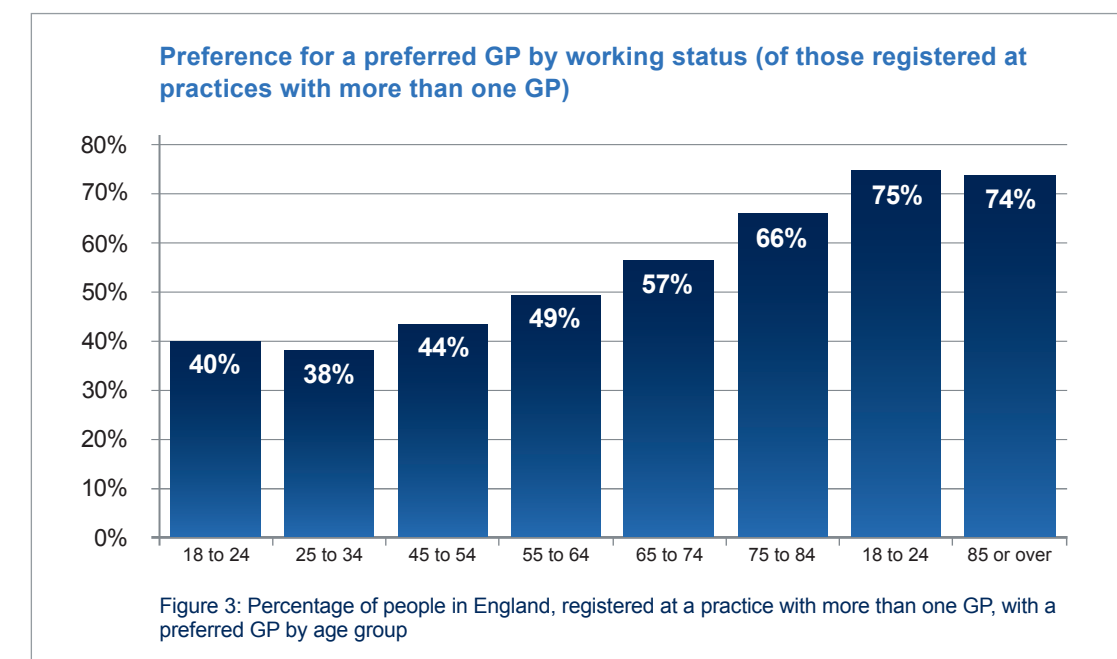
College research into the English GP Patient survey CCG level data and indices of multiple deprivation suggests that, in deprived areas, patients are less likely to express their desire for a preferred GP. This could be due to poor rates of health literacy, or language barriers as a result of not having English as their first language. It could also be due to the fact these patients may have less opportunity to create a relationship with a named doctor, with RCGP analysis showing that there is a slight negative correlation between higher areas of deprivation and the ability to see their preferred GP. It is these patients; however, who would benefit most from continuity of care.

Additionally, patients with multi-morbidities are now taking up a large proportion of 21st century NHS time and budget, and need their care integrated around them. The GP Patient Survey 2015, conducted in England shows that 72% of those who are permanently sick or disabled have a preferred GP, the highest of all the groups by working status. Research into the prevalence of multi-morbidity conducted by the College, has shown that by 2025 the number of people living with more than one serious long term condition will increase by nearly one million, rising from 8.2 million to 9.1 million. This represents a huge challenge for the NHS as a whole, but particularly for modern day general practice, as this is the first point of call for the majority of patients.



Similarly, elderly patients prefer to see a doctor they already know and are familiar with. College research into the GP Patient Survey suggests that in England the preference for a certain GP increases with age. As we are facing an ageing population, GP workload will only continue to increase. At present in England, patients are registered with a practice, rather than a GP; however, the new GP contract requires all patients over the age of 75 in England to have a named GP, as well as receiving a same day appointment if needed<sup>17</sup>. There is evidence to suggest that where practices implement named doctors, continuity of care increases<sup>18</sup>, and patients in practices with named doctors are also more satisfied with the services they receive<sup>19</sup>. While it appears having a named GP will increase continuity, evaluation of the impact of the new GP contract is still unknown.

Continuity is also paramount to those receiving end of life care or dealing with bereavement. GPs can play a vital support role to those receiving end of life care, with the King's Fund reporting that even when patients received continuity of care from district nurses, they still like to remain in touch with their usual GP and for their GP to be responsible for organising their care<sup>20</sup>.



The importance of continuity can also be seen in the experience of those who do not receive it. Patients who experience discontinuity in their care are much more likely to discontinue treatment, miss appointments, or not take their medicine correctly<sup>21</sup>. Research by Sweeney and Pereira (1995) also showed that patients who experienced discontinuity, defined as fewer than 4 consultations in a row with the same doctor, were more likely to have depression, complain of non-cardiac chest pain and have more relationship problems, as well as being more likely to attend accident and emergency and other open access clinics<sup>22</sup>. This highlights the inverse care law, in that those who are most vulnerable in modern society do not have access to adequate care, and this has knock on effects for continuity.

## Factors jeopardising continuity in general practice

Recent policy developments and socio-demographic changes mean the current model of general practice cannot deal with present demands<sup>23</sup>, making delivering continuity difficult, and sometimes impossible. The College's four nations policy action plans for general practice – *A blueprint for building the new deal for general practice in England*<sup>24</sup>, *A blueprint for Scottish general practice*<sup>25</sup>, *Strengthening general practice in Wales*<sup>26</sup> and *Delivering change for general practice in Northern Ireland*<sup>27</sup> – provide actions that the government should take to improve patient care. The combination of greater demand for appointments and a focus from policy makers on offering fast and convenient access, in addition to the funding crisis, means patients are finding it harder to get an appointment with their preferred GP. The GP Patient Survey has shown that whilst 51% of patients in England expressed a preference for a particular GP, only 36% of these patients got to see them all, or almost all, of the time.

### Continuity vs access

Current patient expectations of the NHS are rightly high. However, this has, at times, led to conflict arising between access and continuity, and successive governments have prioritised access over continuity. Relatively recent changes in modern day general practice, for example, extended opening hours, mean that patients have a greater amount of time to access the practice; however, the likelihood that their preferred GP will be available falls.

