

Senior Medical & Public Health Advisory Forum
EVIDENCE REVIEW SUMMARY: Continuity of Care

Date: 19 Aug 2024
Lead Author: Dr Miles Mack

Contents

1. Introduction	3
2. Continuity of Care: the evidence base ⁴	4
2.1 Better patient satisfaction	4
2.2 Developing trust between patients and their GPs	4
2.3 Adherence to medical advice and prescribed medication, less waste	4
2.4 Uptake of personalised preventive medicine	4
2.5 Better quality of GP care	4
2.6 Reduction in workload in practices	4
2.7 Lower rate of attendances at emergency departments	4
2.8 Fewer admissions to hospital	5
2.9 Lower costs in whole health systems, less overuse of medical procedures	5
2.10 Lower death rate in patients	5
2.11 Reduced complaints and litigation	5
2.12 Reduced collusion of anonymity	5
2.13 Better able to address health inequalities	6
3. Barriers to Continuity of Care	10
4. General Practice	11
4.1 Data and Measurement	11
4.2 Personal Lists	11
4.3 Cohort Continuity	11
4.4 Clusters and Quality Improvement	11
4.5 Contractual levers	11
4.6 Developing models of remote consulting	12
4.7 Anticipatory Care Planning and data sharing	12
4.8 Managing “emotional labour”	12
5. Medical Education	13
6. Secondary Care	15
6.1 Need for research	15
6.2 “Sector consultant” models	15
6.3 Interface of care – peer-to-peer decision support	15
7. Public Involvement	15
8. Conclusions & Recommendations	16
9. Appendix 1: Continuity of Care Driver Diagram ⁵⁴	17
10. Appendix 2: Continuity of Care: A worked example: What can it look like in practice? ..	18
11. References	19
12. Continuity of Care Sub-Group Membership	21

1. Introduction

The CMO, in his Annual Report for 2022/23 entitled: *'Doing The Right Thing'*¹, challenged us to think about the way we deliver kind and careful care centred around the principles of Realistic Medicine and Value Based Health & Care. There was a strong emphasis on the need to resist the industrialisation of care in order to protect the art of caring through human connection. This work was undertaken with the primary intention of improving patient care, minimising the effects of inequalities and increasing the efficiency of the NHS.

Going forward to the *CMO's Report for 2023/24: Realistic Medicine: Taking Care*², there was a specific note in relation to the importance of continuity of care and what this means to the way in which healthcare is delivered and experienced:

"Healthcare is not a series of interchangeable and faceless tasks. For many of us, the most fulfilling professional relationships are those we build with the people we care for over time. These deep interpersonal connections help us learn about them as people: their lives, their context and what matters most. It is no surprise, therefore, that for those experiencing healthcare inequalities, relational continuity (seeing the same face) is important. And for those with the most complex health and social care needs, who may find it difficult to establish and maintain trust in our systems, continuity is all too often a missing element of care. When we get this form of relational care right, our patients face fewer hospital admissions, lower mortality and reduced use of wider services resulting in less waste."

In December 2023, the CMO's *Senior Medical & Public Health Advisory Forum* established a sub-group tasked with considering the evidence-base in relation to Continuity of Care with a particular focus on relational continuity of care in General Practice.

This report is not intended as a systematic review of the evidence and acknowledges that although we intend guidance to be relevant across the NHS, the majority of extant evidence is from general practice.

Definitions of Continuity of Care

Continuity of care³ has been described in a number of ways including:

- **Informational continuity:** The use of information on past events and personal circumstances to make current care appropriate for each individual.
- **Management continuity:** A consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.
- **Relational continuity:** An ongoing therapeutic relationship between a patient and one or more providers

2. Continuity of Care: the evidence base⁴

The importance of relational continuity of care between GPs and their patients was demonstrated through the sheer volume and strength of the evidence presented. We must be clear, however; that the parameters of our evidence base did not extend to include *any* 'named clinician' as a definition of effective continuity of care.

2.1 *Better patient satisfaction*

Several studies show that more continuity of GP care is significantly associated with better patient satisfaction.^{5,6,7}

2.2 *Developing trust between patients and their GPs*

Continuity of GP care is associated with patients developing trust in a doctor they get to know. This reduces anxiety and provides a sense of security.^{8,9} Trust also enables earlier disclosure of symptoms.

2.3 *Adherence to medical advice and prescribed medication, less waste*

Patients follow medical advice significantly more when they have continuity with their GP. The trust that develops through a good GP-patient relationship ensures more effective treatment and less waste. Continuity of GP care is associated with significantly better adherence by patients.^{10,11}

"I have been with you for 30 odd years and you have helped me cope when things are tough and things have been very tough. I don't think I would be alive if it wasn't for you. Not that you haven't told me off! Without your support, I would still be drinking and I now feel I have a second chance. You always know what I have been through and understand me."

2.4 *Uptake of personalised preventive medicine*

Continuity of GP care is associated with significantly better uptake of personalised preventive medical advice, such as breast and cervical cancer screening services¹², and vaccination.¹³

2.5 *Better quality of GP care*

GPs offering relational continuity identified more patients at risk of cardiovascular events who would benefit from statins.¹⁴ GPs made better, life-saving decisions with suspected meningitis when they knew the child and family.¹⁵ Patients with diabetes had better glycaemic control when they had relational continuity of care.¹⁶ Patients with dementia with GP continuity have 10% fewer hospital admissions, 35% fewer episodes of delirium, and 57% less incontinence.¹⁷

2.6 *Reduction in workload in practices*

Patients consulting their regular GP re-consult after a significantly longer interval than if they consult another GP. The Cambridge Business School estimates that for patients with ≥4 consultations in 2 years, GP continuity could save 5.2% of GP appointments.¹⁸ In one of the largest studies of its kind, researchers from the University of Cambridge and INSEAD analysed data from more than 10 million consultations in 381 English primary care practices over a period of 11 years. They found that when patients were able to see their regular doctor for a consultation, they waited on average 18% longer between visits, translating to an estimated 5% reduction in consultations if all practices in England were providing the level of care continuity of the best 10% of practices.¹⁹

2.7 *Lower rate of attendances at emergency departments*

Patients receiving GP continuity of care are significantly less likely to attend accident and emergency departments with physical or mental illness.^{20,21,22,23}

2.8 *Fewer admissions to hospital*

In Canada²⁴ and in the UK^{25,26} many studies have shown that patients with good continuity of GP care are significantly less likely to be admitted to hospital, particularly for older patients with ambulatory care sensitive conditions. Hospital admissions are one of the most expensive NHS costs.

