

Relational continuity for general practice patients with new and changing symptoms

Final Report

July 2020

Valentine Health Partnership

Project team

Rebecca Rosen

Yolanda Massey

Samah Abbas

Tony Hufflett

CONTENTS

Summary	2
1. Methods and approaches used	5
1.1 Data analysis	5
1.2 Patient and staff engagement and organisational development activities	5
1.3 Impact assessment of the project on staff, patients and use of services	5
1.4 Stepping down from tagging	6
1.5 Sustaining improved continuity	6
2. Achievements and impact	7
2.1 Data analysis	7
2.2 Improved continuity	8
2.3 Data visualisation	9
2.4 Culture change:	10
2.5 Resources to support continuity	11
2.4 Impact on use of other services	11
2.5 Impact on staff and patients	12
3. Challenges	13
4. What did we learn to support spread and sustainability?	14
5. Policy influence:	15
6. The Health Foundation	16
APPENDICES	17
Appendix 1: Methods for data extraction, processing and analysis	18
Appendix 2: Additional findings from data analysis and case note review	19
Appendix 3: Resources to support continuity	25
Appendix 4: Key themes from ‘internal’ patient and staff surveys	34
Appendix 5: Baseline staff & patient surveys undertaken by external evaluators	36

Summary

This project took place between Jan 2019 and June 2020 in The Valentine Health Partnership, a GP practice with 26000 patients in Woolwich South East London,

The project was inspired by a review of missed and delayed diagnoses which highlighted that some of these occurred in usually healthy adults of working age without long term conditions or complex health problems, who consulted repeatedly but saw multiple different GPs. This raised questions about whether providing these patients with greater continuity would have made GPs more likely to notice the connection between repeated presentations and to actively pursue a definitive diagnosis and treatment plan. The project aimed to address five questions:

- Can we identify patients for whom a period of increased attendance indicates the start of an episode for which outcomes will be improved by relational continuity with a named clinician?
- What processes and resources are needed to help patients with new or changing symptoms to understand the potential benefit of continuity and to enable them to achieve this?
- What is the impact on patient and clinician satisfaction of achieving continuity for the duration of an episode of new or changing symptoms?
- Does relational continuity for patients with new or changing symptoms alter 1) the time to diagnosis and 2) the use of wider health services?
- Is it possible to identify patients who can be 'stepped down' from being identified as needing continuity once diagnosis is made, treatment initiated and symptoms stabilised or removed?

The project involved a mix of data analysis, organisational development and patient and staff engagement activities

- Data analysis to identify and 'flag' patients with increased GP consultations and to compare medication and hospital service use in patients who did and didn't receive continuity of care
- Development of guidance for GPs to review the notes of flagged patients and tag notes of those who could benefit from continuity plus development of operational processes to deliver continuity for tagged patients with their usual GP or his/her micro-team
- Initial surveys and interviews with staff and patients to identify barriers to continuity to be addressed through the project followed by ongoing organisational development activities to raise awareness of the benefits of continuity, embed the processes and resources developed for the project and change the organisational culture in relation to continuity
- Notes reviews to describe the range of patients offered continuity; assess the time from first presentation to definitive diagnosis and quantify use of tests, medications and other services

Main impacts and findings

- Between July 2019 and March 2020, 584 patients were identified in five waves of data analysis as potentially benefiting from continuity and, after their named GP reviewed their notes, 416 (75%) were tagged for continuity.
- These patients experienced improved continuity with their named GP and a larger improvement in continuity with that GP's micro-team
- Patients who received continuity for >50% of appointments had lower use of A&E and urgent care.
- The end of project staff survey showed that 93% of respondents said the project made them more likely to promote continuity. Repeat interviews with patient were delayed by the Covid emergency however, a texted question to tagged patients about their experience of continuity received 37 responses of whom 70% said they found it easier to see their preferred GP while 30% did not.

Opportunities and challenges for replicating the initiative elsewhere

This project has taken a pragmatic approach (different from other projects in the HF continuity programme), targeting continuity to sub-groups of patients who were most likely to benefit from it. For any practice which wants to take this targeted approach, some of the essential ingredients for success are:

- A clinical champion to lead the clinical behaviour changes needed to improve continuity and a managerial/reception champion to implement and maintain operational processes for continuity. These roles are needed for the long term to overcome staff and patient turnover
- Patient facing communications to raise awareness about continuity and how to achieve it
- A data analyst to identify patients who could benefit from continuity; monitor changes in continuity and disseminate findings to staff
- Initiatives to engage all staff in co-designing arrangements for continuity

Key challenges to implementing and sustaining the processes described in this report were

- The time and sustained communications needed to engage staff in understanding and improving continuity and to keep the issue high in people's minds
- Long term involvement of somebody with data analysis skills
- Clinicians who fear that continuity will increase workload and are reluctant to promote it

Concluding reflections

This project is rooted in an assumption that continuity is not needed (or wanted) by all patients, but that the cohort of patients who can benefit from continuity is significantly larger than the archetypal groups who are usually described as needing continuity (eg frail older people; patients with multiple long term conditions or enduring mental health problems or patients at the end of life).

Our data analysis and case note audit provide deep insights into the 10% of the practice population – including many usually healthy adults and children – who are either periodic or sustained higher attenders with ongoing symptoms. In the current context of widespread part time working and patients wanting rapid access, continuity is harder to achieve and there is a case for targeting it onto patients who are most likely to benefit from it. This project has demonstrated one way to do this and other practices wishing to adopt a targeted approach could adjust the criteria and resources for continuity to suit their local context.

Although we were not able to test our hypothesis that better continuity for this group enables faster diagnosis and fewer missed or delayed diagnoses, we have shown that across the whole practice population, patients who received more than 50% continuity with a named GP made less use of A&E and urgent care services. This challenges current policy assumptions that the route to lower A&E attendance lies with immediate access to general practice without paying attention to continuity.

We have established systems for identifying these patients, reviewing their clinical problems and targeting continuity towards those who seem most likely to benefit. We will be reviewing their experiences of continuity when the Covid crisis has settled down.

We have established systems for identifying, reviewing and 'tagging' these patients and will evaluate their experiences of continuity when the Covid crisis has settled down. We have also demonstrated benefits for clinicians associated with continuity including shorter consultations and easier non-face to face follow up consultations. This suggests that continuity can improve some aspects of clinical care and contribute to practice efficiency although we have also identified a need for training to support clinicians with the challenges of providing continuity for the most complex patients.

Overall we think the project provides evidence for promoting continuity both at a national policy level and within practices and we hope the information and resource presented here will support this.

1. Methods and approaches used

1.1 Data analysis to develop criteria for identifying (flagging) and tagging the notes of continuity patients

Methods for extracting, cleaning and analysing EMIS data are described in Appendix 1. We initially tried to identify patients who might benefit from continuity through a combination of frequency of attendance and clusters of related clinical codes. However, the quality of symptom and diagnostic coding was poor (see appendix 2) so we used only data on frequency of attendance.

It was important that the number of patients 'flagged' each month did not overwhelm the GPs who would provide continuity, as some GPs were worried this would increase their workload. We varied the number of attendances recorded over different time period to see how many patients would flag and settled on 6 attendances in the previous 3 months which generated around 40 new 'flaggers' per month (See figure A5 on page 20) to be reviewed by a GP for a decision on whether they needed continuity. Notes were only 'tagged' for continuity after review by their named GP¹ against a set of criteria presented in the flow chart in Appendix 3.4

1.2 Patient and staff engagement and organisational development activities

- Patient interviews and an early patient survey explored their views and preferences about continuity and helped to shape communications and other arrangements about continuity.
- Staff participated in four development workshops to co-design systems and processes to promote continuity (May, Oct and Nov 2019 and Jan 2020). Suggestions about operational processes and clinical criteria for improved continuity were actioned by the project team
- Further ad-hoc discussions were held during clinical meetings if issues or problems were identified with arrangements to provide continuity
- Two micro-team meetings explored ways to support effective micro-team working and identified the processes and resources needed to support this
- Various resources were developed to support patients, clinicians and receptionists to achieve continuity (see Appendix 3)

1.3 Impact assessment of the project on staff, patients and use of services

A staff survey and interviews were conducted by an external evaluator at the start of the project (see appendix 5) but the Covid crisis meant this could not be repeated at the end of the project. We therefore undertook an internal staff survey using survey monkey (see Appendix 4 for results) to explore how the project had affected their views and behaviours in relation to continuity

The external evaluators also undertook a patient survey across the 5 Health Foundation continuity sites with 244 responses from Valentine Health patients (See appendix 5). The Covid crisis changed the delivery

¹ 'Named GP' is the GP under whom a patient is registered in EMIS (that name appears in top left of the medical record screen) but this may not be the GP the patient usually sees (their 'usual doctor' or 'UD'). The project aimed to ensure that the named GP and the 'UD' were the same for patients who present more than 6 times in 3 months. The Named GP was asked to review the notes of flagged patients (see flow chart in Appendix 3). If a patient was already receiving continuity from a different GP, that GP would be asked to accept the patient as a continuity patient. If accepted the named GP would be changed to the patient's UD. If not, the named GP and UD would need to agree how to share responsibility for that patient's care.

of care to such an extent that the survey could not be re-run in the same way at the end of the project so we sent a single question to all allocated patients via SMS text:

A question from your GP clinic: Have you found it easier to see your preferred GP during the last 12 months than in previous years? Please reply, texting Y for yes and N for no.

We tried to use a detailed note review to quantify the time from first presentation of symptoms to making a definitive diagnosis and starting a treatment plan and to quantify service use associated with the presenting condition. The note review revealed that this approach was not possible as many flagged patients had rumbling symptoms over many years so it was not possible to identify a starting point for their condition. However, the note review provided a rich understanding of the clinical and socio-demographic characteristics, summarised in appendix 2, of patients with different patterns of attendance.

We therefore evaluated use of other services through analysis of EMIS data on: A&E attendance; Urgent Care attendance; outpatient referral (all are precisely coded after every attendance by the practice data team); and prescriptions for antibiotics and opiate pain killers. We considered comparing these measures in patients allocated in waves 1 and 2 of the project with a control group but this analysis would have lacked statistical power and there was a risk of 'contamination' of controls by a general shift in the culture of continuity within the practice. As an alternative, we analysed use of these services by all registered patients comparing patients who had seen their named GP at >50% of appointments between Jan 2015 and Dec 2019 and those who saw their named GP <50% of the time (see appendix 2).

1.4 Stepping down from tagging

The process for 'stepping patients down' from tagging was to be developed in the March 2020 all staff development session but the Covid crisis reset organisational priorities. This meeting was delayed but will be held in summer 2020.

1.5 Sustaining improved continuity

The Covid pandemic temporarily disrupted processes for continuity but these have been restored through sustained communications with staff (personal conversations, intermittent messaging to staff on computers; e-mails and reminders at staff meetings) and ongoing advice to patients about seeking continuity.

In the long run, maintaining the processes we have established for continuity will require dedicated time for data analysis; sustained messaging to all staff about continuity and periodic sessions during staff development meetings to reinforce awareness of the value of continuity and how to achieve it. We will also need to develop feedback arrangements from staff and patients about whether our continuity processes need modification due to changes in the design and delivery of services in response to Covid.

2. Achievements and impact

2.1 Data analysis

The project has demonstrated how detailed analysis of patient attendance patterns can provide a rich picture of appointment use by different cohorts of patients. It can identify those who change their frequency of attendance from occasional to regular and who might benefit from continuity of care while reaching a diagnosis and agreeing a treatment plan.

Analysis of 2019 data revealed that 90% of patients attended the surgery less than 6 times and therefore didn't reach our threshold number of appointments for flagging.

Year : 2019

FA Group	# pts	Cumul Pts	Avg. GP appts	# GP appts	% of all patients	Cumulative % pts	Cumul % appts	# of all appts (incl nurse)	Avg. Age	Est VALUE of GP appts (@£...	Cumulative resource value
A. Weekly (35+ /yr)	14	14	46 appts	650	0.0%	0.0%	1%	740	56	£26,000	£26,000
B. Bi-weekly (24-34)	53	67	28 appts	1,482	0.2%	0.2%	4%	1,686	49	£59,280	£85,280
C. 3-weekly (16-23)	175	242	18 appts	3,186	0.6%	0.8%	9%	3,701	48	£127,440	£212,720
D. Monthly (10-15)	669	911	12 appts	7,852	2.3%	3.2%	22%	9,423	44	£314,080	£526,800
E. Bi-monthly (6-9)	1,950	2,861	7 appts	13,962	6.8%	10.0%	46%	17,294	41	£558,480	£1,085,280
F. Quarterly (4-5)	2,829	5,690	4 appts	12,487	9.9%	19.8%	63%	15,916	37	£499,480	£1,584,760
G. Infrequent (2-3)	5,772	11,462	2 appts	13,850	20.1%	39.9%	91%	19,341	33	£554,000	£2,138,760
H. Annual (1)	5,289	16,751	1 appts	5,290	18.4%	58.4%	100%	8,495	31	£211,600	£2,350,360
I. Non-GP attender	1,777	18,528	appts	0	6.2%	64.6%	100%	2,775	31	£0	£2,350,360
J. Zero-attender (any)	10,170	28,698	appts	0	35.4%	100.0%	100%	0	31	£0	£2,350,360
Grand Total	28,698	28,698	2 appts	58,759	100.0%	100.0%	100%	79,371	33	£2,350,360	£2,350,360

Figure 1: Patient subgroups according to annual number of attendances 2019

Among the 10% of patients who consulted 6 or more times during 2019 and into early (pre-covid) 2020, (ie the patient sub groups within the red ring in figure 1 above), 584 were identified in 5 waves of data analysis as having consulted 6 or more times in 3 months and thus, as potentially benefitting from continuity according to the criteria set for this project. After a note review by their named GP, 416 (75%) had their notes tagged for continuity

Wave	Total identified	Not allocated	Allocated
Wave 1 (Q1& Q2 2019)	266	64	202
Wave 2 (July 2019)	39	10	29
Wave 3 (August 2019)	45	7	38
Wave 4 (Sep-Nov 2019)	113	46	67
Wave 5 (Dec-Feb 2020)	121	41	80
Total	584	168	416
	<i>Proportion</i>	25%	75%

Table1: Waves 1 to 5 of allocated flagged and allocated patients

2.2 Improved continuity

Analysis of continuity achieved for patients tagged in waves 1 and 2 of this project found that compared to the four months before being allocated for continuity, during the four months afterwards, continuity with individual GPs and with micro-teams (figure 2) increased. However it only reached 50% continuity in three of the four micro-teams in the practice. Figure 3 shows the % of *all* patients with 6 or more appointments (not just tagged patients) who had continuity with their named GP and their micro-team, 2015-2020 (only Jan-March 2020 included). The practice-wide increase in continuity could be due to a change in organisational culture driven by this project affecting all patients. However, this had only reached 37% continuity with named GP by March 2020 so further improvement is needed. It is worth noting that the practice responded to national pressure for faster access by re-designing clinics to increase non-pre-bookable, on-the-day appointments. Although clinic booking processes promote continuity with micro-teams and support continuity with a named GP if requested, the access clinics probably decrease the chance of seeing a GP who knows you.