Current government proposals to provide access to general practice services 7 days a week, have not only been shown to be unnecessary, with 66% of College survey respondents stating ministers should focus on improving current services as oppose to delivering 7 day access, but also have potential to jeopardise continuity. Relational continuity may be affected by the current lack of GPs available to provide these services, but there also needs to be improved informational and managerial continuity aspects of current 5 day general practice services, before moving towards 7 day services.

Whilst patients may ideally want both ease of access and continuity in primary care, many prioritise access when dealing with short term, low impact, health issues, but prefer to wait for a known and trusted GP for issues they consider more serious or long term<sup>28</sup>. It may no longer be possible for relational continuity to be realised for every single patient, but there is still opportunity for management and informational continuity to be at the forefront of modern day practice for all patients, prioritising relational continuity for those who need it most.

### Increased Workload

The amount of work GPs currently undertake is larger than it has ever been. GPs are conducting more consultations, as well as adapting to new models of care. Whilst 76% of GPs have stated the ability to develop relationships over time with a patient as an attractive factor of general practice, 93% of GPs stated that heavy workloads negatively affected the care they provided to patients, and 37% felt that their workload was unmanageable<sup>29</sup>.

This increase in workload is due to both an increase in patients requiring appointments, particularly from patients experiencing multi-morbidities, but also due to the vast amounts of paperwork GPs are expected to complete. The Roland Commission reported that GPs currently spend 11% of time on administration tasks<sup>30</sup>. If half of this work was completed by administrative staff, this would equate to 1,400 more full time GPs who would be available to provide continuity<sup>31</sup>. Research into the challenges faced by general practice in Northern Ireland, has also shown that workload has increased drastically, with repeat prescriptions issued increasing by 42% between 2003/04 to 2013/14; total consultations rising from 7.2 million to 12.7 million between 2003/04 and 2013/14; and administrative tasks per patient rising by 115% between 2003/04 and 2013/14<sup>32</sup>.

### GP workforce pressures

Modern day general practice has fewer GPs per patient in England than six years ago – down from 62 per 100,000 patients in 2009 to 59.5 in 2013<sup>33</sup>. The College has shown that 8,000 GPs are now needed across the UK to make up for this shortfall, with 74% of GPs surveyed claiming that recruiting more GPs would help resolve workload pressures<sup>34</sup>. Furthermore, a large proportion of the GP workforce is approaching retirement age, with 21.9% of GPs in England, 19.6% in Scotland, 23% in Wales and 24.8% of GPs in Northern Ireland being above 55 years old<sup>35</sup>.

GPs are currently overstretched and under immense pressure, with many working part time, covering a broader time period across the week to increase access. Many GPs are now involved in research or teaching, or are developing specialisms, all of which have the potential to put a strain on their ability to provide continuity to patients. The recruitment of more GPs is essential in delivering continuity in general practice.





## Delivering continuity in modern day general practice

Additionally, in the 21st century, there is an increasing number of GPs choosing to work as locums or salaried GPs, over being practice partners. Salaried and locum GPs are more likely to frequently move between practices, and whilst they are essential in providing care in practices who are struggling to recruit GPs, they therefore have fewer opportunities to prioritise continuity. There is little research into locum GPs; however, it was estimated in 2010 that there are over 4,000 locum GPs in the UK<sup>36</sup>, with 81.7% of practices stating they have used a locum in the previous year<sup>37</sup>. The small amount of data on locums means that understanding their impacts on continuity is difficult to establish. Future general practice models; however, need to establish a method of allowing locums to provide continuity to patients, through informational and managerial continuity, when relational continuity cannot be realised.

### Governance

Whilst the Quality and Outcomes Framework (QOF) is intended to incentivise and reward GPs for achieving results, it can at times result in patient continuity being lost. GPs working towards QOF incentives risk prioritising managerial values over patient values, viewing patients as individual medical conditions, rather than a whole person.

Although QOF requirements have recently been reduced, 55% of GPs still feel there is a need for them to be reduced further<sup>38</sup>. The College's *Blueprint for the new deal for general practice in England*, along with RCGP Northern Ireland's *Delivering change for general practice* document, have recently called for QOF to be replaced with a less bureaucratic funding arrangement that leaves GPs with more time to focus on holistic patient care<sup>39</sup>.

In the face of current challenges, modern day general practice is evolving to reflect the needs of modern day patients. Many practices are looking at innovative ways, both structural and clinical, to provide integrated healthcare, and continuity should be at the core of these models.

Policy makers across the UK have recently been setting out visions for the future of patient care but these visions will only be most effective if continuity is valued.

In England, the *Five Year Forward View* – published by NHS England and five other NHS bodies – stresses the importance of patients leading on their care, and in order to make this a reality, relational, informational and management continuity all need to be prioritised and evaluated. In England general practice is playing a pivotal role in delivering the New Models of Care section of the *Five Year Forward View*. Practices are part of the 13 Multi-specialty Community Provider NHS England vanguard sites, and are centrally involved in all nine Primary and Acute Care Systems. Whilst these vanguard sites are at an early stage of their journey, they aim to bring patient care closer to the community and increase continuity, which should be used as a key metric in their evaluation.

In Wales, like the rest of the UK, there are substantial workforce issues, with several partnerships recently being terminated, which will have significant impact on continuity. The Primary Care Workforce Plan was announced in July 2015 and directors of Primary Community and Mental Health have a shared responsibility to create an action plan and monitor its delivery, with continuity playing a key role. GP Clusters, introduced in NHS Wales' *Setting the Direction* document<sup>40</sup>, offer a great opportunity to provide collaborative community healthcare, focusing on continuity for those patients it will benefit the most. RCGP Wales raises concern in their *Strengthening General Practice* report, that the NHS now needs to focus on those with multiple long term conditions, in order to provide not only continuity, but quality care.



In 2011, the Scottish Government set out its strategic vision for achieving sustainable quality in the delivery of healthcare services in its *2020 Vision*. The paper provides the strategic narrative and context for implementing the Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability. The Scottish Government's *2020 Vision* asks NHS Boards to ensure their local values align with the NHS Scotland values of care and compassion, dignity and respect, openness, honesty and responsibility, and quality and teamwork. Following calls by RCGP Scotland, the Scottish Government has committed to dismantling the current system in time for the new contract in 2017, replacing this with peer-based, values-driven governance. This approach has great potential to mobilise GP clusters, valuing continuity and delivering improved quality care that would otherwise be hard to influence through contractual models. RCGP Scotland have also produced their *Scottish Blueprint for General Practice* which stresses the need to keep general practice local, focus on the doctor patient relationship and increase workforce to do so.