2.9 *Lower costs in whole health systems, less overuse of medical procedures*

Good continuity of GP care was associated with lower costs across the whole health system.^{27,28,29} Good continuity of care provider has also been associated with less overuse of medical procedures³⁰, which has important implications for Realistic Medicine and healthcare costs/sustainability.

2.10 *Lower death rate in patients*

Two systematic reviews show that better continuity of GP care is associated with a lower death rate in patients.^{31,32} A dose-response relationship, which adds considerable scientific weight to the findings, has been shown between continuity and mortality.³³

2.11 *Reduced complaints and litigation*

Human error cannot be avoided in healthcare. A US study³⁴ found that patients who have received good continuity of care previously are more likely to forgive GPs who make moderate mistakes, with implications for time spent on complaints and litigation. Good relationships will give GPs more confidence to practice less defensive and more evidence-based medicine.

"I had a patient I knew for many years who sadly developed a significant side effect of a medication I had prescribed her. Due to the fact we knew and trusted each other we were able to talk this through and appreciate the risks and benefits of treatments while maintaining a trusting therapeutic relationship."

2.12 *Reduced collusion of anonymity*

Clarity of responsibility and continuity reduces the risk of patients becoming 'lost' between clinicians.³⁵

2.13 Better able to address health inequalities

Continuity of care is even more important for patients impacted by socio-economic deprivation and is one of the best current options for reducing health inequalities. Research shows that for these groups:

- they get less GP continuity, when they need it the most.
- they may be less able to manage systems to get continuity than other social groups.
- they often have multiple problems simultaneously where GP continuity is important for good care.
- the social determinants are of particular importance, with the life-course theory helping GPs to understand that the patient's events in childhood may drive adult consultation patterns. The social determinants and how they impact individuals cannot be learned in one-off GP consultations.
- for those with the most complex health and social care needs, and for whom establishing relationships of trust is especially problematic, continuity of care (i.e. the relationship) is the treatment, not just a vehicle for healthcare delivery. It supports earlier disclosure of illness, and the ability for people to accept the care offered.

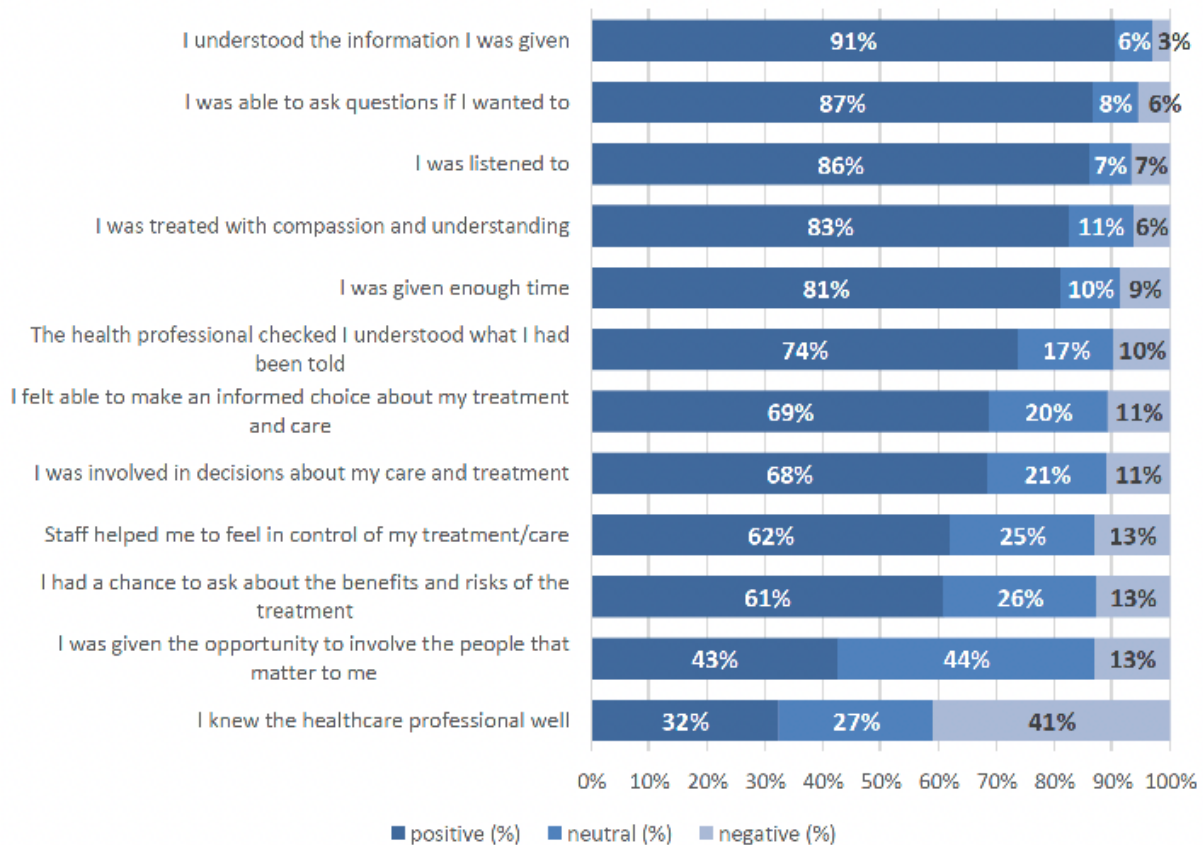
To summarise, relational continuity reduces morbidity and mortality, addresses health inequalities, improves cost-effectiveness and NHS sustainability (facilitates a preventative and value-based approach, reduce unnecessary attendances and admissions, reduces workload in general practice), improves quality of care (both generally eg. more person-centred and specifically eg. dementia outcomes), improves patient satisfaction, improves GP job satisfaction and reduces practice workload. It is a key enabler in many Scottish Government strategies, policies and programmes such as Realistic Medicine, GIRFE, Value-Based Healthcare, Preventative and Proactive Care, Patient Safety, Trauma-Informed care, NHS Sustainability.