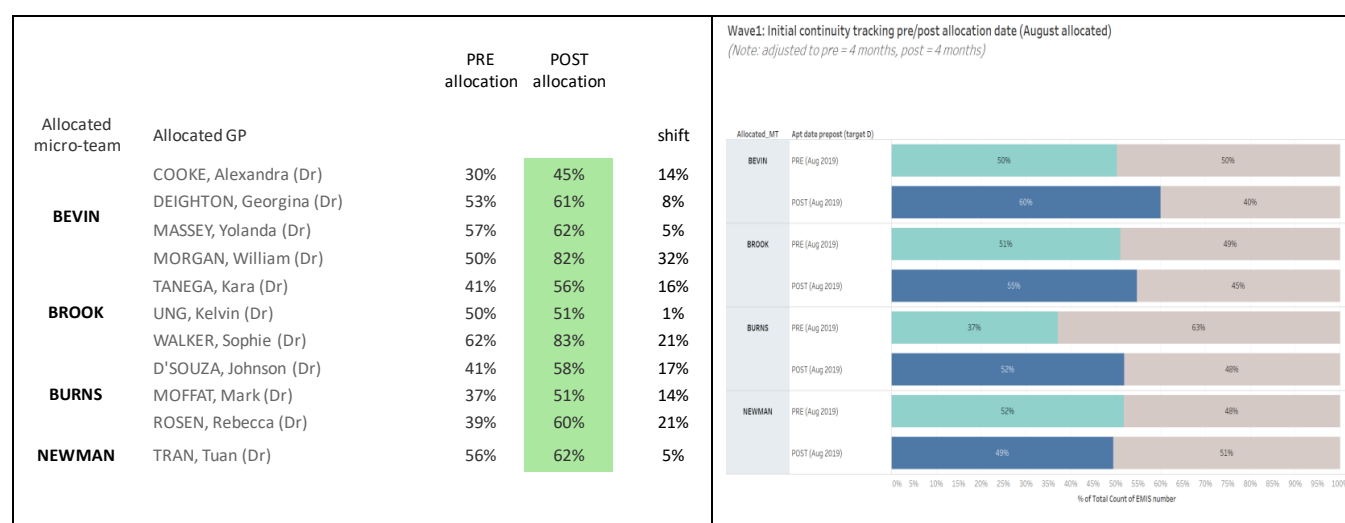


Figure 2: change in continuity for patients allocated in waves 1 and 2 by Named GP and micro- team

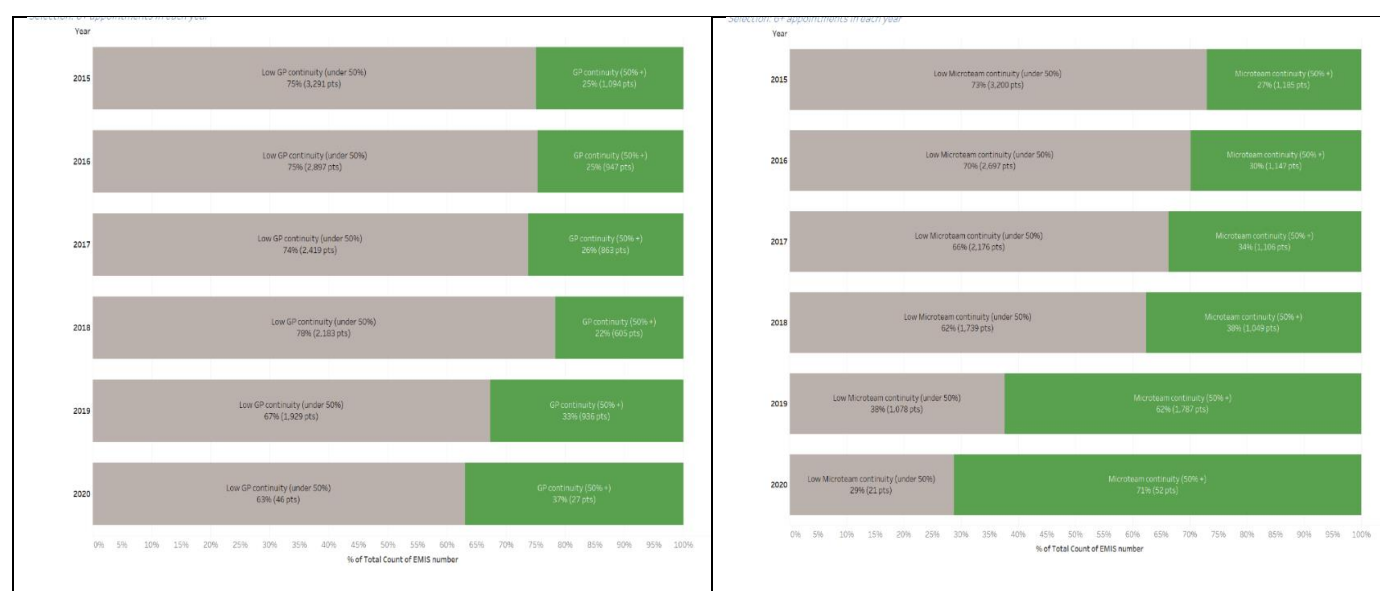


Figure 3: annual % of continuity for all patients by named GP (left) and by micro-team (right) 2015-2020 (Jan – March only)

Further analysis shows that on average, around 60-65% of flagging patients in any 3m period revert to lower levels of attendance (see figure 4 where the size of the blue box in any quarter is proportionate to the number of appointments used). This supports the underlying hypothesis of this

project that some usually healthy patients experience a period of symptoms or illness associated with higher GP attendance and then revert back to being low users. These patients may not always 'need' ongoing continuity (in terms of impact on future clinical outcomes) but they may *prefer* and actively try to achieve continuity if they valued it during the period of higher use.

This matches what we saw before for first-time flaggers - episodic drop-off (regression to the mean)

Q2b: What is the natural drop off from patients who flag for the first time (e.g. with 6+ GP appointments in 3 months)?

A: Average drop off in subsequent quarter is 60% fewer appointments in the next quarter

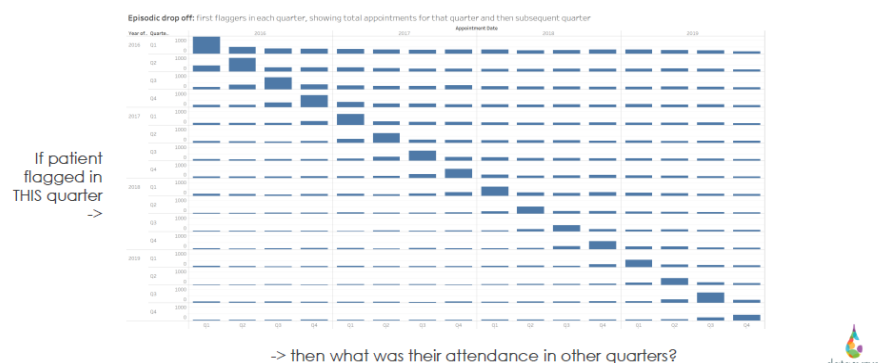


Figure 4: change in appointment numbers in the quarter following first flagging.

2.3 Data visualisation

Figures 5-7 shows how **data visualisation** can help GPs to interpret consultation patterns in flagged patients. The left-hand image shows that in some patients 'flagging' represents a single episode of illness which resolves and they revert to being low users. Some have longer periods of higher use before reverting (middle image) and some are long term high users who flag because their rate of attendance periodically peaks to >6 contacts in 3m (right hand image).

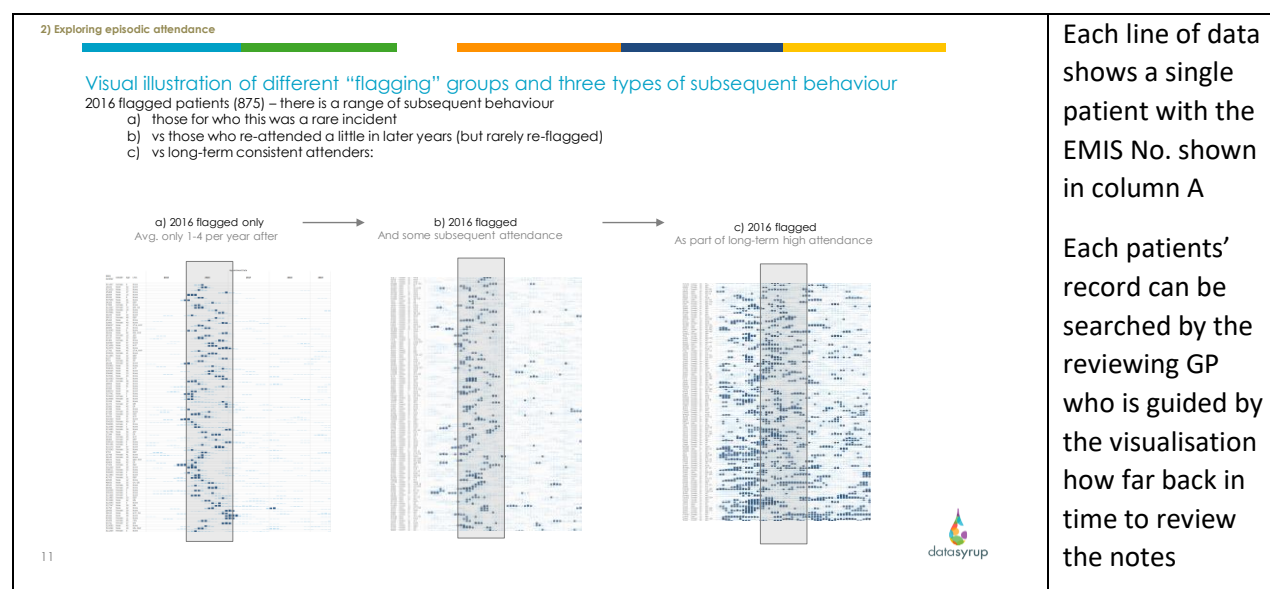


Figure 5: data visualisation of three patterns of flagging patients – once only increase in attendance left hand image, intermittent higher use (middle images) and long term frequent attenders (right image)

We also used data visualisation to create a quick visual impression of the extent of continuity for patients in each micro team.

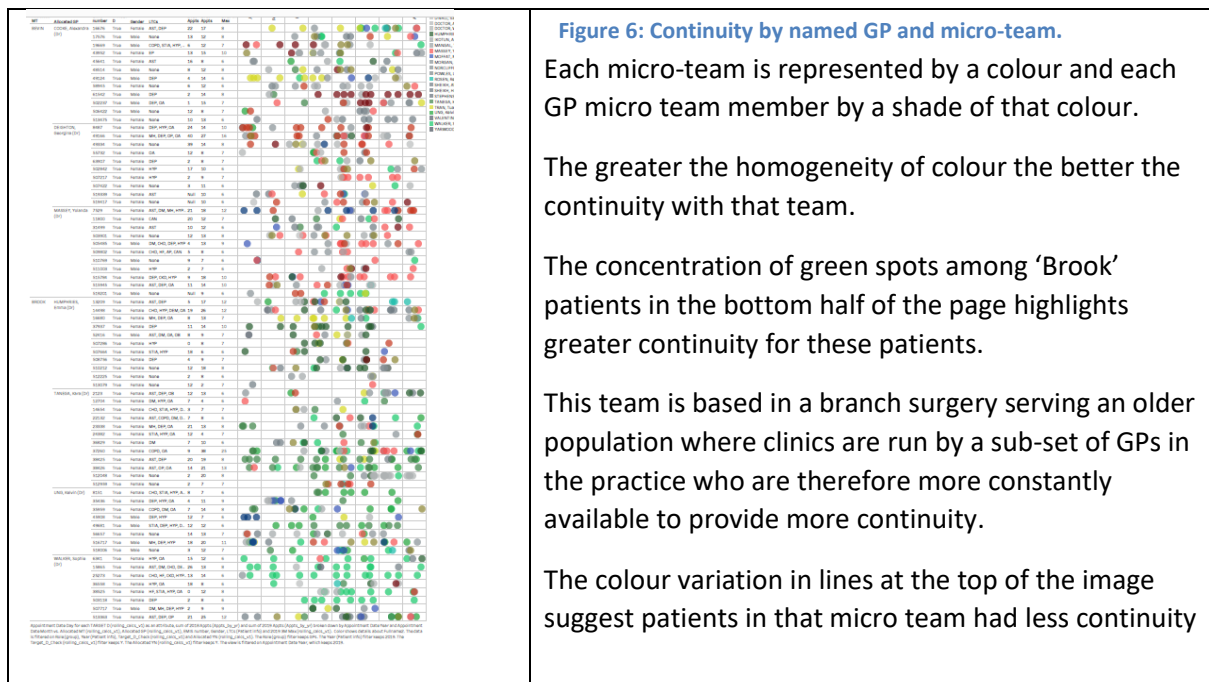


Figure 6: Patient continuity with named GP and micro-team

Figure 7 displays the intensity of appointment use, year on year, for flagging patients. Each line represents a single patient with the colour of each block representing the number of appointments used in a month (darker represents more appointments). The patients named GP can quickly see his/her pattern of use over previous years and be guided where to look in the patient's notes to understand periods of higher use.