Northern Ireland is in the early stages of establishing GP federations, and needs to ensure these are implemented successfully to prioritise continuity. Northern Ireland already has the Electronic Care Record, which allows GPs to access hospital letters and reports, and allows hospitals and ambulance staff to access GP prescribed medications and patient allergies. Similar to the other nations; however, Northern Ireland faces a recruitment crisis having knock on effects for continuity with their *Delivering change for general practice* document calling for an increase in workforce and adoption of diversified teams.

UK general practice would benefit from investigating overseas models of integrated care which prioritise continuity, for example, Accountable Care Organisations in the United States, which provide care for a population for a certain amount of time, under a contract with a commissioner<sup>41</sup>. Practices across the UK are also adopting micro-teams and demand-management systems, as well as implementing new clinical models of care, such as care and support planning and longer consultations.

Here the paper highlights news ways of working, at GP level, practice level, and regional and national level, and their potential to deliver continuity in modern day general practice.

## GP consultation level

- Longer consultations

Patients value time with their doctor; however, current consultation lengths over-stretch GPs to deliver too much in a short period of time, and for some patients a 10 minute consultation is not enough to receive the care they need. This is especially the case for the rising number of patients with multi-morbidities, as the population ages and patient records become increasingly complex. According to the most recent GP Workload Survey in England, in 2006/07 the average consultation length in England was 11.9 minutes, already longer than the standard 10 minute appointment slot, putting GPs under pressure to make up this time elsewhere<sup>42</sup>. The Roland Commission stated that countries with longer consultation lengths have around a quarter of consultations than in the UK, with Swedish doctors having consultations with patients for up to 25 minutes when necessary.

The BMA National Survey of GPs has shown that only 8% of GPs in the UK feel that the standard consultation is long enough. 43% of GPs surveyed stated that insufficient time with patients negatively impacts on their commitment to general practice<sup>43</sup>. 70% of GPs stated that implementing longer consultation times would help resolve some of the pressures they were under in relation to continuity<sup>44</sup>. RCGP Scotland has specifically called for longer consultation times in its 2015 manifesto, especially in the areas of mental health, multi-morbidity and in localities of high deprivation.

Whilst the knock on effects of longer consultation times are not fully known, doctors with longer consultation times have been proven to prescribe less medication and spend more time discussing the importance of a healthy lifestyle, if this is of more benefit to the patient<sup>45</sup>. Studies have also shown that patients who have longer consultations play a greater role in their care<sup>46</sup>, an essential factor of future models of care.

A study by Mercer *et al.* (2007) in Scotland found that patients in the most deprived areas had more problems to discuss (especially psychosocial), yet clinical encounter length was generally shorter – at 8.2 minutes on average compared to 8.6 minutes in more affluent areas<sup>47</sup>. Further research in Scotland that looked into the impact of longer consultations in deprived areas found that an increase in consultation length for patients with complex needs to an average of 15 minutes was associated with enhanced levels of patient enablement<sup>48</sup>. The study recommends that 15 minute consultations should be standard for patients with multi-morbidity, and suggests that more integrated working would free up time to allow this to happen<sup>49</sup>.





The Deep End Project in Glasgow has taken these insights and helped to apply these by supporting practices to explore a range of approaches to increase face to face clinical time with patients in deprived areas including offering longer consultations<sup>50</sup>.

Pioneering vanguard site Lakeside surgeries is also breaking the consultation length mould to deliver modern day patient care. The practice no longer uses standard 10 minute appointment slots, but allows patients to book to see their GP for up to an hour if needed. This is of great value to those patients with multi-morbidities, yet, as the vanguard is at an early stage of its transition journey, this will need on-going evaluation.

There is concern; however, that if practices offer longer consultations to provide quality care for increasing number of patients with multiple long term conditions, another aspect of general practice, or a another group of patients, will suffer as a result. Adapting to meet the demand for longer consultations whilst continuing to deliver the usual service will require more funding and resource in general practice.

- **Video consultations**

Access and continuity of care are fundamentally linked, and in order to increase continuity, patients need to be given options which improve access. Allowing patients to have face to face contact with their GP, without attending the practice is one method of doing this. Video consultations have potential to be beneficial to frail and elderly people, or those with physical conditions or disabilities that mean they are less mobile, in addition to patients whose illness may be contagious. It also benefits those who may not have time to attend the practice, such as those employed full time or those caring for young children. However, more research is needed to robustly assess the effects of video consultations on continuity.

Manchester Medical has already adopted video consultations using Skype. The area has a diverse demographic with people from different cultures, and a high numbers of students. Both these groups already use Skype and, the uptake of appointments via video conferencing has been high. Dr Sirfraz Hussain from the practice stated that the use of Skype consultations has been adopted by a wide variety of patients, and many are able to still see their GP when they cannot leave home.

“ If you think about winter, not everyone is able to come out to you. If you are able to see someone via telephone call you are saving them a trip to the doctors. It benefits those who are housebound or elderly as it means they don't have to get ready or get a family member to take them to the practice. We see more patients but they don't have to come in. ”

(Interview – Dr Sirfraz Hussain)

Video conferencing can prove particularly beneficial for patients receiving palliative care, and is a means of providing continuity for these patients outside of their regular appointments.

“ Elderly patients on the palliative care list can be seen more often. Rather than having to do a home visit more often, or only do a visit when they request it, you can do it to check up on them. I have done it before when I have been worried about a patient and their relatives are very anxious, you can really improve quality of care at critical times. ”

(Interview – Dr Sirfraz Hussain)

Additionally video conferencing works to provide continuity for patients when they have an illness where they are advised not to come to the practice.

“ With all these illnesses...swine flu...Ebola scare, every time there is a scare we are told not to bring these patients to the practice. We don't want to expose ourselves to these illnesses too. If you have one doctor who does skype triage it would save lives in a national health scare. ”

(Interview – Dr Sirfraz Hussain)

As highlighted in RCGP's paper - *Patient access to general practice: ideas and challenges from the front line*<sup>51</sup>, video consultations will never be able to replace doctor-patient consultations within the practice itself, and need more evaluation into their impacts on continuity, and their impacts on GP workload. However, they provide great opportunity for patients to contact their preferred GP in 21st century general practice.