Despite this impressive evidence-base, there has been a worrying fall in continuity in general practice in recent years:

“The General Practice Patient Survey shows that continuity for patients in the UK with their GPs has been falling, with a 27.5% decline between 2012 and 2017.³⁶ Multiple factors contribute including a severe shortage of GPs, fewer GPs consulting five days a week, and national policies that focus on access times at the expense of continuity.³⁷”

In Scotland, the Health and Care Experience (HACE) Survey from 2020-2021³⁸ includes a question on 'Experience of Care' the last time a responder received treatment or advice at their general practice. The results are shown below in Figure 1.

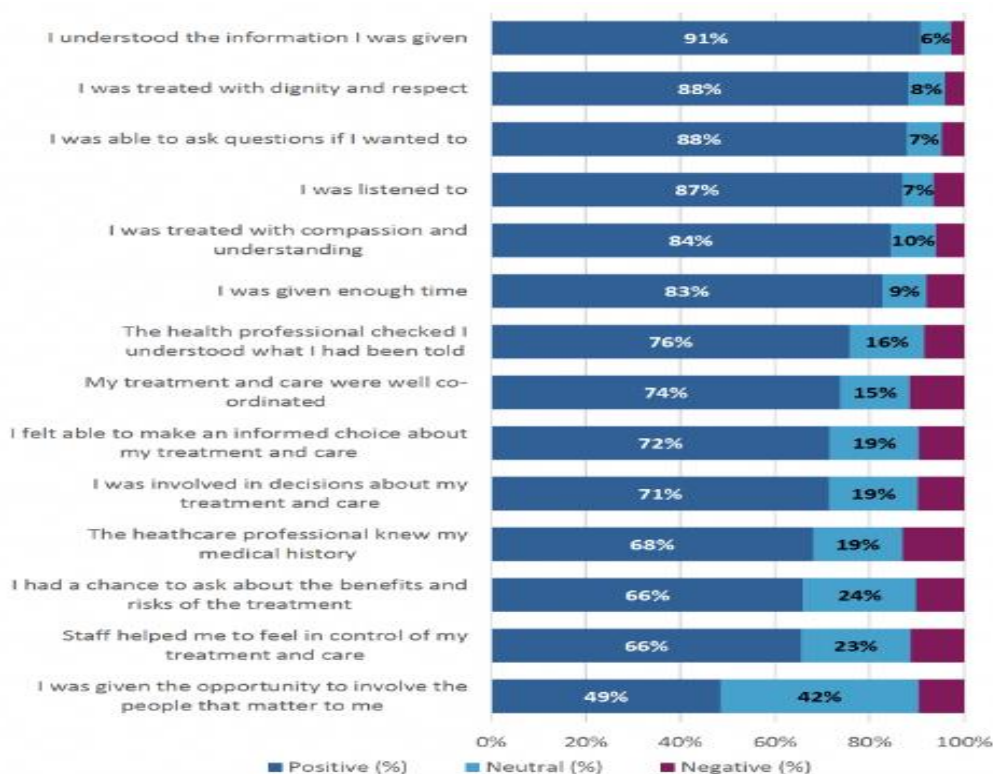
Figure 1: Summary of responses to person-centred statements



Recognising the limits of what can be concluded from the HACE survey (small sample size, non-representative sample) it is still important to note that the statement with the lowest positive and highest negative scores was '*I knew the healthcare professional well*'.

The results of the 2023 – 2024 HACE survey were published in May 2024³⁸. **Relational continuity is no longer measured.** It has been replaced by informational continuity, with the statement '*the healthcare professional knew my medical history*'. This is shown in the figure below.

Figure 2 Person-centred care statements, agreement, weighted percentages (HACE 2023 - 2024)



This is mirrored in the views of the GPs responding to the 2023 RCGP tracking survey. Which found that “53% of GPs said that they are not able to deliver relational continuity care in the way they want and that would meet their patients’ needs”.³⁹

It is important to also recognise that relational continuity of care has not just fallen in general practice, but across the whole of the NHS, which impacts every service. General practice has the most impact, not because it is the ‘worst offender’, but because of the scale and longevity of patient interactions.

Continuity of care seems to have greatest benefits to:

1. **Multimorbid Individuals:** Patients dealing with multiple health conditions benefit significantly from continuity of care.
2. **Older Adults:** Elderly patients often have multiple chronic conditions and require ongoing support.
3. **Mental Health Patients:** Individuals with mental health difficulties benefit from a stable doctor-patient relationship.
4. **Terminal Care Patients:** Those receiving end-of-life care benefit immensely from continuity.
5. **People affected by Alcohol and Substance Misuse**
6. **People living in poverty**

This is in keeping with work by Victor Montori⁴⁰, seeking to reverse the industrialisation of healthcare and return to a model of caring that puts the patient at the centre of our work. Falling continuity of care will increase requests for appointments and make the adoption of “Realistic Medicine” impossible. Iona Heath and Victor Montori discussed how re-discovering relationship-based care was essential to respond to the present crisis in care and counter the cognitive dissonance and moral injury that many clinicians face daily.⁴¹

A Health Foundation project⁴² showed that it was possible to reverse the trend in reductions in continuity. A structured programme is important with clear leadership, data dashboards and measurements of continuity. Clinicians' satisfaction levels improved as they felt more comfortable managing risk without referral. This report emphasised that it does not need to be a choice between access and continuity and provided clear evidence about the patient benefits of continuity of care, as well as how it helps the team.