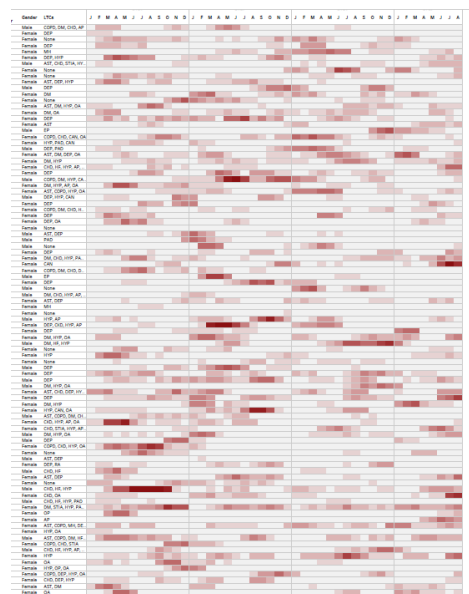


Figure 7: Monthly intensity of appointment use by individual patients

2.4 Culture change:

The project has also demonstrated it is possible, through sustained staff engagement, awareness raising and support, to improve understanding about continuity and commitment to delivering it. This was achieved through sustained activities to: highlight the value of continuity to staff and patients; involve staff in designing and adjusting systems to provide continuity; and support patients to understand and request continuity. **The end-of project staff survey found that 93% of**

respondents reported that they were more likely to promote continuity as a result of the continuity project,

The meetings to develop better micro-team working identified several factors to support this including the need for a continuity a template to support better communication and shared management plans between team members (see Appendix 3); the importance of trusting the clinical judgement of other members of your team and being able to question decisions by other team members if you do not understand why they were made. We planned to use one of the weekly clinical meetings every 4-6 weeks to meet as a micro team to review complex patients and share thinking on how to manage them. However this plan was interrupted by the Covid pandemic.

Overall, the culture change arising from this project must be seen as an ongoing process needing **repeated reinforcement** (due to staff turnover, decay of thinking about continuity and other priorities taking clinicians' attention) of why continuity is important and how to achieve it.

2.5 Resources to support continuity

The project resulted in various processes & resources to support continuity (See appendix 3)

- Standardised searches to identify repeat attenders with the criteria for tagging set to identify a manageable number of continuity patients each month
- Data visualisations to enable GPs to easily understand patterns of consultation
- Resources to inform patients about continuity and support GPs to offer continuity
- Receptionist scripts and protocols to steer continuity patients to their usual GP
- Continuity template to support communication and a shared clinical and social management between micro-team members
- Guidance on consultation methods to explore symptoms and change health behaviours

2.4 Impact on use of other services

Methods for the analysis of impact on use of A&E, Urgent Care, outpatient appointments, antibiotics and opiates are described in Appendix 1 below. Analysis revealed that compared to patients who did NOT receive continuity more than 50% of the time, continuity patients made lower use of A&E and UCC (see figure 8),

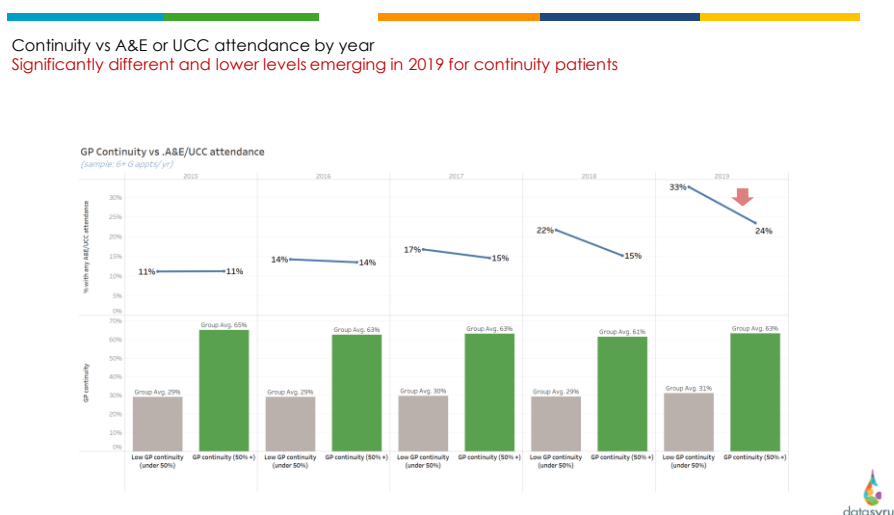


Figure 8: Use of A&E and Urgent Care Centre by patients who did (green bar) and did not (grey bar) achieve continuity

We also compared outpatient clinic referrals in patients above and below 50% continuity, finding that a higher % of continuity patients were referred to outpatient clinics than non-continuity patients (see figure 9).

GP Continuity vs .OPD attendance
(sample: 6+ G appts/ yr)

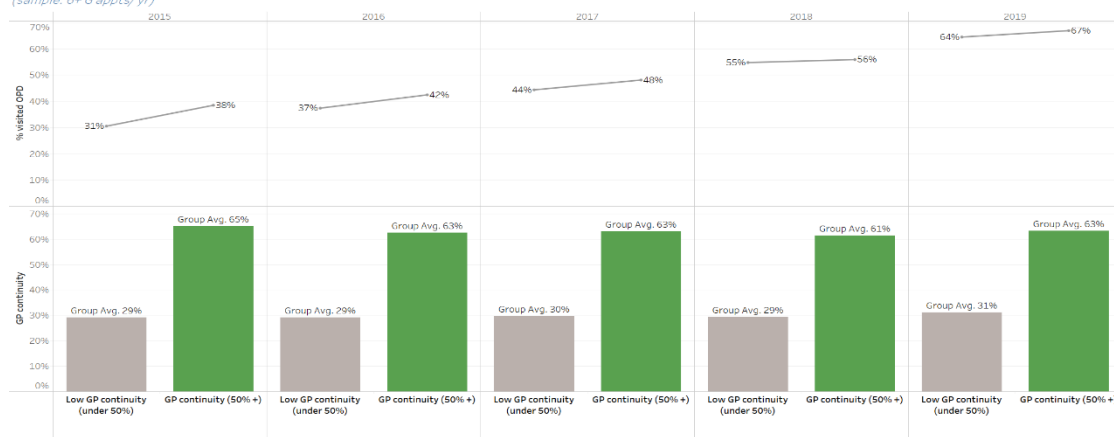


Figure 9: Outpatient referrals for patients who did (green bar) and did not (grey bar) achieve continuity

And we looked at numbers of antibiotic and opiate prescriptions issued in patients above and below 50% continuity

GP Continuity vs Opiate prescription and AB drugs in a year
(sample: 6+ G appts/ yr)

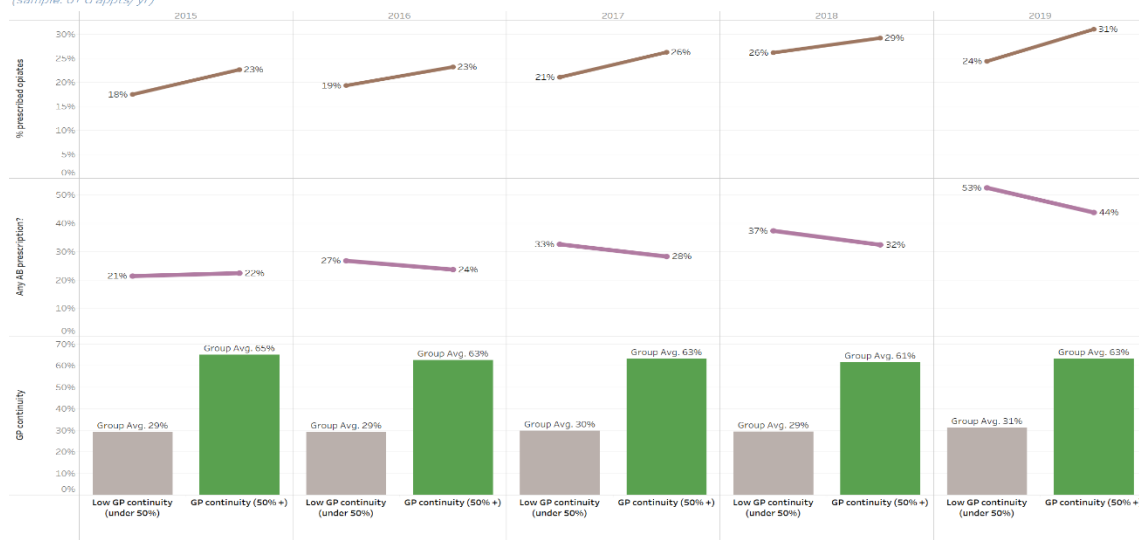


Figure 10: antibiotic and opiate prescriptions in patients who did (green bar) and did not (grey bar) achieve continuity

Patients who achieved 50% continuity with a named GP were less likely to have received a prescription for antibiotics and more likely to have received a prescription for opiate medications.

This basic comparison of percentages may have been confounded by the fact that antibiotics are more likely to be prescribed for acute illnesses, when patients are less likely to seek continuity so they could be under-represented in the continuity cohort. And conversely, patients with complex health problems and long term pain are more prevalent among patients tagged for continuity so they could be over-represented in the continuity cohort and therefore more likely receive an opiate.

2.5 Impact on staff and patients

Evaluation of impact on staff and patients was limited by the Covid outbreak. Processes to promote continuity were disrupted through March and April although they were re-instated in May. Follow

up interviews with patients would have been affected by the recent reduction in continuity and were therefore delayed. Prioritising staff input to re-designing services in response to Covid meant that the external end-of-project staff evaluation was also delayed. Nevertheless, the internal evaluation survey provided some insights into the impact on the 30 staff members who responded:

- 17 (57%) thought the project had enabled tagged patients to see their continuity doctor most of the time and 8 (27%) thought this was true some of the time.
- 93% of respondents across all professional groups (GPs, nurses, receptionists and clinical assistants) reported being more likely to inform patients of the benefits of continuity and help them to achieve this with their named GP.
- Only 57% of GPs reported having used the continuity visiting cards (although several respondents were very new to the practice and had not yet been given cards).
- 73% of respondents said the increased continuity achieved through the project had made their working life easier or not affected it. 17% said it made their working life harder due to a small group of very complex patients booking frequent appointments.
- Regarding the impact on consultations of targeting continuity to patients with 6 or more appointments in 3m, 62% agreed that it allowed shorter consultations while 24% disagreed; 80% agreed that it increased trust between patient and GP while 5% disagreed; 62% agreed that it made it easier to manage clinical uncertainty without referring to another service while 14% disagreed; and 76% agreed that it made it easier to provide follow up by telephone or video consultation while 14% disagreed
- In response to the question (to clinicians only): Do you feel a greater sense of professional responsibility to achieve a good outcome for your health foundation continuity patients than for other patients? 48% responded feeling greater responsibility for some or all of their continuity patients while 35% did not feel this and 17% were unsure

The end-of-project text message was sent to 417 patients of whom 37 replied.

- 26 patients (70% of responders, and 6% of all tagged patients) reported that it was easier to see their preferred GPs
- 11 patients (30% of responders and 2.6% of all tagged patients) reported that it was not easier to see their preferred GP

3. Challenges

There were several challenges, including the impact of Covid-19, in delivering this project and fulfilling some of its aims. The main challenge we faced were:

1) Historic decisions about how to book appointments and organise clinics created problems with cleaning and analysing data and flagging patients.

The EMIS system for booking patients into the daily walk in clinic made it hard to attribute a patient to a named GP in some appointments. We could not persuade the GP partners and practice data lead that it was worth changing the booking processes to support easier identification of flagged patients. We therefore had to develop 'work arounds' for these problems, for example, attributing a walk in consultation to the most senior clinician seen on that day

2) Responding to the views of sceptical clinicians

A small number of clinicians feared that providing continuity would increase workload - allowing other GPs to 'dump' complex patients onto their registered list. This was a credible fear (with examples presented and discussed at clinical meetings). We used staff development sessions to identify solutions based on the named GP negotiating with a potential alternative continuity GP to accept a patient onto their list, agreeing that the potential receiving GP had the right to decline.