## Practice level

- **Micro-teams**

Micro-teams are a method of enabling modern day general practice to provide continuity whilst employing part time staff or when GPs take leave. They can be defined as a small group of GPs, and sometimes a nurse, working together in a practice covering an allocated number of patients. Continuity is prioritised by patients first trying to book an appointment with their preferred doctor, and if this fails, another doctor from their micro-team. With the new GP contract stating that all patients should soon have an assigned GP, micro-teams could be a solution to providing continuity in areas where this proves difficult.

An example of micro-teams working successfully can be seen at Limehouse practice in Tower Hamlets, London. The practice has always had patient lists and has always valued continuity, yet decided to implement a job share style of working after staff started working part time.

The practice paired doctors and looked at patient lists, ensuring that all sessions across the week were covered by someone from each micro-team. Receptionists took on the task of ensuring patients booked an appointment with someone from their micro-team, with patients not even being aware that their appointments were being managed in this way. Micro-teams ensured that there was continuity, so patients would rarely see more than 3 doctors of the total team of 12, with particularly high continuity rates occurring for complex patients. The practice disseminated their work to 4 other practices in Tower Hamlets through a CCG led project. Practices reported that after implementing a micro-team approach the percentage of patients seen by a regular GP rose from 27% to 42%, having substantial positive effects on continuity of care<sup>52</sup>.

Furthermore, working in a micro-team enabled doctors to learn from each other. All doctors now work to same standard, as their work would be picked up by others in their team, meaning that patients' notes and histories are easily deciphered, improving informational continuity. Additionally, the doctors in the practice feel that relationship continuity with their patients gives them greater job satisfaction, so reducing risk of burnout.

“ In the past doctors may have done things certain ways and we didn't want that. It makes reception difficult when one doctor does something one way and one doctor does something the other way. We pulled all that back, we are working much more together...we have gelled more as a team. ”

(Interview)

The current usage of micro-teams across the UK is unknown; however, they have potential to be scaled up across the country to deliver a new model of general practice that is tailored to current workforce and workload challenges. Micro-teams could even be successful in federations, and could be considered for the unexplored combination of both micro-teams and skill mix.

- **Diverse skill teams**

Whilst the modern primary care workforce already offers a range of skills in the community, this needs both consolidation and development. Modern day general practice is facing significant workforce shortages and workload pressures, and skill mix uses the expertise of non-GP staff to deliver certain aspects of care to patients which would have been traditionally done by a GP. Skill mix is tailored to each individual practice, with a practice's requirements being based on the different challenges faced in that area; an essential model for the success of modern day general practice. It has; however, both positive and negative implications for continuity. In theory GP time is freed up to care for patients with more complex issues. However, patients interacting with a wide range of general practice staff means they could be at risk of discontinuity.

It should be highlighted that skill mix should not be seen as a resolution for the present shortage of doctors and funding within general practice, but it can be used to free up GP's time, and allow them to focus on continuity, as opposed to completing tasks which can be performed by other members of the general practice team. Skill mix; however, needs to be proportionate, and allow GPs to continue to work in a holistic role which originally attracted them to general practice.

The RCGP and the Royal Pharmaceutical Society have already outlined plans to ease pressures on general practice by utilising practice based pharmacists, and in Scotland the government has already pledged for 140 new pharmacists in primary care. Northern Ireland has received funding for a pharmacy project to be piloted in five of the seventeen federations, with plan to roll this out across the region. Whilst there is currently a shortage of GPs, there is an oversupply of pharmacists, with many leaving university and few jobs to match their skillset.



The recent collaboration of the BMA's General Practice Committee, the Royal Pharmaceutical Society and Health Education England has introduced a £15 million scheme three year scheme<sup>53</sup> to fund pharmacists based in practices across England. It will see pharmacists working as part of the general practice team, freeing up GP time to provide care for the most ill patients. Pharmacists could work with GPs to resolve medication issues by conducting medicine reviews, and could liaise with hospitals, community pharmacists and care homes to ensure continuous care for patients. This would improve continuity, and be particularly beneficial for the numerous patients taking different medications for long term conditions in the 21st century. Additionally, pharmacists have the knowledge to advise patients whether an appointment with their GP is necessary, ensuring GP time is used most effectively<sup>54</sup>.

This way of working has already proven successful at Mile Oak Medical Centre in Brighton and Hove. The practice combined funding from Brighton and Hove innovation fund and self funding to allow them to recruit two part time pharmacists, covering four sessions a week. The pharmacists aimed to alleviate administrative pressures and prescription queries that GPs were dealing with. They dealt with patient medication issues when discharged from hospital, conducted polypharmacy reviews, and reduced prescription delays and errors at the practice. These pharmacists then trained one of the receptionists to become a prescription lead to resolve prescription issues before patients see their GP. Pharmacists increased continuity at the practice as they were able to forge relationships with those with multi-morbidities:

“ I think there is great potential for pharmacists to build up relationships with patients, particularly ones who are on complex medications. They can also be an easy point of access where patients can talk to them about on-going issues. The prescription lead is now a really good point of contact for patients too. ”

(Interview)

The pharmacists also helped the practice to highlight any areas that needed streamlining in their prescribing system. The pharmacists identified that GPs were sending patients for unnecessary drug tests triggered by the I.T. system, and the amendment of these triggers lead to improved quality of patient care and also improved informational continuity at the practice.

There were also ideas that, in the future, pharmacists could potentially run clinics to allow doctors to focus on diagnosing patients:

“ You could also get them to run some disease management clinics for illnesses such as hypotension or asthma, and they could lead on the repeat prescription system. I think overall it feels like a big additional help in terms of health and safety and the quality of prescribing in general practice. Now we are doing so much complex prescribing it seems essential that we have back up. ”

(Interview)

In addition to integrating current aspects of care into general practice the College has suggested a trial of the use of medical assistants in general practice, as a short term measure to alleviate some of the pressure doctors are under, allowing them to focus more on continuity. Medical Assistants are a cross between healthcare assistants and a doctor's personal assistant and they have already proved to be significantly helpful in the US.

Whilst patients may initially be apprehensive about receiving their care from staff other than a GP, skill mix can lead to higher satisfaction levels within general practice. For example nurses being able to provide certain patients with longer consultations<sup>55</sup>, frees general practitioners up to focus on more sick patients and those with multi-morbidities.

Not only can those with medical backgrounds implement skill mix, but in modern day general practice it is essential that those with organisational and business skills are fully utilised. In order to implement models that prioritise continuity, time and resources will need to be invested to develop ways of working that are effective and these individuals will play an essential role in creating business plans for practices.