3. Barriers to Continuity of Care

A number of barriers are acknowledged to exist in our ambition to improve continuity of care:

- **Speed of access targets.** As general practice has come under increased pressure patients have faced longer waits to be seen. Unfortunately, responding to this pressure has led to systems that prioritise speed of access (regardless of clinical urgency) over waiting to see a patient's usual doctor. This loss of continuity may be leading to increasing pressures on the system e.g. Phone triage systems will make delivering continuity more complex.
- **Care is increasingly being delivered by a complex mix of different professional groups,** breaking down the opportunity for continuity of care and risking "collusion of anonymity" when no single individual takes responsibility for the overall care of a patient.
- **Workforce.** Scottish Government target for increasing GP numbers has been difficult to deliver. This is in the context of an ageing population, increasing prevalence of multi-morbidity, a shift of care to community settings and increasing complexity of medical care that have all increased workload for GPs, whilst the workforce (measuring as either WTE or as qualified GP headcount) is in decline.
- **Workload and "Emotional labour"**. Providing close continuity of care to patients with complex emotional and psychological needs may take an emotional toll on the care giver. If this is shared equally between the team and GPs are appropriately supported the overall demands will be lessened. If not, individual GPs may be hesitant to provide continuity to too many patients fearing for their own well-being. Whilst it is undoubtedly hard work it can also be the most rewarding aspect of the job.
- **Clinical workload intensity.** A GP's working day is often 10-12 hours long. This, together with an increasing number of GPs working full time hours over three or four days or working part-time to accommodate other non-clinical work such as teaching, research etc.
- **Centralisation of nursing and other services.** Nursing teams are often covering wider areas with less chance to develop relationships with patients.
- **Specialisation.** Hospital services are increasingly organised to subspecialties. As a result, patients with complex multi-morbidity are attending multiple clinics, complicating the task of coordinating the care of a patient and reducing continuity of care in the secondary care setting also.
- **IT and Data management.** The roll out of electronic patient notes has been slow, especially in the hospital setting and the systems used in hospitals and General Practice do not make data sharing and communication straightforward within and between local areas.

4. General Practice

4.1 *Data and Measurement*

Presently it is difficult for practices to extract measures of continuity from their IT systems. The present round of IT Re-Provisioning is an opportunity to embed these measures into the GP IT systems so it is possible to measure continuity of care for individual clinicians, Practices, Clusters, Health Boards and Nationally. It is suggested that two measures are made available: the St Leonards Index of Continuity of Care (SLICC), which is appropriate to practices running personal lists, and the Usual Provider of Care index (UPC) that will be applicable across the full range of GP surgeries. This will facilitate quality improvement and peer-referencing of practices across Scotland.

4.2 *Personal Lists*

Personal Lists where one GP is the named doctor for long term care of each practice is the gold standard model to enable and improve continuity, even in larger practices. Practices that are under particular workload pressure or who are short of GPs may struggle to adopt this model.

4.3 *Cohort Continuity*

In this model, groups of patients who are known to most likely benefit from continuity of care are identified and systems put in place for them to have a key doctor who will have an increased responsibility for that patients care. Groups are likely to include patients with complex medical or psychological needs, those with problem alcohol and substance use, patients at the end of life and those resident in care homes. Staff are empowered to flex the appointment system to allow continuity. (Dr Mack's practice adopted this model, it was well received, and the practice is now looking to moving to a full personal list system).

4.4 *Clusters and Quality Improvement*

Practices across Scotland are organised into small groupings called quality Clusters. These groups are tasked to improve the quality of care in their practices. They need to be supported with easy-to-use tools to review, measure and improve the continuity of care in their practices.

There is a compelling evidence base that relational continuity of care improves quality of care. Both the intrinsic quality improvement role and extrinsic influencing/strategic of Clusters aligns well with supporting practices to develop and offer continuity of care within practices and across the wider system. This would need adequate project support, and data support from LIST analysts. Off-the-shelf 'improvement bundles' that Clusters could use to make best use of their data may help here.

4.5 *Contractual levers*

Phase 2 of the new GP contract is under discussion. It will be important to consider continuity of care in this context, with appropriate incentives built in to aid practices deliver appropriate models of care. Equally it will be important to avoid changes that might jeopardise the continuity being presently provided.

4.6 *Developing models of remote consulting*

Use of remote consulting via telephone and video increased during the COVID-19 pandemic. These models should be assessed for their effects on continuity of care, especially if they can be used to improve access for hard-to-reach groups.

4.7 *Anticipatory Care Planning and data sharing*

The GP Emergency Care Summary (ECS) presently allows limited sharing of information with agencies outside of the practice. Informational continuity would be greatly improved if this summary included the high priority diagnoses from the electronic patient record. The quality of anticipatory care plans will be enhanced if completed by GPs who are well acquainted with their patients, enhancing the ability of other agencies to provide patient centred care.

4.8 *Managing “emotional labour”*

To create meaningful solutions and ways forward, we need to understand the current barriers to relational continuity in general practice. Some of these are previously mentioned in this paper (declining GP workforce with resultant reduced capacity, MDT-based models risking fragmentation, rising workload in general practice, remote consulting models, the skills and support required to enable relational continuity), but there is another important element that does not always feature in research papers, that of **‘emotional labour’**. Although continuity of care can improve practitioner wellbeing and job satisfaction, maintaining and investing in long-term care relationships, especially with people who have a significant history of psychological trauma, can also be challenging and harmful for the care-giver, if that work is not supported by mechanisms such as mentorship, peer support or reflective practice. These supports would not just enable relational continuity, but would also enable trauma-informed care, and would improve practitioner wellbeing and reduce burnout. Given the current challenges around recruitment and retention of our general practice workforces (especially GPs and GP nurses), investment in this could reap multiple benefit.