3) Mixed impact on workload

Some doctors described having work 'dumped' on them as the continuity GP if a patient was seen by a different doctor who ordered tests but wasn't willing to follow up the results. Others described an increase in workload associated with the project due to having several complex continuity patients who book frequent consultations to talk through problems. This highlighted a need for skills in managing patient expectations about appointment frequency associated with continuity and led some GPs to limit the number of new continuity patients they would take on.

4) Reaching a definitive diagnosis and stepping down from continuity of care

Our aim to compare the time to diagnosis for flagged patients who were and were not allocated for continuity was thwarted because 1) Symptom codes were often absent; 2) some patients presented with a flare up of past symptoms which made it difficult to pin down the start of an episode of care 3) many flagged patients did not have a definitive diagnosis and their symptoms resolved but were unexplained.

4. What did we learn to support spread and sustainability?

We learned that targeting continuity to a subset of registered patients requires two areas of sustained organisational development: the first to build staff commitment to improving continuity and the second to implement a range of operational processes to identify patients who might benefit from continuity and support them to achieve it.

Practices with a mix of full-time and part-time clinicians which do not run personal lists and which want to improve continuity could consider the targeted approach used in this project. Key points to support spread to other practices are:

- Identify a clinical champion who can lead work to build an organisational culture committed to continuity and a managerial or receptionist champion to implement and embed the operational processes to support continuity.
- Develop patient-facing communications to encourage patients to request continuity with their named or preferred clinician
- Ensure somebody with skills in data extraction/analysis has protected time to identify patients who may benefit from continuity. Criteria for identifying patients can be locally tailored.
- Ensure staff have time freed up to engage with discussions about continuity and how best to achieve it in a local context.
- Issue regular reminders to reception staff and clinicians – both groups being instrumental in achieving continuity – on the value of continuity and flagging patients to achieve this.
- Adapt the practice induction process to include alerting all new clinicians about the practice's approach to continuity and the expectation that they will contribute to this.
- Continue to monitor the level of continuity achieved and the experience of clinicians providing continuity and continue to adapt processes for continuity as new issues arise.

- Maintaining this improvement in the longer term will require a sustained campaign to keep the issue prominent in people's minds.

Practices wanting to replicate this project can draw on the resources in appendix 3, adapting them for local use as necessary. However, freeing up time to engage staff and patients in improving continuity is difficult to do in the face of many other competing priorities. The association between continuity and lower use of A&E identified in this project creates a case for policy makers to focus on improving 'access to continuity' alongside rapid access for acute illnesses (see next section). This would help to ensure that continuity could compete with other practice development priorities for the time and resources needed to improve it.

5. Policy influence:

This project was conducted during a period where political priorities were on improving rapid access to general practice rather than on relational continuity with a named GP. Our results suggest that improving continuity will increase the likelihood of general practice acting as an alternative to A&E and urgent care services and there are various ways in which policy makers could harness this potential.

- Ensure that contractual requirements for access to primary care include providing access to continuity for patients for whom continuity could contribute to better outcomes and lower use of other services.
- Consider including measuring and/or improving continuity in the quality and outcome framework or creating an enhanced service payment for continuity. This would allow continuity to compete for the time and 'headspace' needed to deliver it.
- Support the dissemination of information and resources to support practices to combine rapid access for acute problems with access to continuity for ongoing issues.
- Require that all electronic medical records in primary care include modules to identify patients who could benefit from continuity and booking systems that make it easier to offer continuity where it is needed
- The project revealed variable use of clinical coding. While improving coding is not a policy priority, initiatives to improve coding for other aspects of GP activity could have helpful spin off consequences for tracking and delivering continuity.

6. The Health Foundation 's continuity programme

The broad aim of the programme fitted exactly with the practice's quality improvement and development aims and was timely in that it coincided with NHS England efforts to improve access in general practice. The project enabled the practice to develop a pragmatic method to create continuity where it is most likely to confer benefits to patients and staff, improve outcomes and reduce use of other services.

- How have you found the support from the Health Foundation and RCGP?

The support offered for the continuity project was valuable and proportionate. It provided an opportunity to share learning, hear about other projects, report on progress and describe challenges. The RCGP provided the infrastructure to share learning and resources quickly between sites, which was very welcome. It's a shame that we did not arrange visits to different sites before lockdown, although perhaps a zoom meeting with video 'documentaries' about each site could work

The external evaluators felt only loosely connected (which perhaps fits with their remit) and their evaluation was limited by the Covid crisis.

- What could we improve and do better?

Please change the format of the final report! The suggested five pages makes doesn't allow enough space to provide information about methods and findings in the main body of the report. A longer final report would make it easier to describe and share the processes and resources we have developed.

APPENDICES

Appendix 1: Methods for data extraction, processing and analysis	18
Appendix 2: Additional findings: data analysis & case note review	19
Appendix 3: Resources to support continuity	25
3.1 Business cards with usual working days of each GP	25
3.2 Waiting room Slides about continuity room	25
3.3 Guide to clinicians on working with continuity patients	26
3.4 Flow chart for allocating patients to the most appropriate GP for continuity	30
3.5 Suggested script for receptionists: booking continuity patients with named GP.	31
3.6 EMIS Continuity template: sharing information between microteam members	32
Appendix 4: Key themes from 'internal' patient and staff surveys conducted by the project team	34
4.1 Summary of structured patient interviews:	34
4.2 Summary of responses to end-of-project staff survey	35
Appendix 5: Baseline staff and patient surveys undertaken by external evaluators	36

Appendix 1: Methods for data extraction, processing and analysis

A 1. Data extraction and assembly

Data was extracted as raw and complete (non-aggregated) datasets from practices clinical system

a) Core dataset files

- Patient level data (non-identifiable) - including registration dates, demographics, usual doctor, long terms condition registers
- Appointment data – all appointments in detail (5 year period)
- Coding data – all codes used in the same time period

b) Support files

- e.g. clinician roles, e.g. classification of appointment/slot types, e.g. coding dictionary (read, snomed)

c) Additional files / developed during the project

- e.g. allocation of GPs to continuity patients, e.g. additional datasets (such as Opiate prescriptions)

2. Processing and cleaning

- Creation of multi-stage algorithm to identify GP for walk-in appointments due to system data anomalies
- De-duping of appointments (multiple reported by the system)
- Identification of other data issues / illogicalities

3. Data connections, analysis and aggregations

- Connection of all sets via patient identifier
- Aggregate of appointment by patient - e.g. total by year
- Calculation of continuity by patient and year
- Aggregation of codes by patient
- Other calculations e.g. episodes/ flagging, # different GPs seen, etc

4. Data visualisation

- Summary and discussion of aggregated and historical data to check accuracy and discuss patterns
- Discussion of anomalies and comparison to other practices

5. Data analytics

- Core assessment of project objectives (e.g. continuity improvement)
- Hypothesis led analytics for the project (e.g. link of continuity to other factors)

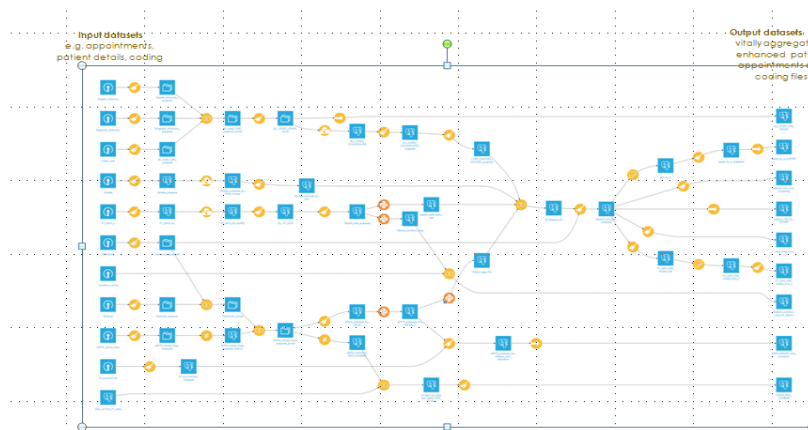


Figure A1: Flow diagram of data processing and aggregation steps

Appendix 2: Additional findings from data analysis and case note review

A2.1: Characteristics of flagged patients and patterns of service use:

As noted on page 5 above, we wanted to identify a monthly cohort of flagged patients that would not overwhelm the GPs who were asked to review their notes to check the need for continuity. We decided that 40-50 new flaggers a month would be a manageable number of notes reviews across 12 WTE GPs. **On this basis we set 6 or more appointments in a 3 month period as the criterion for asking a named GP to review the notes and decide if the patient might benefit from continuity. This number emerged through trial and review of findings. Another practice wishing to adopt our approach to continuity could adjust these criteria to suit their own circumstances.**

We analysed data from 2016 onward to generate a picture of patients who flagged for the first time in each year. Ages of first flaggers ranged from 1 to 99 years, and across the four years there were consistently more women than men and between 64% and 85% were in the 17-64 age group.

Year	TOTALS	Female	% female	Male	% Male	Av Age	Age Range	Under 16	%<16	17-64	17-64 yrs %	over 65	over 65%
2016	347	201	58	146	42	42	3 to 102	69	20	221	64	57	16
2017	264	159	60	105	40	42	1 to 99	26	6	387	85	40	9
2018	189	100	53	89	47	42	1 to 99	31	17	129	68	29	15
2019	228	149	65	79	35	48	1 to 94	10	4	170	75	48	21

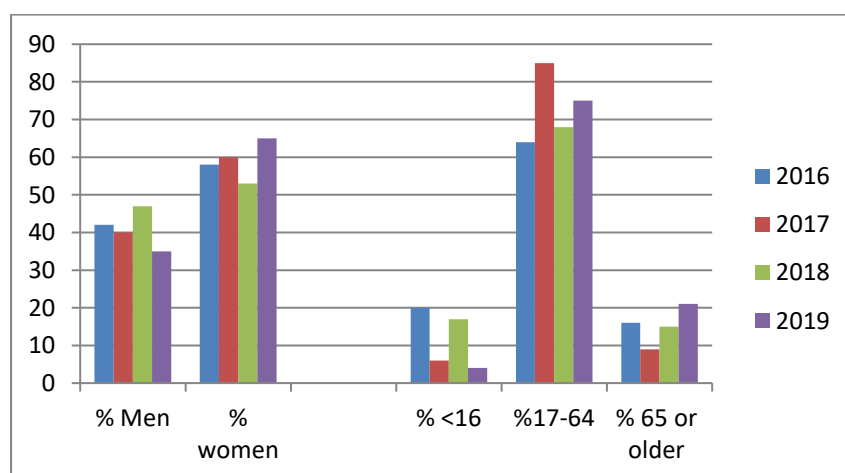


Figure A2: Age and sex of first flaggers 2016-2019

This demographic mix is different from the 'archetype' of patients who are typically the target for care coordination and continuity. Furthermore, approximately 60% of flagged patients had none or one long term condition, again defying the archetype of clinical complexity. And while this group had generally low rate of hospital admissions compared to 'archetype continuity patients', the case note audit below shows that they had some significant clinical conditions. As such, they are a group in which the risk of missed and delayed diagnoses carries significant adverse consequences for individual patients and medico-legal risk for the health system as a whole.

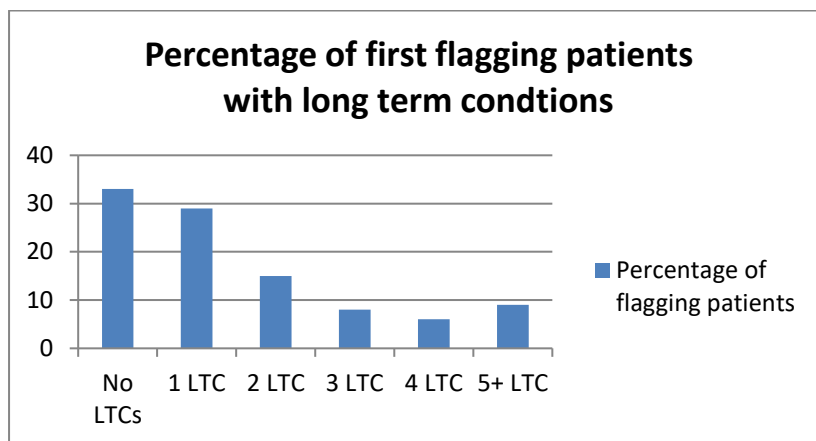
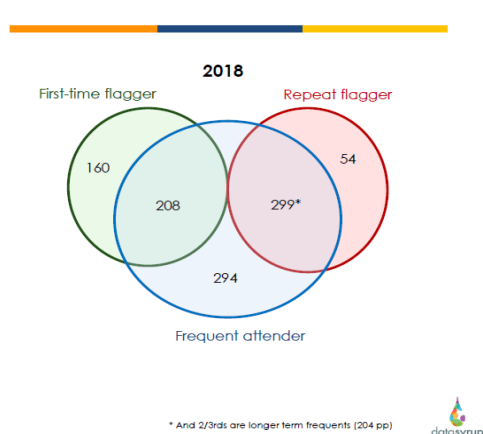


Figure A3 number of long term conditions in first flagging patients

A2.2 Overlap between clustered contacts (> 6 in 3 months) and all-year frequent (> 10 per year) attenders

When developing criteria for ‘flagging’ patients, we tried various combinations of time periods and numbers of attendances (ie clustered together or spread over the year) and compared these with ‘frequent attenders’ who attended more than 10 times in a year. Figures A4 and A5 below show the relationship between first time ‘flaggers’, repeat flaggers (flagging in > one calendar year) and frequently attending patients whose appointments may or may not cluster to 6 or more in 3 months.