Practice managers for example, will be responsible for creating a strategy for the practice that ensures it runs most efficiently. At the College's recent seminar with Simon Stevens, Sheinaz Stansfield, a practice manager from Gateshead, spoke about the vital role that practice managers can play in improving all forms of continuity and patient care.

“ Practice managers have a huge role to play in continuity. We make sure clinicians are practicing evidence based practice and that there are no variations in the system. You are quality assuring the staff you employ. It's all about continuity and patient experience. You might not necessarily see the same person but you will get the same experience. ”

(Interview - Sheinaz Stansfield)





As a practice manager Sheinaz also looked at ways to free up GP time. The practice created a frailty nurse post to provide care for patients who need it most. This led to a 54% reduction in hospital admissions and an 81% reduction in home visits, having great implications for the care these patients received. Sheinaz states how the work of a practice manager can ensure that general practice works most efficiently.

“ It’s not only about seeing the same GP. Patients don’t always need to see a GP. It is about the different roles that can provide continuity...Every Tuesday morning we have a multidisciplinary meeting and talk about patients who have more complex needs, we identify who should see these patients, whether this be the primary care navigator, the nurse practitioner or the frailty nurse. We ensure that anyone and everyone who is involved in a patient’s care come together to allow us to care for a patient responsibly. ”

(Interview - Sheinaz Stansfield)

- Demand Management - GP led telephone triage

GP led telephone triage is an example of a demand management system that is becoming increasingly used within modern day general practice. Here the patient calls their practice and a GP calls patients back to discuss their problem, then, if necessary, an appointment with a GP or nurse is arranged<sup>56</sup>. This method of working means patients can have easy access to their GP, which facilitates continuity and saves patients time traveling, or waiting to be seen in the surgery. It fills in the gap that many general practices have, where patients either have to phone in on the day for an appointment, or book one a well in advance, meaning continuity is not available when patients need it.

The GP led telephone triage model of working has shown the number of patients in contact with their GP increase, whilst the number of face to face appointments fall<sup>57</sup>. Additionally, Primary Care Commissioning research showed that in 2009, 12% of general practices used this type of system and the percentage of people who called and actually needed an appointment was between 50-80%<sup>58</sup>.

James Street Family Practice, Louth, South Lincolnshire, successfully implements this model. Patients call the practice and are made aware of the doctors available on that day and choose which doctor they would prefer to call them back. This prioritises continuity as patients are given the choice of the doctor they speak to, allowing them to continue current relationships or

forge new ones. This model also benefits the practice as a whole, as since its implementation in 2011, the rate of appointments not attended has fallen, and the capacity to consult with patients has increased by 30%<sup>59</sup>.

Similarly in Bury, as a result of the Prime Minister’s Challenge Fund, 180,000 patients, across 30 GP practices can now have telephone conversations with their GP instead of face to face appointments. In principal this aims to improve continuity as it removes access issues, making it easier for patients to create and maintain relationships with their GP or general practice team; however, evaluation of the effects of this initiative on continuity is yet to be completed.

There is debate that whilst telephone consultations can lead to increased access and therefore continuity, they can result in increased workload, especially for GPs with named lists. The ESTEEM<sup>60</sup> study showed that whilst more patients are in contact with their GP as a result of telephone triage, it actually redistributes workload as oppose to reduces it. It appears evidence regarding both the benefits and fall backs of telephone triage is scarce, and whilst telephone triage may have a role to play in delivering modern day primary care, more research is needed, especially in relation to delivering continuity.

- Online appointment booking

Due to the high demand for appointments, many patients struggle to book an appointment with their preferred GP. Booking online; however, is becoming increasingly popular, with technology playing a greater role in modern day practice than ever before. 91% of patients were registered with practices that offer online booking in January 2015<sup>61</sup>. Booking online reduces calls to GP practices, freeing up lines for those who want to book same day appointments, and means that those who prefer online systems can use this method, allowing all patients are able to book appointments with their preferred GP.

Melrose Surgery in Reading implemented an online booking system for GP appointments when patients were not able to easily book appointments with their preferred GP due to busy phone lines, with this being the main issue raised by patients. Adopting online booking allowed them to access the booking system from numerous points:

“ They can do it on their smartphone. If they haven’t got a computer, they can use the library. ”

(Interview)



Initially the practice only put 20% of their GP appointments online, as they were unsure of what the uptake would be and didn't want to make booking appointments difficult with those who did not have access to online services. The positive uptake of online booking led to 50% of next day appointments being available to book online, with the remaining 50% being released the morning after. Patients can now use online booking to get an appointment at anytime; either on the same day, or two or three weeks in advance<sup>62</sup>. 30% of the patients at Melrose Surgery are now registered to use online patient services, with those with multiple long term conditions being encouraged to do so:

“ I try to sign up all my patients with disease modifying drugs to online booking where they can see their own records. These people need regular appointments and call in to get their test results, but they can now get these online. ”

(Interview)

The system benefited those who did not use online booking as the phone lines were freed up. It also benefited the surgery as it reduced the number of patients coming into the practice to book appointments:

“ The more people we can deflect away from the reception desk the better. We only have small reception with two receptionists. It is a grade two listed building so we can't make any changes to the actual structure to increase reception size. ”

(Interview)

- Advertising continuity to patients

When patients do contact the practice, receptionists are often the first people they interact with. As a result they have a key role in delivering increased continuity where necessary. The Colleges *Continuity of Care Toolkit*<sup>63</sup> highlights how receptionists could use tags to stress the need for certain patients to see the same GP.

Research into how receptionists prioritise continuity and access; however, has shown that when receptionists refer to continuity they tend to define this as continuity between different aspects of the health care system, as oppose to seeing a usual doctor. Furthermore, receptionists surveyed felt it was more important for a patient to be seen quickly, than by a usual

doctor, with 93% of receptionists surveyed providing this response<sup>64</sup>. This has obvious implications for the increasing numbers of patients who have multi-morbidities, and benefit from continuity of care most.

Starting a conversation with those wanting to book appointments by asking who their usual doctor is, as well as this being noted on the patient's records, one simple method of improving continuity for patients who will benefit from it most. Receptionists should aim to book appointments with a preferred doctor but if this doctor is not available, a second or third preferred doctor should be requested. If a certain doctor is more popular then the receptionist can play a role in encouraging patients who do not have a preferred doctor to not book with this GP<sup>65</sup>. If practices are struggling to provide continuity for patients and have suitably trained receptionists, these receptionists could look to provide patients with the same GP through a specific bout of short term illness.