5. Medical Education

The way we train future doctors will be important in delivering continuity of care for our patients in the future with many doctors in training having scant experience of delivering continuity of care due to the short attachments to multiple teams, often in different clinic or hospitals. These issues are important:

1. Adequate visibility and priority in undergraduate and postgraduate medical training. If we wish our workforces of the future to value and deliver relational continuity, it is important that the evidence-base is taught, and that training enables confidence and competence in how to do this well, valuing (rather than discouraging) relational continuity of care by trainees, where this is clinically appropriate⁴³. There are good examples of training experiences (such as longitudinal clerkships for GP training through the Scottish Graduate Entry Medicine (ScotGEM)) that specifically prioritise relational continuity and continuity of training experience.
2. Experiencing delivery of continuity of care. In a recent paper⁴⁴ written for InnovAIT magazine (RCGP publication for GPs in training), a recommendation is made that all GPs in training should be aware of the evidence base for relational continuity, and have the opportunity to experience it in action, by visiting (or spending some of their training time in) practices that have high measured continuity of care. This is of course easier to implement when continuity is being routinely measured, such as in many practices across England. Practices considered to have good continuity measure >50% on SLICC or equivalent scores, and practices with excellent continuity score >75%.
3. Continuity in medical education. This concept refers to providing consistent, long-term clinical experiences and mentorship throughout the training process, from undergraduate medical education through postgraduate training. Traditionally, medical education has been characterised by short-term rotations and frequent changes in clinical settings. Moving to a model of better continuity would:
 - Be optimal for developing deep clinical skills and professional identity⁴⁵.
 - Give opportunities for enhanced learning and skill development. By spending extended periods in a single clinical environment or with consistent educators, students and doctors can build their knowledge and skills progressively⁴⁶.
 - Allow professional identity formation. Consistent exposure to a clinical environment or mentor supports the gradual transformation from student to physician. This process is essential for developing a strong sense of professional identity and confidence as a doctor⁴⁷.
 - Improve patient care experience it offers to learners. LICs and longer rotations enable students and doctors to follow patients over time, providing a more comprehensive understanding of patient care and chronic disease management. This longitudinal perspective is invaluable for developing patient-centred care practices and understanding the holistic patient experience⁴⁸.
 - Enhance the feedback and assessment process. Educators who work with learners over extended periods can provide more meaningful, personalised feedback based on observed growth over time. This targeted feedback is crucial for learner improvement and helps identify areas for further development⁴⁹.
 - Provide benefits beyond the training years and positively influence clinical practice. Doctors who experienced continuity in their training often demonstrate better clinical reasoning skills and decision-making abilities. They tend to show a greater commitment to patient-centred care and have improved communication skills with patients⁵⁰.
 - Foster a better understanding and navigation of healthcare systems as practicing physicians. This familiarity can contribute to more efficient and effective care delivery⁵⁰.

- Strengthen professional behaviours and improved interprofessional collaboration⁵¹. The strong mentorship relationships and professional identity formation fostered by educational continuity may contribute to higher career satisfaction and resilience against burnout in practicing physicians⁵².

While implementing more longitudinal programs in medical education presents challenges, including curriculum redesign and resource reallocation, the potential benefits are substantial. As healthcare becomes increasingly complex, producing well-rounded, competent, and resilient doctors is more important than ever. By prioritising continuity, we can enhance the quality of medical education and, ultimately, improve patient care and healthcare outcomes.

In postgraduate education the effect of frequent job and hospital changes should be acknowledged and pilots of models with longer attachments developed.

Importantly, the experience of continuity of medical education would model the person focused care that is so important in delivering complex medical care to our patients.

“I spent a year in General Practice as part of ScotGEM’s longitudinal integrated clerkship and had the opportunity to provide continuity of care to patients within a supported environment. I believe it is a powerful tool that should be used more within medical school curricula, as patient continuity matured my understanding of holistic disease management. Furthermore, the satisfaction I gained from building long term relationships with patients reaffirmed my choice to pursue a degree in Medicine, and I will actively seek out patient continuity over the course of my career.”

6. Secondary Care

6.1 *Need for research*

We found insufficient evidence for how continuity of care can best work in a secondary care setting. Informational continuity, managerial continuity and episodic continuity are likely to be the key focus, whereas in general, long-term relational continuity is less possible, or indeed necessary. We suggest research is commissioned to fill this important gap.

6.2 *“Sector consultant” models*

In some specialties, predominantly paediatrics, psychiatry and geriatric medicine, consultants organise themselves to split up the workload by geographical “sectors”. This is felt to improve the opportunity to provide relationship continuity, but also allows closer team working with other multidisciplinary team members and GP colleagues.

6.3 *Interface of care – peer-to-peer decision support*

Work led by RCGP⁵³ on improving the interface between GP and hospital services has led to important benefits in information and management continuity. In particular, the ability to easily seek peer-to-peer decision support via IT systems such as Clinical Dialogue has streamlined patient care and improved professional relationships. Such systems should be rolled out across all departments, to allow two-way discussion and may need to be extended to cover other community services such as optometry, podiatry, pharmacy and other professions allied to medicine.

7. Public Involvement

The public understand and value continuity, although they may value it less than access if they believe their care may be delayed due to pressures on the system. There needs to be an ongoing public conversation on the value of continuity of care, whilst maintaining access appropriate to the level of clinical need.

We should ensure they know who is responsible for their care both in general practice and secondary care. Informational continuity should be extended to patients, considering the development of an app or web-based solution so patients can access more of the important information in the patient records.