The Venn diagram shows that 85% of repeat flaggers were also in the frequent attender category while only 57% of the first flaggers were frequent attenders. The 43% of first flagging patients who were not frequent attenders were our primary target group: previously low use patients who were assumed to have been healthy who had started to consult more often. The clinical, socio-demographic and personal characteristics of patients in each category are described in the case vignettes below.



first time flagging each month

Q: How many patients flag up each month having 6 or more GP appointment in the last 3 months? (but did not flag in the previous month)

A: About 80 patients* flag each month, which is 35 “first time flaggers” and 45 “repeat flaggers” (have flagged before – over a month ago)

First flagging per month (6+ in 3 months)

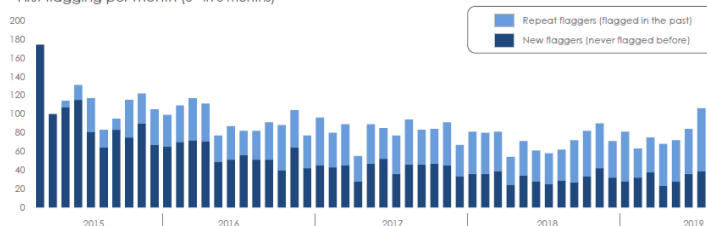


Figure A4: relationship between first flaggers, repeat flaggers and frequent attender patients

Figure A5 relative proportion of first flaggers (dark blue) and repeat flaggers (light blue) identified each month

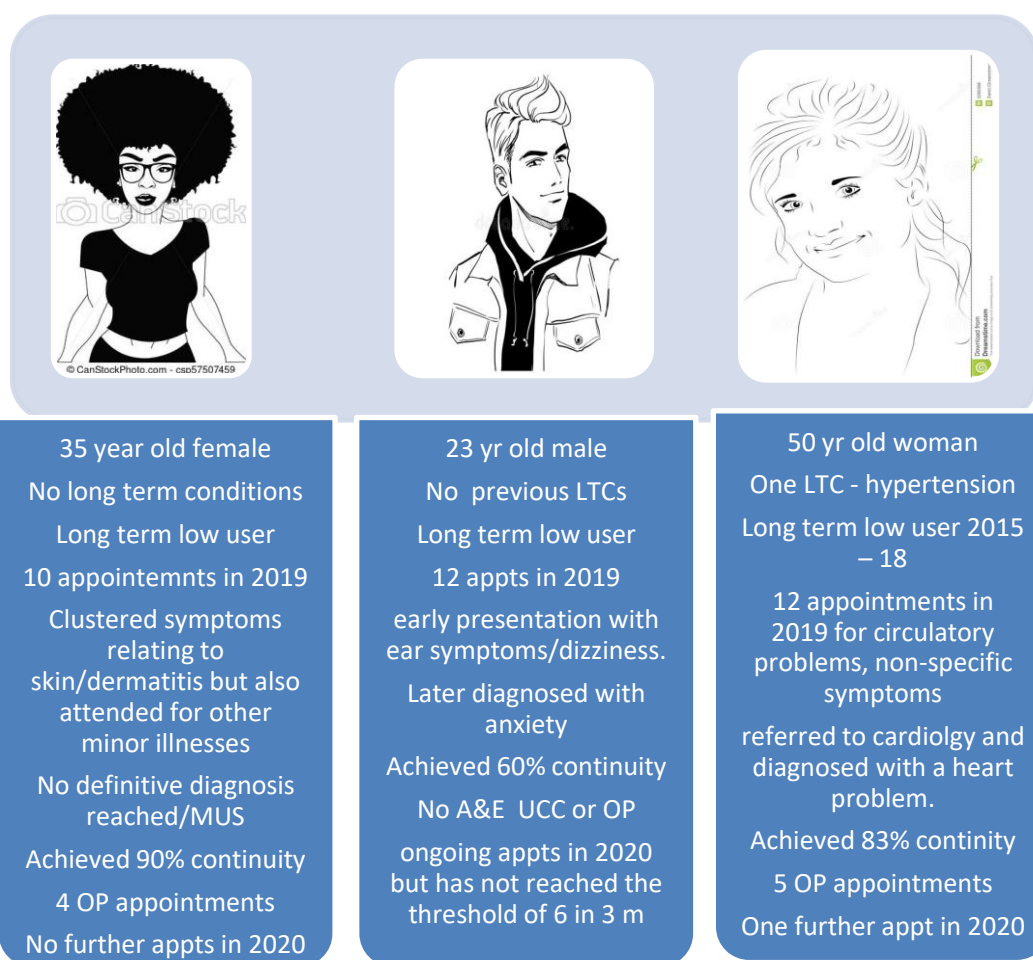
A2.3 Illustrative, anonymised ‘case studies’ of different types of flagged patients

Among the 10% of patients who attended more than 6 times a year, the Venn diagram in figure A4 above describes the relationship between first time flaggers, repeat flaggers and long-term frequent users. Although there was overlap between the socio demographic and clinical characteristics of the three groups, they had some distinguishing features too.

We reviewed 150 notes of patients who had flagged for having 6 or more appointments in 3 months during 2019. 110 notes were of patients who had only flagged once (our main target population for this project). We also reviewed 10 additional notes each for patients who had flagged two three, four and five times in the years since 2015.

First time flaggers in 2019

Out of 110 patients who were allocated for continuity and whose notes were reviewed 32 (29%) had multiple appointments for unrelated symptoms (for example cough, rash, dizziness, abdominal pain) or for planned interventions (such as dressing changes or injections) that did not require continuity with a GP. Some flagged patients had repeated clusters of consultations for relatively minor problems (for example 3 visits for an ongoing ear problem and 3 for a whiplash injury) while others had longer lasting clusters of related systems that needed investigation to reach a diagnosis.



MUS = medically unexplained symptoms. OP = out patient. UCC = Urgent care centre. LTC = long term condition

Repeat flaggers during 2 or 3 years 2015 – 2019

This group was more likely to include recurrences of longstanding problems some of which were flare ups of episodic conditions such as ulcerative colitis or migraines and others were recurrent symptoms such as low back pain in association with social stressors such as housing, financial or relationship problems. Fifteen of the 20 patients reviewed reported symptoms of pain (6 of these also had mental health problems) and 7 were noted to have safeguarding issues including domestic violence and drug dependence. This suggests that additional 'categoric' criteria are needed (alongside the 6 in 3 month criterion for continuity) such as being a victim of domestic violence, or drug and alcohol dependence. This issue has not yet been discussed in a practice meeting or clinical meeting due to the Covid pandemic.

Only one of the 7 'safeguarding' patients achieved 50% continuity (see vignette below). The older patient below who did not receive continuity was seen several times in the practice's walk in clinic which provides rapid access for acute problems but makes it harder to maintain continuity.



56 yr old female Flagged in 2015, 2016, 2019

3 – 22 appts per year
One LTC (depression)
and thyroid problems
Initial flagging due to
mixed presentations of
low back pain and
housing issues.

Later presentation for
low back pain after
experiencing domestic
violence and later still
for thyroid problems

50% continuity in 2019
5 OP appointments



70 year old male Flagged in 2015, 2017, 2019

2 – 11 appts per year
5 LTC, CHD, hypertension,
stroke, arthritis, obesity
First year flagging related
to chest pain and angina.

2017 flagging due to
unrelated self limiting
symptom.

2019 flagging due to
ongoing abdominal pain
needing surgical treatment

Low attender in 2016,
2018

45% continuity in 2019
7 OP appointments



11 yr old boy Flagged in 2017, 2019

2 - 11 appts per year
One LTC - Diabetes

First year flagging
related to abdo pain ,
tiredness, minor illness,
hearing, skin diabetes

Low attendance during
2018

Second year flagging
due to chest pain, abdo
pain, social issues,
diabetes.

38% continuity in 2019
21 A&E, hospital and
outpatient contacts

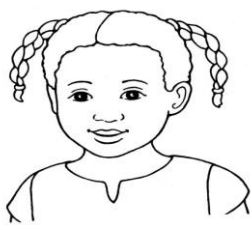


LTC = long term condition. OP = outpatients CHD = coronary heart disease

Multiple year frequent attenders

This group (flagging in 4 or 5 of the years 2015-2019) included 164 patients, of whom 12 (7%) were under 16; 115 (70%) were aged 16-64 and 38 (23%) were over 65. Among children, 5 had asthma and 1 had asthma and epilepsy and the rest had no recorded LTCs.

Among the 17-64 age group, 9 had no LTC. 31 had one LTC (mainly hypertension or depression); 22 had 2 LTCs (50% mixed physical & mental health problems, 35% with physical problems only and 15% with mental health problems only). Only 53 (46%) had 3 or more long term conditions which is perhaps consistent with the stereotype of poly morbid patients that would benefit from continuity.

Among long term frequent attenders over 65 years, all but 6 had 4 or more long term conditions, consistent with the archetype of patient requiring continuity and care coordination as poly morbid older patients. 50% had only physical LTCs and 50% had mixed physical and mental health conditions.

		
<p>4 year old girl 1 LTC - asthma 11 - 24 appts/ year Not tagged for continuity Mainly seen in walk in clinic Achieved only 37% microteam continuity Presented with skin or respiratory symptoms Asthma as a driver of frequent attendance 1 UCC attendance No A&E/OP/hospital admissions</p>	<p>33 yo woman 3 LTCs (mixed MH and physical) 12 - 33 appts/year Tagged for continuity Achieved 47% micro-team continuity Mixed presentations: gynae/pelvic pain, urology, depression, symptoms medically unexplained/No definitive diagnosis reached 9 A&E attends, 9 hospital admissions</p>	<p>75 yo man. 6 LTCs: all physical conditions DM, OA, stroke, CHD, PAD hypertension 8 - 26 Appts/year Tagged for continuity Achieved 63% micro-team continuity mixed presentations: urology, MSK, neurology, circulatory 3 outpatient appts No A&E or UCC No hospital admissions</p>

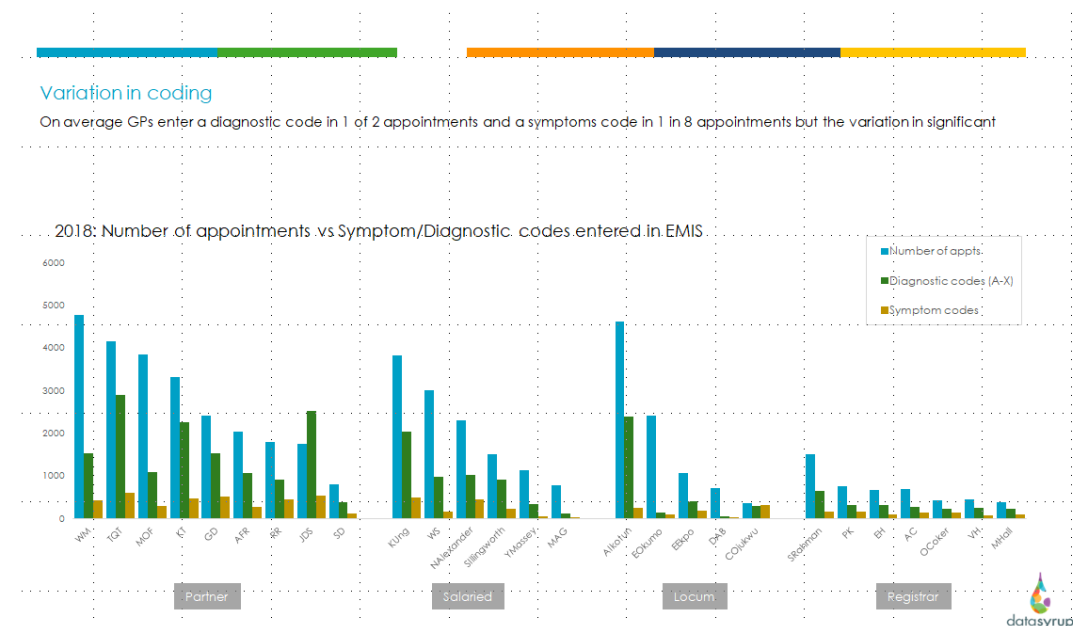
MH=Mental Health. OA = osteoarthritis, DM = diabetes melitus. CHD = Coronary heart disease. PAD = Peripheral arter disease. MSK = Musculo skeletal

A2.4 Significant variation in coding

Coding of symptoms and diagnoses varied across GPs, with some doctors using free text to record all but confirmed diagnoses (thus not recording any symptoms). This made it impossible to identify continuity patients through a combination of frequency of attendance and clusters of symptoms

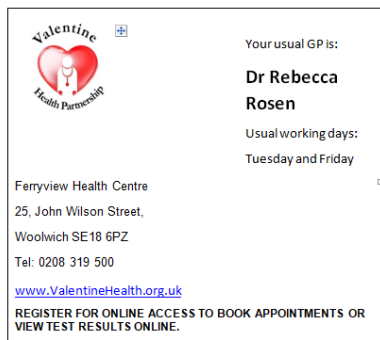
Coding variation among GPs was discussed during an all staff development meeting and some of the GP trainers in the practice taught registrars not to add a problem code until a particular diagnosis had been confirmed. On discussion, this habit had extended to 'free texting' symptom codes, making it impossible to run a search for all patients with, for example 'cough' or 'abdominal pain'. The group acknowledged that this could create problems if a public health need emerged to identify all patients with a particular symptom.