The Exchange Surgery in London is currently advertising the benefits of continuity to patients. The practice even actively encourages whole families to register with them so the practice is aware of their whole family situation. They suggest patients prioritise continuity by requesting to see their preferred GP each time they book an appointment, advertising that those with long term illnesses would especially benefit. All GPs are permanent and wherever possible annual leave is covered internally. When locums are needed to cover leave, the surgery uses the same locums each time to prioritise continuity for patients<sup>66</sup>.

## Regional and national level

- GP Federations

GP federations, networks and clusters all cover a variety of ways in which multiple practices collaborate to develop and deliver high quality patient care. They exist in various sizes, acknowledging that one size no longer fits all in modern day practice, and expand the scale and scope of clinical and community services general practices can provide. They allow organisations to share back office functions, reducing cost and broadening skill mix whilst retaining the local nature of general practice, preventing unnecessary appointments in secondary care. As these federations differ greatly in what they are aiming to achieve, the College is currently producing a RCGP Supporting Federations programme, in collaboration with NHS and the Nuffield Trust, to obtain better understanding of the formation of federations and what makes them successful, with continuity being a key factor.





As the needs of patients become more complex, GP federations are one model that are able to offer specialist services that take a whole person approach to health care. However, the impact of GP federations on continuity is yet to be fully understood, as they are still in early stages of establishment. GP networks, that keep practices local, will have obvious benefits for patient continuity, with patients seeing a familiar team. Where super-partnerships develop, there may be negative implications for patients to see their preferred GP, despite links to community resources, such as local authority services being improved. Initial research by the BMA into patient views on general practice show that patients are willing to support the development of larger practices and federations where they can have both improved access to care and the care of a practice team, but accept that at times they will not be able to have both. 52% of GPs surveyed also gave this response<sup>67</sup>.

In Scotland, GP clusters are already developing to provide a successful version of modern day practice, working together to agree and deliver shared values for their local community. GPs from Academy & Ravenswood medical practices merged to form the largest practice in Tayside with 14,126 patients. The model was design and delivered following the ethos of the Alaskan Nuka System<sup>68</sup>. This is a system designed to improve the healthcare and social conditions of Alaska Native and American Indian people by focusing on the whole healthcare system. The practice developed a micro-team approach within the federation by setting up 6 co-located integrated teams of 1.5 GPs, a nurse, a healthcare assistant, an administrator and named community nursing staff, adding more staff to the team as the model progressed<sup>69</sup>.

Additionally, in Northern Ireland there are currently 17 established federations which, in addition to piloting the pharmacy project, have received funding to assist with practice phlebotomy services.

As federations continue to evolve, in order to be successful all forms of continuity should be at the heart of their development. Informational technology can play an especially important role in sharing information between GP federations. Furthermore, adopting a micro-team approach to patient care will mean that patients receive management continuity, with all members of a micro-team within a federation, treating patients' illnesses in the same manner.

- **Multi-speciality community provider**

Multi-speciality community providers have developed as part of vanguard sites, leading the way on the New Models of Care Programme aspect of the Five Year Forward View. They move towards a more integrated health system, transitioning patient care away from hospital settings and into the community. They also aim to make community based services led by community based clinicians, allowing GPs to act as independent advocates for their patients. They bring together nurses, pharmacists, psychologists and social workers etc., and aim to integrate healthcare services, and adopt digital technologies, new roles and skills. This benefits continuity by bringing all aspects of a patients care into one easily accessible place for patients.

NHS vanguard site Lakeside Surgeries is a multi-speciality community provider that merged four practices alongside other aspects of primary and secondary care. Lakeside Surgeries offers bespoke effective long term condition management, urgent care models, ambulatory care services, and hospital outpatient planned-care services. The practice wanted to better organise the care they provided to patients, as they recognised that modern day practice is very different from healthcare delivered to patients in the past. They mapped out the primary care and secondary care pathways patients take, looked at demand using patient segmentation, understanding necessary responses and delivery points, and integrated more IT services to deliver a community based service.

Patient segmentation is a method of highlighting which patients should be prioritised for continuity and could potentially be adopted by other practices that are facing an increasing number of patients with multi-morbidities:

“ We used our deep understanding of the clinical needs of patients, and we look at health economic modelling of their projections. The broad categories are ‘severe multi-comorbidities’ at the top...cancer... liver disease, then ‘frail elderly’...comorbidities plus old and frail, and then ‘serious mental illness’ and so on. Segmentation is quite detailed. We go back through their patient record, looking at primary and secondary care and the projections we make are based on if we continue what we are doing, do nothing, or do more. ”

(Interview)



As previously mentioned, the practice breaks convention of 10 minute appointments and offers hour long appointments to those who need it. They use the skills of pharmacists and nurses to enable GPs' time to be reserved for the sickest patients, and they use a buddy group system, similar to micro-teams, to ensure continuity is provided by senior staff. The practice states that patients who are more healthy, and not multi-morbid, may have to wait up to two weeks for an appointment with their preferred GP; however, they also know that these patients are more willing to see any GP, valuing access over continuity. This model accounts for a balance between both access for those who would prefer it and continuity for those patients who will benefit most from it.

Whilst the increase specialism in general practice causes debate, especially in relation to continuity<sup>70</sup>, at Lakeside surgeries, GPs are encouraged to specialise in certain healthcare topics, as part of the multi-speciality community provider team, enabling specialist services to be provided, alongside expert generalist care. The practice believes they successfully attract young doctors due to the combination of both generalist and specialist medicine. Although the vanguard site is still overcoming any barriers it faces, it is monitoring its effects on continuity by:

- assessing if patient conditions are maintained or improving
- assessing if cost are the same or less
- reviewing anecdotes from their Patient Participation Group.

#### ● Information technology and record sharing

Accurate record keeping and the ability to share records between either, GPs who form a micro-team, or across different practices that form part of a federation, is essential to providing informational continuity in modern day general practice, and therefore aid relational continuity. This is especially important to GPs working as locums. While GPs who are partners in a practice have a vested interest in their local community, 2/3 of sessional GPs stated they would not be looking for a partnership in the future<sup>71</sup>, meaning general practice needs to continue to develop to enable locums to provide continuity too.