8. Conclusions & Recommendations

The Sub-Group recommends that continuity of care is prioritised in the governance structure of the NHS in Scotland and makes suggestions for specific actions. Changes will need to be proportionate but incremental and data needs to be available to monitor progress in its delivery. Appendix 1 sets out a Driver Diagram which includes a number of change ideas that the Advisory Forum may wish to consider.

At a strategic level, the Sub-Group recommends:

- The development of an infrastructure which supports data collection and usage focusing on key measures to support clinicians to improve their approach to continuity of care within their own practice setting. It would be worth considering the role of GP Cluster Leads in the design and implementation of this.
- Based on the evidence base of what works, and using the existing educational resources from RCGP and the Exeter research team, there could be the potential for a HIS 'Continuity Collaborative' (akin to the Primary Care Access Programme, delivered through the Primary Care Improvement Collaborative, which specifically recommends that practices offer a balance of same day and advance appointments). This would offer additional support and structure to practices to become 'continuity' practices and could also help to generate and evidence base of 'what works' on the frontline when delivering continuity through teams.
- Further research is commissioned in order to develop an evidence base for continuity of care within secondary care.

TEACH	<ul style="list-style-type: none"> • Teach the evidence base, encourage proportionate continuity in practice. • Enable continuity of training experience to support this
MEASURE	<ul style="list-style-type: none"> • Prioritise the inclusion of Usual Provider of Care (UPC) in the primary care dashboard for all general practices in Scotland • Measure continuity in the 4 'demonstrator sites' operating as part of the Primary Care Phased Implementation Plan (PCPIP) reform agenda • Commission research into the evidence-gaps, specifically secondary care, MDT-based care
ENABLE	<ul style="list-style-type: none"> • Workforce planning (lead orgs: SG, NES) • Renewed focus on growing and retaining the GP workforce • Prioritise relational continuity in the development of Phase 2 of the 2018 GMS contract
SUPPORT	<ul style="list-style-type: none"> • Develop a policy paper within the general practice policy team which seeks to 'operationalise' the evidence base (this is already planned) • HIS Continuity Collaborative (possibly in partnership with RCGP Scotland) • Cluster work on continuity (develop 'improvement bundles' or 'toolkits' via Improving Together Advisory Group- ITAG) • Prioritise the development of high-quality primary-secondary care interface groups (to develop approaches that support informational and managerial continuity across systems)
CELEBRATE	<ul style="list-style-type: none"> • CMO report 2025 • Other high visibility workstreams – GIRFE, CWP, VBH&C... • Public engagement work

9. Appendix 1: Continuity of Care Driver Diagram⁵⁴

<u>Aim</u>	<u>Primary Drivers</u>	<u>Secondary Drivers</u>	<u>Change ideas</u>
1. To improve patient experience of continuity of care in their consultations with their GP	The role of GPs in facilitating continuity	<ul style="list-style-type: none"> • <i>Professional commitment to continuity</i>: Share research evidence about continuity and discuss and teach on its importance as a cornerstone of general practice • <i>Positive team views and culture towards continuity</i>: Training on continuity for the practice team; development of a culture that values continuity and the introduction of supportive policies and procedures • <i>Readily used measures of continuity are available and accessible</i>: The GPPS will show how continuity has changed over years. The UPC1 and SLICC7 provide data from the electronic health record to help monitor and improve continuity 	<ul style="list-style-type: none"> • Create educational resources for GPs (trainees and qualified) eg. PBSGL module, webinar • Promotion of the continuity of care tools available on the RCGP website (Continuity of Care work at RCGP) • Shared worked examples of how UPC and SLICC can currently be used to 'pathfinder' practices • Shared worked example of 'how to do continuity' as a practice QI project (see appendix at the end of my paper) • HIS Continuity Collaborative to provide QI support and analytic support to practices (similar to HIS Access Collaborative) • Celebrate continuity 'flagship' practices in the CMO report
2. To improve patient experience of continuity of care across the NHS.	The role of patients and/or close persons in facilitating continuity	<ul style="list-style-type: none"> • <i>Empowerment of patients and their carers</i>: Inform patients about practice policies on continuity and encourage patients to request it • <i>Improve patients' ability to request continuity</i>: Discussion with the practice patient group; information for patients on the benefits of, and the practice policies on, continuity • Good patient-clinician relationships: Allow patients choice of their usual doctor 	<ul style="list-style-type: none"> • Promotion of existing RCGP resources on community engagement and education around the importance of continuity of care (Continuity of care: Templates and resources RCGP Learning) – could be incorporated into a PBSGL module, webinar, PLT session. • Prompts in patient records to consider a discussion on whether they would benefit from a named clinician and a continuity conversation • <i>Create resources that can be used in GP practice websites</i>
3. To improve staff morale & strengthen professional relationships based on a culture of continuity of care	Changing needs throughout the disease trajectory	<ul style="list-style-type: none"> • <i>Organisational links with secondary care that facilitate informational and management continuity</i>: Negotiate effective arrangements with specialist services on communication about patient care through dedicated and effective interface groups • <i>Patients who develop knowledge of their condition and understand which clinician to consult for different problems</i>: Identify a lead clinician for each patient with multimorbidity. Educate patients about their condition and the team that is? (managing them) 	<ul style="list-style-type: none"> • Worked examples with existing high-functioning Interface Groups (eg Lothian Interface Group - LIG) about how they can support informational and management continuity of care, to be shared across the wider system • Support practices to identify which patients stand to benefit most from continuity of care, based on the evidence.
	The organisational context in primary care	<ul style="list-style-type: none"> • <i>Adequate numbers of GPs</i>: Continue to make the case for more GP capacity and the 'expert medical generalist' role to NHS management and workforce planning to enable high quality relational continuity of care for those with the most complex care needs. Grow capacity through effective retention and recruitment strategies. • Consider how existing and planned primary care reform and policy can support and embed continuity (eg. Phase 2, Primary Care 'demonstrator sites' work) • <i>Improved efficiency</i>: Continuity can improve productivity. Review the appointment system for continuity-focused booking. Highlight the records of patients especially in need of continuity • <i>NHS managers who understand the importance of continuity to patient outcomes</i>: Ensure managers have the research evidence on the importance of continuity, and how to facilitate it 	<ul style="list-style-type: none"> • While continuing the focus on growing the capacity of the GP workforce, encourage 'proportionate continuity' for these patient cohorts who are known to benefit the most • Promotion of the existing RCGP resources on continuity which include educational and support resources for practice teams, patients and clinicians. • Commission research into what works for continuity in an MDT-based model