We noted this variation between clinicians' practice styles but did not prioritise it as an area for change during the project and developed a different method to identify 'flagged' patients for continuity.

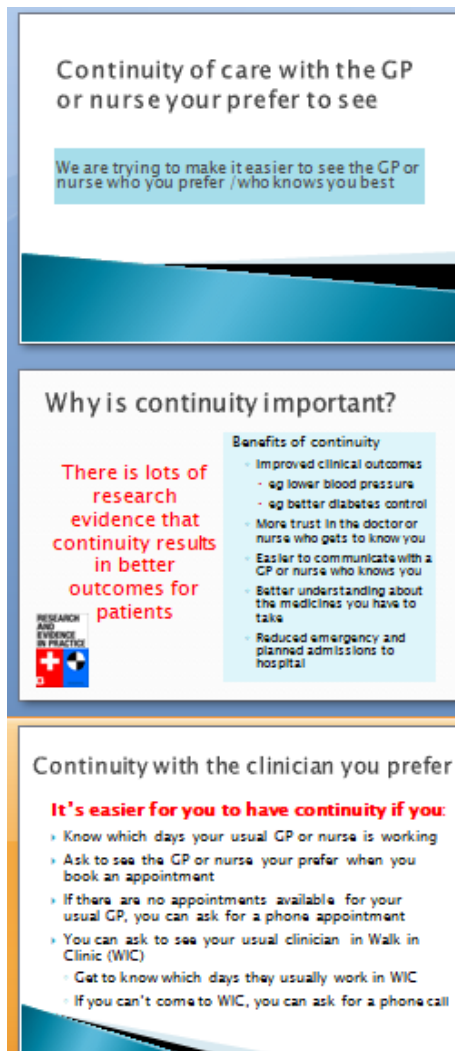


Appendix 3: Resources to support continuity

A3.1 Business cards with usual working days of each GP



A3.2 Slides to inform patients about continuity in the waiting room



CONTINUITY PATIENTS

What should I be doing with them?

Continuity patients in this project have ongoing symptoms and conditions for which we may not yet know the cause or where we are trying to find the best treatment plan. Some have symptoms for which there is no perfect treatment and the challenge may be to 'de-medicalise their care and help them to live well with their condition. Research shows this is easier if they know and trust their GP and that continuity can result in higher patient & clinician satisfaction and better clinical outcomes. Background resources provided in pages 2 – 4.

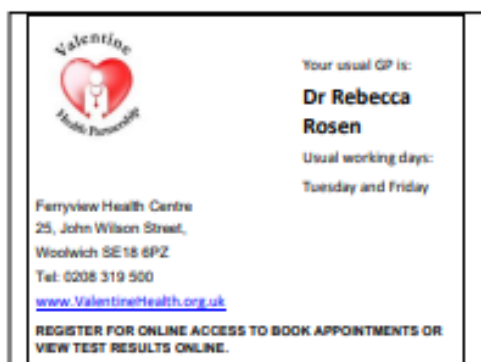
1. 'Educate' patients

What you can do:

- ▶ Explain why continuity can be important
- ▶ Explain how to achieve continuity
- ▶ Use your 'visiting cards'

What the wider practice is doing

- ▶ Promoting continuity on waiting room TV
- ▶ Receptionists encouraging tagged patients to book with their named GP



2. Take professional responsibility

If a continuity patient has ongoing symptoms/ conditions for which you don't yet know the cause, take **personal responsibility for following up test results/ making a diagnosis/ creating a treatment plan.**

Many of our complaints and missed/ delayed diagnoses occur because these patient spin around many GPs and no-one person puts all the results together or notices they are deteriorating.

- ▶ Take time to review their notes/get to know their current and previous problems
- ▶ Follow up on results (don't send pts back to a random GP who doesn't know them)
- ▶ Be conscious of whether they have had similar symptoms before. Decide if it's worth further investigation or should you try to de-medicalise their care (see below)
- ▶ Get to know the patient – is their current state typical for them? If not, why not?

3. Collaborate with your buddy group

- ▶ **GET 2nd OPINION IF YOU ARE NOT SURE WHAT TO DO (FROM BUDDY OR OTHER GP)**
- ▶ Do a short hand over of 'active' continuity pts if you go on AL
- ▶ Use the continuity/micro-team template in EMIS to share information
- ▶ Get to know each other's continuity patients so you can cross-cover each other

SUPPORTING RESOURCES FOR PROVIDING CONTINUITY OF CARE

1. SCRIPT TO ENCOURAGE CONTINUITY FOR SELECTED PATIENTS

If you think a patient might benefit from continuity but you're not sure what to say to say to them, here is one possible 'script'

- I see that you have been coming to see us more frequently in recent months. When you come to the GP more often you will tend to have better outcomes if stick with just one or two doctors. you won't have to keep repeating your story each time you come and it helps us to get to know you better. Can I suggest that until we get on top of your current symptoms/problem, that you stick with me [or the GP they usually see]
- I am in the practice on [state the days] so you can ask to book an appointment with me on those days (Give visiting card). Or give days that their usual GP works
- If you can't book an appointment with me, you can use the walk in clinic on the days shown on the card. Tell the WIC receptionists that you want to see me or ask for a phone call, and I will call you back.

2) EVIDENCE BASE FOR THE OUTCOMES OF CONTINUITY OF CARE



Source: Palmer, Hemmings, Rosen and others (2018) *Improving access and continuity in general practice*. Nuffield Trust

3) SUB GROUPS OF CONTINUITY PATIENTS

We have reviewed the notes of many of the patients on the continuity lists and seen a few characteristics that may be helpful to understand:

- **Repeat attendances for new physical symptoms**

- Eg mix of abdo pain and pelvic pain
- Eg headaches, tiredness, backpain
- Eg multiple joint and MSK symptoms

Some of our complaints and missed/delayed diagnoses (including missed cancers) arise because people with new and unexpected symptoms see several different GPs. Nobody feels responsible for reaching a firm diagnosis. Different people order different tests but don't dig deeper if a result comes back normal.

- **'Flare up' of previous physical symptoms**

- If an established diagnosis (eg endometriosis or Crohns) flares up. **You could consider buddy group 'management continuity'** where you all follow a single treatment plan rather than 'relational continuity' where the patient is encouraged to stick with a single GP

- **Flare up of mental health problems**

- Continuity will help you to understand the personal, family and social factors which underlie their current symptoms

- **Mix of physical and mental health symptoms**

- Long standing physical problems such as abdominal or pelvic pain or headaches which become worse when social or personal stressors affect mental health / ability to cope

- **Children who attend frequently with worried parents**

- We have allocated all kids who've attended more than 6 times in 6 months to a continuity doctor with the aim of using consistent advice and education to build parental confidence to self manage.

4) METHODS TO HELP CONTINUITY PATIENTS TO LIVE WITH ONGOING SYMPTOMS

Some patients on your continuity list will present with new or recurrent physical symptoms that have been fully investigated (either currently or in the past). You may conclude that:

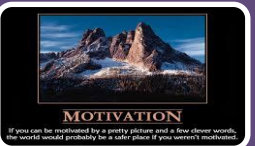
- appropriate treatments are in place but the symptoms or conditions are likely to persist.
- patient perception about the severity of symptoms is related to health anxiety
- there is no clear medical explanation for the symptoms (can be coded as MUS – medically unexplained symptoms) so you need consider either symptom control or learning to live with the symptoms
- The underlying cause of their symptoms are non-medical (eg work stress, financial pressures)

In these situations, you may want to explore options for '**de-medicalising**' the response to their condition. Here are some options



Medically unexplained symptoms

- Explain MUS concept to patient
- Identify and treat psychological co-morbidities (eg anxiety)



Motivational support

- Key aim is to encourage patient to make a behavioural change



Solution focused interviews

- conversations to identify patients' visions of solutions
- focus on things that have made them feel better

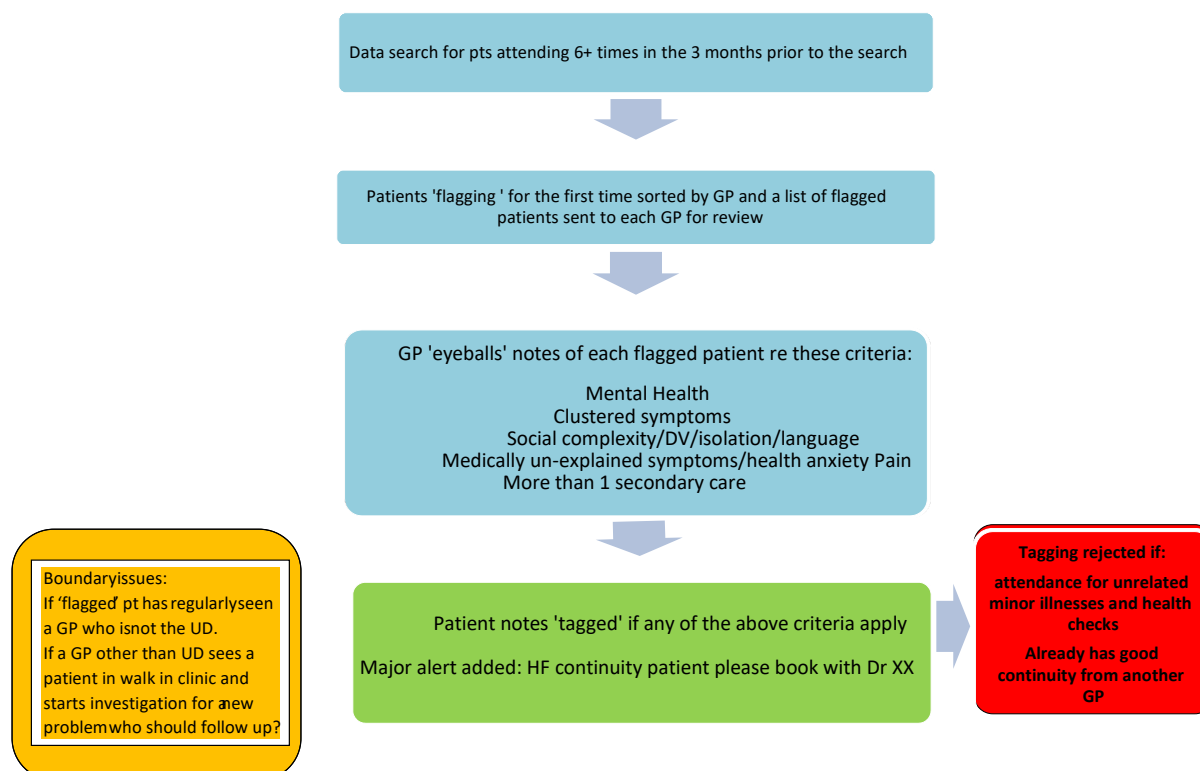


Social prescribing

- Refer to join the staying healthy gardening group
- Refer to social prescribers

3.4 Flow chart for Identifying patients to be tagged for continuity and allocating to the most appropriate GP for continuity

The flow chart shows the process for identifying and reviewing patients flagged in the data search who might benefit from continuity. Those who meet the criteria for continuity have a major alert added to their notes. This appears when receptionists load the medical record to book an appointment.



There were three situations in which this process created some tension

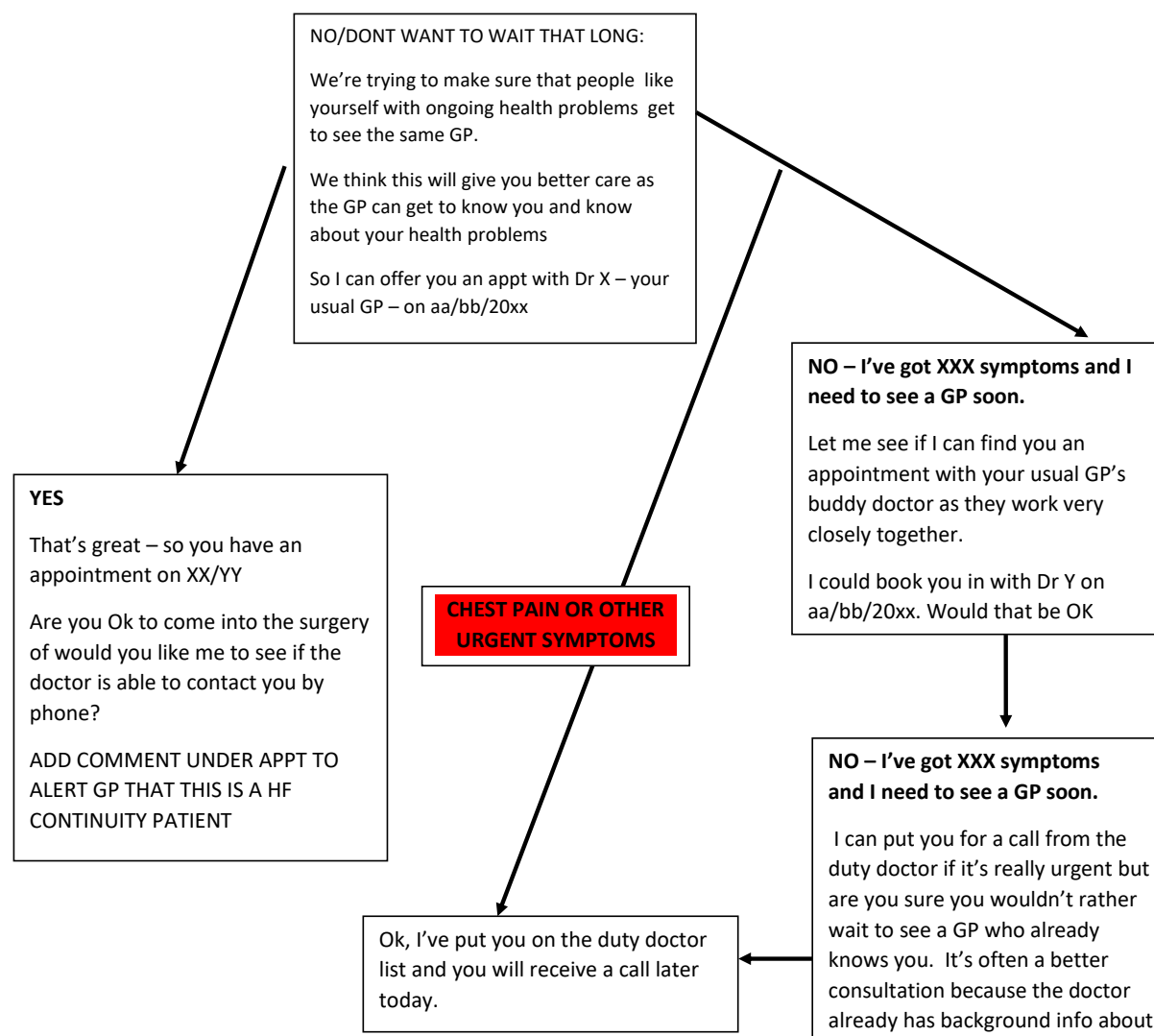
- 1) A GP other than the doctor named as usual doctor (UD) in the EMIS record consulted with a patient during the daily acute 'walk in clinic' and started some investigations for a problem for which continuity of care might improve outcomes and wanted the UD to follow up.
- 2) A patient who had consulted several times for the same symptoms but had seen one GP – not the patient's UD - more often than others. If the most frequently seen GP believed that patient would benefit from continuity but didn't want to take over as that person's UD
- 3) The UD reviews a flagged patient but notes they appear to have seen another GP on multiple occasions and thinks that person would be more appropriate as the continuity GP.