Utilising technology to record and share patient information offers a more accurate view of a patient's health condition, rather than relying on doctors' memories or recollections<sup>72</sup>. Records provide a longitudinal account of patients' health care, being particularly valuable to those with long term conditions. Informational technology also prompts general practice staff to act on a patient's care, such as conducting tests or reviews, improving the

continuity of their care. Whilst there may be concerns within the profession regarding sharing patient records, the College supports greater sharing of data, as long as appropriate safeguards are in place to protect patient confidentiality.

Information technology is especially important in remote and rural areas where lack of investment has resulted in poor mobile phone signal and broadband internet connections. RCGP Scotland has called for increased resourcing of existing I.T. structures to enable safe and efficient communication across the interfaces, prioritising continuity. Furthermore, the SPIRE<sup>73</sup> project is a collaboration between the Scottish Government and NHS National Services Scotland which aims to simplify and standardise the process for extracting data from GP practice systems, valuing the patient record as lifelong documentation of patients' healthcare and treatment, enabling continuity.

In Northern Ireland the Electronic Health and Care Record is currently being developed. This allows hospitals, GP out of hours services, emergency departments and GPs to share information. Repeat medication, acute medication, laboratory results, and discharge and outpatient letters, can all be seen across different departments. There are also plans to move towards electronic referrals and radiology requests, all of which will ensure informational continuity is prioritised. The Health and Social Care Board in Northern Ireland is also developing I.T. systems for risk stratification that will interrogate patient records and identify patients with multi-morbidities, polypharmacy and their statistics on hospital admissions. The information found will be relayed back to practices and ensure that continuity is prioritised for these patients.

Dr Rachel Marchant states how information technology and record sharing is especially important for out of hours services and recently gave an account of her experience as an out of hours GP, where ineffective information technology prevented continuity of patient care.

“ I was working as an out of hours GP in the same area I worked in hours. The patient had gall stones and needed scans for this but as an out of hours GP I was not able to request this, even though I was this patient's in hours GP... Even if it is not your patient you should still be able to send off for tests. It is better for me to send off for a test for a patient, as the patient may have to wait four days to see their in hours GP. I could sort their issue. ”

(Interview - Dr Rachel Marchant)



Dr Marchant also highlighted the risks of not being able to share patient records between in hours GPs and out of hours GPs, as well as between general practice and different parts of the health system. As we integrate more in new models of care, any barriers within the healthcare system will have a knock on effect for continuity that patients receive.

“ We use System One out of hours, as do the hospital and nurses, but in hours we use EMIS. Out of hours doctors can't see patients' normal notes so there is no patient history more or less. Often you are starting from scratch which is less safe and duplicating work. If an out of hours doctor admits a patient to hospital they write a letter knowing no patient history. If a patient is admitted at the weekend, they won't get the full notes until Monday. ”

(Interview - Dr Rachel Marchant)

Information technology can; however, have drawbacks. Online records do not capture all the nuances of a patient, and it can act as a disruption to consultations<sup>74</sup>. Furthermore, accurate patient records are of little value if they are not easily retrievable.

In Leicester, Saffron Group Practice used information technology to prioritise continuity for patients who would benefit from it most. The practice flagged certain patient records in because of their particularly high need for continuity. When patient records were accessed, a 'CC' icon would be displayed and receptionists were given permission to access otherwise embargoed appointment slots to allow these patients to see their usual doctor. The usual provider index, which shows the proportion of consultations a patient has with their preferred doctor, rose from 53.01% in non-flagged patients, to 55.0% in those who were flagged. For flagged patients alone, the amount of time they saw their preferred increased by 3.27% after the system was implemented. While these differences are small, they did prove to be statistically significant and could act as a method of I.T. systems being used most effectively to deliver continuity for patients who benefit from it most.

On a larger scale in Bury all GPs can now access a single Primary Care Record for each patient, regardless of the practice the patient first registered at. This is the first time a GP record can be viewed and amended by any GP. A patient can be seen by any GP and the GP will have a full up to date record of their health history. This puts continuity first, with patients no longer having to explain their health history if they have to see a doctor other than their usual one. This is particularly beneficial for the more patients with multiple long term illnesses<sup>75</sup>.

GP practices in the CCG areas of Blackburn with Darwen, Somerset, West Hampshire and Leeds North, West and South and East have also been piloting ways of sharing patient records by taking parting NHS care.data programme in

the hope that it will improve efficiency across the NHS. Patient groups have raised concerns about the programme and patient confidentiality; however, the NHS states it is keen to provide support to GPs to explain the benefits of the programme to their patients, with continuity of care being one of these benefits.

### • Multidisciplinary teams

Multidisciplinary teams comprise different healthcare professionals, each with specialist skills and knowledge, working together to deliver patient care, a revolutionary development of modern day general practice. Team members use their expertise to ensure that all aspects of a patients' care are coordinated. This is particularly beneficial for the increasing number of patients with multiple long term conditions.

Concord Medical Centre in Bristol is adopting multidisciplinary-style working, with GPs recognising that much of their time was spent on patients with mental health issues. These patients required longer appointment times and often needed more follow up sessions than other patients. This led to additional demands on the practice and a lack of continuity, for patients both with and without mental health needs. As a result a Mental Health Specialist was recruited and now provides continuity for patients with mental health, but has also freed up 3,000 GP appointments a year. The Mental Health Specialist sees 60 patients a week, which frees up almost 1,000 hours of GP appointment time per year. GPs now have an expert within the practice which they can direct mentally ill patients to and this enables them to provide continuity for other patients who need their care most<sup>76</sup>.

Whilst multidisciplinary teams are essential in the evolution of modern day primary care, it is important that they do not inadvertently lead to loss of continuity. When GP time becomes freed up, continuity has the potential to increase; however, there is also risk that continuity will be lost due to the greater number of primary care staff interacting with the patient. To avoid this, there must be clear lines of responsibility and accountability, in addition to a mechanism that ensure patients see the same specialists, when essential. In particular, it is important to ensure that collaborative working is supported by the use of shared electronic medical records between healthcare teams.

### • Care and support planning

Care and support planning aims to make interactions between people with long term conditions and the healthcare system more effective, delivering continuity in their care. It is similar to multi-disciplinary teams; however, it supports people with these conditions to develop and increase their knowledge, skills and confidence in managing their own health. Care planning partners, such as a practice nurse, or a peer supported or trained volunteer, assist general practice in making personalised decisions in partnership with these patients.