10. Appendix 2: Continuity of Care: A worked example: What can it look like in practice?

Relational continuity of GP care would appear to work best in general practice when:

- GPs are working a minimum of 4 sessions/week in practice
- Each GP has a personal list, with a proportionate spread of age, sex, complexity
- In addition to named GP, there is a second named GP (or other clinician) clearly recorded in the notes to accommodate LFTF workforces and on-call rotas
- Coding of consultations is accurate and easy (consulter, consultation type)
- There is 'whole-practice' sign up to continuity principles and application
- Educational needs of staff and patients are addressed to explain the rationale (that continuity is at least as important as access); this is included in staff induction, practice PLT, in the 'telephone script' for care navigators answering the phone; thought is also given to patient education and support to make best use of the system
- The appointment system supports continuity (ie allows pre-booking with named clinician and doesn't operate solely as an 'on-the-day' model)
- Continuity is ideally applied to the whole practice list (not just specified cohorts) although for pragmatic reasons, those who stand to benefit most could be prioritised – 'proportionate continuity', or those with significant shorter-term care needs could be prioritised – 'episodic continuity')
- Continuity reaches >50% for the practice list (as measured by tools such as SLICC)
- There are 'flagship' practices who have adopted the model and shown it to work, who can then help to 'make the case' to the wider profession
- The practice is not too large (although continuity can still be achieved through careful organisation, such as micro-teams)
- There is a clinical lead within the practice to coordinate the work
- There is access to high quality support resources (such as those hosted by RCGP)
- There is explicit acknowledgement that the benefits will take around two years to manifest in terms of improved outcomes, reduced practice workload etc.

11. References

[1] [Realistic Medicine: Doing The Right Thing. CMO for Scotland Annual Report. 2022/2023](#)

[2] [Realistic Medicine: Taking Care. CMO for Scotland Annual Report. 2023/2024](#)

[3] [Continuity of care: a multidisciplinary review | The BMJ](#)

[4] Examples 1-12 shared as a summary by Denis Pereira Gray and research team, Exeter University.

[5] [What type of general practice do patients prefer? Exploration of practice characteristics influencing patient satisfaction. | British Journal of General Practice \(bjgp.org\)](#)

[6] [Exploration of the relationship between continuity, trust in regular doctors and patient satisfaction with consultations with family doctors: Scandinavian Journal of Primary Health Care: Vol 21, No 1 \(tandfonline.com\)](#)

[7] [Relationship between continuity and patient satisfaction: a systematic review | Family Practice | Oxford Academic \(oup.com\)](#)

[8] [Family Medicine \(stfm.org\)](#)

[9] [Patient-Doctor Depth-of-Relationship Scale: Development and Validation | Annals of Family Medicine \(annfammed.org\)](#)

[10] [Continuity of Care, Medication Adherence, and Health Care Outcomes Among Patients With Newly Diagnosed Type 2 Diabetes: A Longitudinal Analysis on JSTOR](#)

[11] [Association of Continuity of Primary Care and Statin Adherence | PLOS ONE](#)

[12] [Continuity of Care and the Use of Breast and Cervical Cancer Screening Services in a Multiethnic Community | JAMA Internal Medicine | JAMA Network](#)

[13] [AJP.90.6.962 \(aphapublications.org\)](#)

[14] [s11606-021-06638-3.pdf \(springer.com\)](#)

[15] [Recognizing meningococcal disease: the case for further research in primary care - PubMed \(nih.gov\)](#)

[16] [Is having a regular provider of diabetes care related to intensity of care and glycemic control? - PubMed \(nih.gov\)](#)

[17] [Continuity of GP care for patients with dementia: impact on prescribing and the health of patients | British Journal of General Practice \(bjgp.org\)](#)

[18] [Continuity of Care Increases Physician Productivity in Primary Care by Harshita Kajaria-Montag, Michael Freeman, Stefan Scholtes: SSRN](#)

[19] [Having a 'regular doctor' can significantly reduce GP workload, study finds | University of Cambridge](#)

[\[20\] Association Between Infant Continuity of Care and Pediatric Emergency Department Utilization | Pediatrics | American Academy of Pediatrics \(aap.org\)](#)

[\[21\] Accessible and continuous primary care may help reduce rates of emergency department use. An international survey in 34 countries | Family Practice | Oxford Academic \(oup.com\)](#)

[\[22\] Association between continuity of care in Swedish primary care and emergency services utilisation: a population-based cross-sectional study - PubMed \(nih.gov\)](#)

[\[23\] Impact of family practice continuity of care on unplanned hospital use for people with serious mental illness - Ride - 2019 - Health Services Research - Wiley Online Library](#)

[\[24\] Does continuity of care with a family physician reduce hospitalizations among older adults? - PubMed \(nih.gov\)](#)

[\[25\] Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data | The BMJ](#)

[\[26\] Characteristics of general practices associated with emergency admission rates to hospital: a cross-sectional study | Emergency Medicine Journal \(bmj.com\)](#)