The tensions arose because some GPs through others would 'dump' complicated patients on to them, creating additional work. In contrast, some GPs thought continuity reduces workload (you don't have to spend time asking about health and personal background) and that if each GP agreed to provide continuity to their own patients the extra workload would balance but there would be less chance of seeing complex patients you don't know.

3.5 Suggested script for receptionists: booking continuity patients with their named GP.

Continuity patient phones to request an appointment and you see their notes have been tagged

I'd like to try to book you with your Dr X who is your own doctor and s/he next has an appointment on XX/20XX. Would that be ok?



3.6 EMIS Continuity template for sharing physical, social and functional information between microteam members

The free text boxes in the first screen shot relating to medication changes, main symptoms, goals and social circumstances are the main elements defined in the micro-team meeting as helping to provide buddy group cover for a continuity patient

Continuity Patient Template

This clinical template uses the following CE-compliant calculator: QRISK2. Using this calculator in your own clinical templates is entirely the responsibility of the organisation and its users. Some codes in the template may not be considered in the score calculations. EMIS Health recommends that you use the CE-compliant EMIS-authored QRISK2 template, which is accessed from the EMIS Library.

Diary Entry Please put 12m in date box before ticking

Follow Up	02-Jul-2020	No previous entry
<input type="checkbox"/> Chronic disease annual review	Text	No previous entry
<input type="checkbox"/> Chronic disease management annual review completed	Text	No previous entry
<input type="checkbox"/> Agreement of care plan and repeat prescription monitoring	Text	No previous entry
<input type="checkbox"/> Medication changed	02-Jul-2020 Text	08-Dec-2011
<input type="checkbox"/> Main symptoms	Text	No previous entry
<input type="checkbox"/> Goal identification	Text	No previous entry
<input type="checkbox"/> Housebound	Text	14-Apr-2005
<input type="checkbox"/> Social/personal history NOS	Text	No previous entry
<input type="checkbox"/> Mobility - assessment	Text	No previous entry
<input type="checkbox"/> Occupations	Text	No previous entry
<input type="checkbox"/> Patient's next of kin	Text	03-Aug-2011
<input type="checkbox"/> Has care/s carer	Text	23-Aug-2005 Carer

[Link to all Lambeth CCG local guidelines](#)

Reviews

<input type="checkbox"/> Flu Vaccination		No previous entry
<input type="checkbox"/> Influenza Vaccination		06-Nov-2009
<input type="checkbox"/> Pneumococcal Vaccination		07-Apr-2008 Pneumococ...
<input type="checkbox"/> Ethnicity		07-Aug-2012 British or mix...
<input type="checkbox"/> Main spoken language		07-Aug-2012 Main spoken ...

Body Parameters

Latest Contacts

Body Parameters

Blood Pressure		2060 130/60 mm Hg
O/E - pulse rate		20-Mar-2012 100 beats/min
Pulse Character		No previous entry
O/E - height		04-Feb-2015 55 cm
O/E - weight		04-Feb-2015 60 kg
Ideal Weight		10-Mar-2011 59.2 kg
Body Mass Index		04-Feb-2015 198.35 kg/m2
Abdominal circumference		No previous entry

Cardiovascular Risk

[CV Risk graphic demo](#)
[Exercise Advice and Goals Sheet](#)

☐ "Cardiovascular disease risk assessment done"

☐ % over 10 years [View](#)

Latest Contacts

Summary Consultations Medication Problems Investigations Care History Diary Documents Referrals Growth Charts New Consultation

Report Management - 42 SCR - 205 Test Requests - 320 Documents - 2 GP2GP - 12 (12) Medicine Management - 18386 (18386) Registration - 451 (4) Lab Reports - 7 (1) Tasks - 48 (18) Mail Inbox - 49

You have 1 screen message. Click this link to view.

Deceased **MOUSE, Michael (Mr)** Born 23-Nov-2005 Gender Male NHS No. 999 000 5249 Usual GP MOFFAT, Mark (Dr) Died Unknown Age at Death Unknown

Continuity Patient Template

This clinical template uses the following CE-compliant calculator: QRISK2. Using this calculator in your own clinical templates is entirely the responsibility of the organisation and its users. Some codes in the template may not be considered in the score calculations. EMIS Health recommends that you use the CE-compliant EMIS-authored QRISK2 template, which is accessed from the EMIS Library.

Cardiovascular Risk

CV Risk graphic demo

Exercise Advice and Goals Sheet

*Cardiovascular disease risk assessment done

QRISK 10 y CVD Risk % over 10 years Calculate View

Serum total cholesterol level mmol/L 02-Jul-2020 13-Jan-2009 6 mmol/L

Serum cholesterol mmol/L 02-Jul-2020 26-Feb-2009 6 mmol/L

Serum HDL cholesterol level mmol/L 02-Jul-2020 13-Jan-2009 1.5 mmol/L

Serum cholesterol/HDL ratio No previous entry

Cholesterol /HDL ratio needs to be < 0.35

Random blood sugar No previous entry

Haemoglobin A1c level - IFCC standardised mmol/mol 02-Jul-2020 No previous entry

HbA1c level (DCCT aligned) % No previous entry

Renal Function

GFR mL/min 02-Jul-2020 01-Jun-2006 95 mL/min

ACR mg/mmol 02-Jul-2020 01-Feb-2007 3 mg/mmol

Serum prostate specific antigen level u/L 02-Jul-2020 No previous entry

Prostate specific antigen nanogram/mL 02-Jul-2020 No previous entry

Latest Contacts

NHS Clinical ABBAS, Samah (Misa) Organisation: Valentine Health Partnership Location: Ferryview Health Centre

In Consultation Alerts

13:57 02/07/2020

Summary Consultations Medication Problems Investigations Care History Diary Documents Referrals Growth Charts New Consultation

Report Management - 42 SCR - 205 Test Requests - 320 Documents - 2 GP2GP - 12 (12) Medicine Management - 18386 (18386) Registration - 451 (4) Lab Reports - 7 (1) Tasks - 48 (18) Mail Inbox - 49

You have 1 screen message. Click this link to view.

Deceased **MOUSE, Michael (Mr)** Born 23-Nov-2005 Gender Male NHS No. 999 000 5249 Usual GP MOFFAT, Mark (Dr) Died Unknown Age at Death Unknown

Continuity Patient Template

This clinical template uses the following CE-compliant calculator: QRISK2. Using this calculator in your own clinical templates is entirely the responsibility of the organisation and its users. Some codes in the template may not be considered in the score calculations. EMIS Health recommends that you use the CE-compliant EMIS-authored QRISK2 template, which is accessed from the EMIS Library.

standardised

HbA1c level (DCCT aligned) % No previous entry

Renal Function

GFR mL/min 02-Jul-2020 01-Jun-2006 95 mL/min

ACR mg/mmol 02-Jul-2020 01-Feb-2007 3 mg/mmol

Serum prostate specific antigen level u/L 02-Jul-2020 No previous entry

Prostate specific antigen nanogram/mL 02-Jul-2020 No previous entry

Smoking Status & Alcohol

Smoking Status 08-Dec-2011 Never smoke...

Alcohol consumption U/week 15-Jul-2009 5 U/week

H/O: recreational drug use No previous entry

Women's Health

Smear Taken No previous entry

Smear Result 15-Sep-2006 Cervical sme...

Diary Entry 15-Sep-2006

Assessments

Frail elderly assessment 02-Jul-2020 No previous entry

Case management by GP 02-Jul-2020 No previous entry

Latest Contacts

NHS Clinical ABBAS, Samah (Misa) Organisation: Valentine Health Partnership Location: Ferryview Health Centre

In Consultation Alerts

13:58 02/07/2020

Appendix 4: Key themes from 'internal' patient and staff surveys conducted by the project team

A4.1 Summary of structured patient interviews:

- 17/20 know how get continuity with their preferred GP
- 6/20 do not want continuity, preferring to access any GP at a time suitable for them/their needs. They work around their health and needs rather than working around ability to see named GP hence will access UCC /A&E if unable to see a GP
- Trade-off for continuity: will see known GP for a LTC + pre-existing conditions for continuity and follow up-; however happy to see any GP for new problems.
- Perceptions of acute/illness warrants deviating from continuity- immediate access with 1st available GP as trade off to getting seen for acute/emergency
- Positives of continuity: Established relationships/ time saving/ comfort/confidence/ safety and trust
- Trust in 1 Dr who will listen as opposed to several who won't/ value attributed to active listening
- Barriers to achieving continuity: limited availability of appointments/suitable access
- Some perceive continuity to be a barrier to receiving care when they need/want it
- Some patients seem to assume GP's can rapidly review their medical history and as such eliminating the need for continuity with the assumption their GP will rapidly review their entire Hx
- Negatives of continuity: limiting access to care. Preference to see any GP knowing if limiting themselves to 1 or 2 doctors, they would never be able to get an appointment

Suggestions for achieving continuity at a practice level

- by ensuring availability of appointments/ and allocating smaller 'case loads' for doctors to ensure continuity
- Explain which doctors offer particular services.
- Better triage/messages on TV screen / promotions/ info re services provided by who, pharmacists etc
- Promote working days of doctors
- **Patient education:** more information around which doctors are covering Walk-in Clinic. Triage patient's to see whether they are best suited to see a nurse/physio/ pharmacist in order to make the right choices
- Increased appointments for professionals i.e. weekends/evenings
- Inform patients of availability for continuity with preferred GP

A 4.2 Summary of responses to end-of-project staff survey

Responses from 7 receptionists, 14 GPs, 6 nurses, 2 clinical assistants and 1 other staff member.

- 93% of respondents reported that since the start of the continuity project, they are more likely to inform patients with ongoing problems about the benefits of continuity and/or suggest they stick to seeing a particular GP
- 83% of respondents thought that the Health Foundation project has enabled patients who are 'tagged' for continuity to see their named GP or a member of their micro team most of the time or some of the time
- Of 14 GPs who responded, 8 reported using visiting cards (see Appendix 3) to increase patient awareness about achieving continuity while 6 had not used them
- 17% of respondents feel that the continuity project has increased their workload while 23% felt it had reduced their workload, 30% felt their workload was not affected and 30% were unsure of effect on workload
- 48% reported feeling a greater sense of professional responsibility to achieve a good outcome for some or all of their continuity patients, while 35% did not feel an increased sense of responsibility and 17% were unsure of impact on sense of responsibility.
- In response to the question (to clinicians only) 'Do you think the Health Foundation project 'criterion' of providing continuity for patients who consult more than 6 times in 3 months was useful for any of the following reasons', the responses were:

	YES	NO	NOT SURE	TOTAL RESPONDENTS
Allowing shorter consultations with these patients because you already know them	61.90% 13	23.81% 5	14.29% 3	21
Reducing the likelihood of consulting with a complex patient about whom you know nothing	90.48% 19	9.52% 2	0.00% 0	21
increasing trust between the GP and these patients	80.95% 17	4.76% 1	14.29% 3	21
Making it easier to have difficult conversations with these patients	76.19% 16	14.29% 3	9.52% 2	21
Managing 'clinical uncertainty' in these patients without referring to another service	61.90% 13	14.29% 3	23.81% 5	21
Making it easier to provide follow up by telephone or video consultation	76.19% 16	14.29% 3	9.52% 2	21

Respondent views on how the project affected patients were as follows:

	NO PATIENTS	SOME PATIENTS	MOST PATIENTS	DON'T KNOW	TOTAL
They find it easier to see or speak to a doctor who knows them	0.00% 0	48.15% 13	44.44% 12	7.41% 2	27
They have higher trust in their GP	0.00% 0	48.15% 13	37.04% 10	14.81% 4	27
They have noticed a different in the nature of their consultation with their GP	3.70% 1	40.74% 11	22.22% 6	33.33% 9	27
No difference at all	7.69% 2	50.00% 13	11.54% 3	30.77% 8	26

Appendix 5: Baseline staff and patient surveys undertaken by external evaluators

A5.1 Baseline staff survey



Baseline Staff Survey

Highlight Report - Valentine Health Partnership

26 November 2019

Contents

Valentine Health Partnership – Baseline staff survey highlights	38
1.1 Who completed the survey?	38
1.2 Importance of Continuity of Care	38
1.3 Strategic Priorities	39
1.4 Advantages and disadvantages of continuity of care in general practice	39
1.4.1 Advantages	39
1.4.2 Disadvantages	41

Tables

Table 1: Advantages of continuity of care in general practice – Valentine Health Partnership	40
Table 2: Disadvantages of continuity of care – Valentine Health Partnership	41

Figures

Figure 1: Importance of continuity of care in general practice - the views of Valentine Health Partnership staff	38
Figure 2: Priority groups for continuity of care	39
Figure 3: Highest-ranked strategic priorities	39

Valentine Health Partnership – Baseline staff survey highlights

Who completed the survey?