## Measuring continuity

Having a care planning partner means that patients are getting the support they need from specific health care professionals within general practice, allowing them to create on-going relationships with these experts. 50% of GP appointments are made by patients with long term conditions<sup>77</sup>, so it is vital that these patients are put in control of the care they receive, to enable them to deliver their own care when they are away from the practice, and reduce any unnecessary avoidable workload pressures on general practice. The College is running a three year programme of work on Collaborative Care and Support Planning and recently launched a new guide *Stepping Forward: commissioning principles for collaborative care and support planning*, to support practices taking this pioneering approach.

In Scotland, the Scottish Government is working in conjunction with Health and Care Alliance Scotland to promote the adoption of care and support planning across several primary care practices and localities. The aim of the approach is to promote 'more than medicine', stressing the importance of social and peer support in local communities. NHS Scotland have also been ensuring patients are able to receive continuity through care and support planning by working to respond to people's health literacy needs through their Making it Easy<sup>78</sup> campaign. Patients and carers with greater health literacy are more engaged in their care and therefore receive better health outcomes.

An example of care and support planning can be seen in Holmside Medical Group in Newcastle. Here the practice ensured that care was focused on what mattered to patients and achieved this through a care and support plan that focused on all their long term conditions, rather than each illness individually. The practice ensured that when patients were sent letters they covered all their illnesses, as opposed to sending a separate letter for each illness. Staff were trained so they could assist in providing more services, with receptionists training as phlebotomist and then as healthcare assistants, freeing healthcare assistants to coordinate care planning. When patients had review appointments, they were always with the person whom they initially developed their plan with; however, they could also book appointments at any time with this person if they wished. Patients were also able to book longer appointments with a GP or nurse if they wished<sup>79</sup>.

Continuity is prioritised as patients are cared for, and taught to self-manage, through all aspects of their illness, not just at regular appointments with their GP. Modern day general practice faces the challenge of delivering care to patients who want rapid access and continuity; however, care planning has potential to empower patients with long term conditions to provide consistency and continuity of their own care, alongside the care they receive from their GP.

As general practice goes through a period of transformation and adopts new models of care, it is essential that these models are monitored and their impacts on continuity measured. Certain models of care may prove more effective at providing continuity of care in certain areas, demographics or age groups for example. Furthermore, if continuity is to be incentivised within general practice, methods of measurement need to be established.

In July 2015 the Health Foundation launched a consultation to review the quality indicators for general practice in England, with many current indicators not being patient focused, it is essential that continuity of care play a role in future indicators.

Salisbury *et al.* have shown that there are four aspects of continuity that could be measured<sup>80</sup>:

- Concentration – *this is the proportion of consultations a patient has with one specific provider*
- Dispersion – *the number of different professionals a patient consults*
- Distribution – *the number of consultations between providers, giving a higher score to those who consult fewer providers*
- Sequence – *whether each consultation was with the same provider as the previous consultation.*

However, assessing continuity within general practice should be treated with caution. Continuity means different things to different people and is a subjective topic. Furthermore, gathering information on continuity is difficult. The General Practice Patient Survey raises questions relating to continuity; however, these do not establish continuity with a particular doctor but within a particular practice itself. The Usual Provider Index, which states the proportion of consultation a patient has with their preferred doctor, could be a method of establishing this; however, is not widely used by practices.

In addition to monitoring a patient's ability to see their preferred GP, relationship continuity could be measured to establish how well a patient feels their doctor knows them. The Patient Perception of Physician Responsiveness Scale<sup>81</sup> is one method that aims to review this difficult to measure variable.





## Key principles

The following principles aim to prioritise continuity of care within modern day general practice and should be valued and followed by all those in the health service:

- 1 Continuity of care based in general practice is vital to the future sustainability of the NHS; however, currently the NHS is not set up to encourage and promote continuity of care for modern day patients. Resources, infrastructure and expertise currently flow towards parts of the system that deal with individual aspects of patient care, rather than the holistic approach that underpins continuity of care. Future visions for the health service being set out by politicians across the four nations of the UK will not be achievable if they do not put protecting and championing continuity of care at their core.
- 2 Continuity is currently under threat in modern day general practice, as a result of both demographic changes and the transition to new ways of working within the health system. Whilst healthcare system changes aim to improve patient care, they also have the potential to disrupt patient continuity and action should be taken to prevent this from occurring. Despite these challenges; however, the GP-patient relationship remains the best model through which the NHS can deliver a service that provides strong continuity of care for patients.
- 3 In light of modern day challenges, the NHS must find ways to retain the values that underpin continuity of care whilst adapting to new ways of working. In the context of changing patient expectations and a movement towards primary care services being delivered at a larger scale, it is inevitable that relational continuity cannot be realised for every patient - but this should be counterbalanced by improved informational and management continuity.
- 4 Continuity of care in current society will only be realised where services are integrated and a diverse range of skills are adopted into the general practice team. Management continuity is a key part of achieving this, enabling different professionals to provide joined up, whole person care.
- 5 Continuity for patients with multi-morbidities should be prioritised, as it is these patients who both value, and benefit from, continuity most. Furthermore, the number of patients with multi-morbidities is continuing to rise, along with an ageing population.
- 6 The benefits of continuity are increased if patients are engaged, and conversely engaging patients is likely to be easier where continuity of care exists. Informed and engaged patients play a more active role in their healthcare, which is especially beneficial for the increasing number of patients living with multi-morbidities.
- 7 Prioritising continuity within general practice is not only the responsibility of clinical staff but also receptionist staff and other practice staff, as a first point of contact for many patients. These staff should receive appropriate training to allow them to identify patients who need continuity most.
- 8 General practice and the benefits of continuity that it has the potential to provide should be at the heart of the development of new models of care. As new models of care and ways of working are rolled out continuity of care needs to be a key criteria against which they are evaluated.
- 9 Clinical models, information technology and government structures all need to align to support continuity of care. If continuity is to be realised, barriers to sharing information within general practice and between primary and secondary care must be removed.
- 10 If continuity in modern day general practice is to be prioritised, more, and better quality data needs to be gathered and analysed to robustly evaluate its effect on patient care.

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Authors: Professor Maureen Baker, Holly Jeffers

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**Royal College of General Practitioners**

30 Euston Square, London NW1 2FB

Telephone: 020 3188 7400

Fax: 020 3188 7401

Email: [policy@rcgp.org.uk](mailto:policy@rcgp.org.uk)

Website: [www.rcgp.org.uk](http://www.rcgp.org.uk)

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