[\[27\] Provider Continuity in Family Medicine: Does It Make a Difference for Total Health Care Costs? | Annals of Family Medicine \(annfammed.org\)](#)

[\[28\] Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations | Annals of Family Medicine \(annfammed.org\)](#)

[\[29\] The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review | Annals of Family Medicine \(annfammed.org\)](#)

[\[30\] The Association Between Continuity of Care and the Overuse of Medical Procedures | Health Care Quality | JAMA Internal Medicine | JAMA Network](#)

[\[31\] e600.full.pdf \(bjgp.org\)](#)

[\[32\] Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality | BMJ Open](#)

[\[33\] Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway | British Journal of General Practice \(bjgp.org\)](#)

[\[34\] The doctor—patient relationship in US primary care - PMC \(nih.gov\)](#)

[35] Freeman G, Hughes J, 2010, Continuity of care and the patient experience, Continuity of care and the patient experience, London, Publisher: The King's Fund

[36] <https://www.bmj.com/content/383/bmj-2022-074584>

[\[37\] Recent Treatment or Advice from the GP Practice - Health and Care Experience Survey 2021 to 2022: national results - gov.scot \(www.gov.scot\)](#)

[38] <https://www.gov.scot/publications/health-care-experience-survey-2023-24-national-results/pages/3/>

[39] [RCGP Tracking Survey 2023](#)

[40] Why We Revolt: A Patient Revolution for Careful and Kind Care Paperback – September 29, 2020 by Victor Montori M.D.

[41] BMJ 2023;380:p464 <http://dx.doi.org/10.1136/bmj.p464> Published: 24 February 2023

[42] [Increasing Continuity of Care in General Practice - The Health Foundation](#)

[43] [fit-future-relationship-based-care-june-2022.pdf \(rcgp.org.uk\)](#)

[44] [GP continuity: The keystone of general practice - Dr Kate Sidaway-Lee, Professor Sir Denis Pereira Gray, Dr Nada Khan, LISPETH ABRAHAM, Professor Philip Evans, 2024 \(sagepub.com\)](#)

[45] Christakis DA, Feudtner C. Temporary Matters: The Ethical Consequences of Transient Social Relationships in Medical Training. *JAMA*. 1997;278(9):739–743.

[46] Bonnie LHA, Cremers GR, Nasori M, Kramer AWM, van Dijk N. Longitudinal training models for entrusting students with independent patient care?: A systematic review. *Med Educ*. 2022; 56(2): 159-169.

[47] From Apprenticeship to Assembly Line: Recovering Relationships in Medical Education *Journal of Graduate Medical Education*. Sawatsky, Adam P.; Rea, Joanna R.; Hafdahl, Luke T.; Vaa Stelling, Brianna E.; Huber, Jill M.; Wingo, Majken T.; Leasure, Emily L. Vol. 15 Issue 6, pp. 627-631, 2023.

[48] Poncelet, A.N.; Hudson, J.N. Student Continuity with Patients: A System Delivery Innovation to Benefit Patient Care and Learning (Continuity Patient Benefit). *Healthcare* 2015, 3, 607-618.

[49] Ramani, Subha MBBS, PhD; Könings, Karen D. PhD; Ginsburg, Shiphra MD, PhD, FRCPC; van der Vleuten, Cees P.M. PhD. Relationships as the Backbone of Feedback: Exploring Preceptor and Resident Perceptions of Their Behaviors During Feedback Conversations. *Academic Medicine* 95(7):p 1073-1081, July 2020.

[50] Evans, D.B., Henschen, B.L., Poncelet, A.N. *et al.* Continuity in Undergraduate Medical Education: Mission Not Accomplished. *J GEN INTERN MED* 34, 2254–2259 (2019).

[51] Osman NY, Atalay A, Ghosh A, Saravanan Y, Shagrin B, Singh T, Hirsh DA. Structuring Medical Education for Workforce Transformation: Continuity, Symbiosis and Longitudinal Integrated Clerkships. *Education Sciences*. 2017; 7(2):58

[52] McKenna, Kathleen M. MD, MPH; Hashimoto, Daniel A. MD; Maguire, Michael S. MD; Bynum, William E. IV MD. The Missing Link: Connection Is the Key to Resilience in Medical Education. *Academic Medicine* 91(9):p 1197-1199, September 2016

[53] <https://www.rcgp.org.uk/representing-you/policy-areas/interface>

[54] [Baker R, Maarsingh O R, Couchman E, Winkel M T, Levene L S and Freeman G K. British Journal of General Practice 2024; 74 \(743\): 279-282. The decline in relationship continuity in England: can a European perspective help?](#)

12. Continuity of Care Sub-Group Membership

Dr Miles Mack (Chair)	GP / Past Chair RCGP Scottish Council
Delina Cowell	Chief of Staff to the CMO, Scottish Government
Professor Graham Ellis	Deputy Chief Medical Officer, Scottish Government
Dr Emma Fletcher	Director of Public Health, NHS Tayside
Jennifer Graham (Secretariat)	Events & Engagement Lead to the CMO, Scottish Government
Dr Carey Lunan	Senior Medical Advisor on Health Inequalities and Mental Health / GP Chair of Scottish Deep End Project / Honorary Senior Clinical Lecturer Edinburgh University / Past Chair RCGP Scottish Council
Dr Calum McPherson	Scottish Clinical Leadership Fellow
Professor Rowan Parks	President, Royal College of Surgeons of Edinburgh
Dr Chris Provan	Chair, RCGP Scottish Council
Professor Sir Lewis Ritchie	Mackenzie Chair of General Practice, University of Aberdeen / Honorary Professor, University of Edinburgh and University of the Highlands & Islands, Honorary Consultant in Public Health Medicine NHS Grampian
Professor Steve Turner	Chair, Scottish Academy
Professor Emma Watson	Director of Medicine, NHS Education for Scotland
Dr Simon Watson	Medical Director, Healthcare Improvement Scotland