There were 23 respondents to the survey; 8 GPs, 3 wider clinical team and 12 practice management and administration team. To maintain anonymity throughout the results, we will not provide a breakdown of views of staff groups or per practice but instead would direct the reader programme level insights for trends across staff groups.

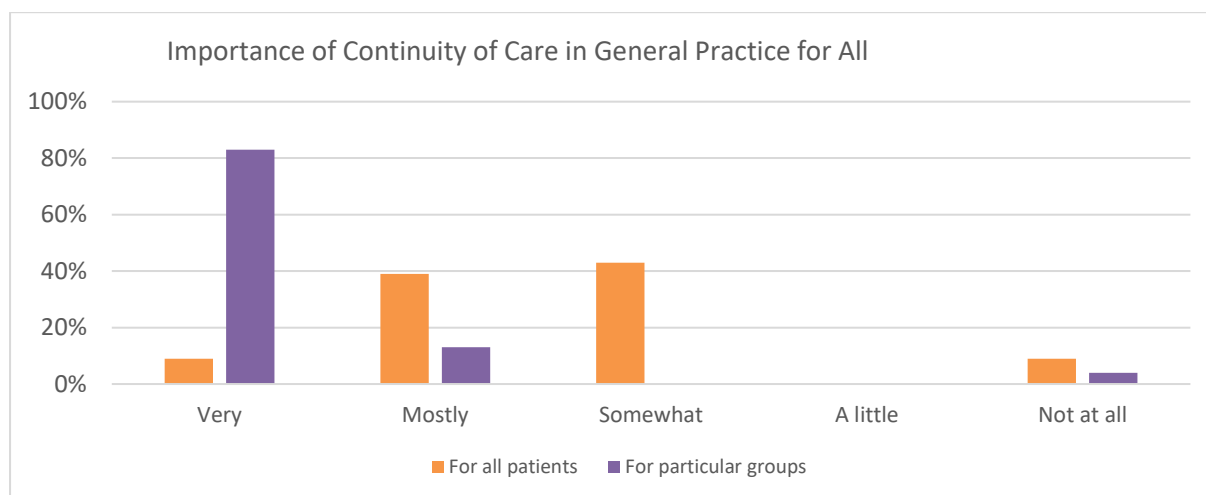
Importance of Continuity of Care

Staff were asked to rate how important they think it is for patients to have continuity of care within General Practice. Questions were posed to distinguish difference of views on the importance of continuity of care for *all* patients and for a selected group of patients. This was measure on a five-point Likert scale, ranging from “very important” to “not at all” and is depicted in **Error! Reference source not found.**

For all patients, 9% of respondents believed that continuity of care is “very important”, with a further 39% rating continuity as “mostly important”. 9% respondents considered that it was “not at all” important.

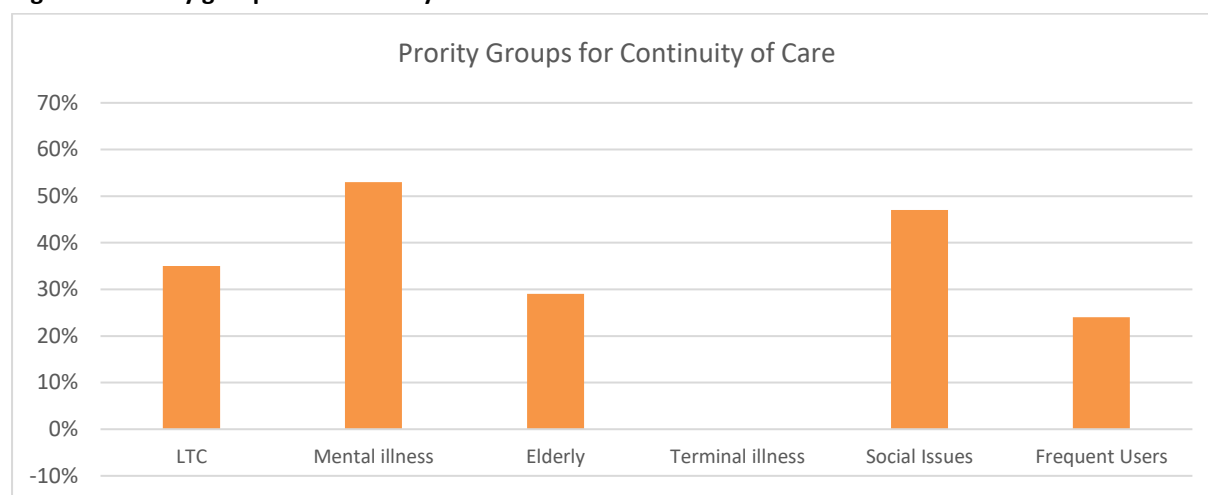
The importance of continuity of care increases when staff are asked about particular groups of patients; 83% of respondents state that “very important” for particular groups of patients, with a further 13% describing it as “mostly important”.

Figure 1: Importance of continuity of care in general practice - the views of Valentine Health Partnership staff



Staff were asked to describe the characteristics of patients in this group. Figure 2 shows the most common descriptions.

Figure 2: Priority groups for continuity of care

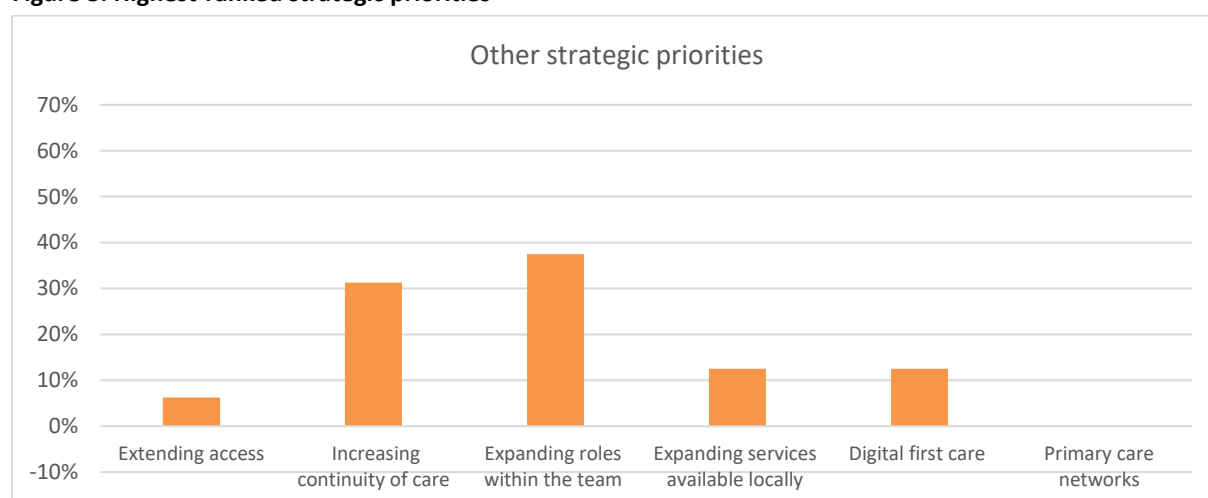


Strategic Priorities

To understand how staff view continuity of care within the context of other competing priorities, six key priorities were taken from the NHS Long Term Plan and GP Forward View. Staff were asked to rank the three priorities which they believed to be most important.

Valentine Health Partnership staff ranked 'expanding team roles' as the top ranked priority, followed by 'increasing continuity of care'.

Figure 3: Highest-ranked strategic priorities



A free-text box was provided for staff to give details about any other strategic priorities in their place of work and examples include:

- Growing the practice list
- Retaining good staff members.

Advantages and disadvantages of continuity of care in general practice

Advantages

Staff were asked to describe, if any, the advantages of continuity of care. Responses underwent thematic analyses and comments were attributed to the seven themes outlined in Table 1.

The most commonly described advantage of continuity was described as improved patient outcomes or standard of care.

Table 1: Advantages of continuity of care in general practice – Valentine Health Partnership

Themes	%
Building trust / confidence/ a good relationship/ rapport	26%
Better patient knowledge / information	26%
Improved standard / outcomes of care/ patient outcomes	32%
Increased job satisfaction	21%
More efficient consultations	26%
Patient safety	5%
Cost savings / reduced burden on other areas of the health service	26%

Note: i.e % of respondents making comment on this theme.

An example of the quotes where Valentine Health Partnership staff describe the advantages of continuity of care are provided below.

- “Patient not having to keep going over their history if seeing different clinicians. Telephone follow-up rather than face-to-face.
- “you might also know about patient's social network, i.e., friends and family, work conditions which is important in delivering holistic care”
- “Cost effective in the long run and satisfaction for patient and clinician”
- “More efficient / shorter consultations”
- “Better outcome usually as relationship allows for greater trust and sometimes better understanding by both parties resulting in improved outcomes.”
- “better doctor and patient satisfaction”
- "helps to know somebody well if aiming to demedicalise the response to their symptoms”

Disadvantages

Staff were asked to describe, if any, the disadvantages of continuity of care. Responses underwent thematic analyses and were attributed to the eight themes outlined in Table 2. **Error! Reference source not found..**

The three most commonly described disadvantages of continuity of care are delays or restrictions in patients booking appointments, patients becoming reliant on a single GP and a lack of fresh clinical approach.

Table 2: Disadvantages of continuity of care – Valentine Health Partnership

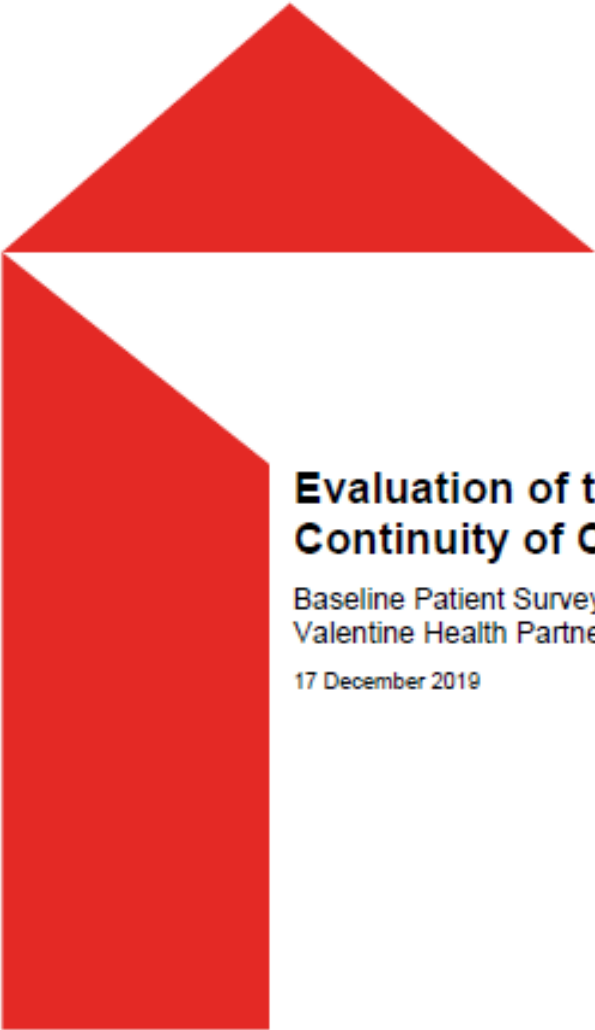
Themes	%
Delays or restrictions in patients being able to book an appointment	53%
Lack of 'fresh approach'	18%
Issues in providing cover when GPs are absent or work part time	6%
Patient becomes reliant/dependent on the same GP	35%
No disadvantages	0%
Increased or excessive workload for clinicians	0%
Need for different GP / specialism for certain issues or second opinion	12%
Not required for acute issues/ patient lack of interest	0%

Note: i.e % of respondents making comment on this theme.

An example of the quotes from Valentine Health Partnership staff which describe the disadvantages of continuity of care are provided below.

- “Difficult if clinician is part time - restricts when patients can book appointments”
- “Becoming 'blind' to alternative causes of ongoing symptoms”
- “Buddy system in place but on occasion there can be days when buddy group members are not in”
- “If there are issues that cannot be dealt with by a particular clinician and the expectation is there that you can this creates disparity and difficult situation for clinician and disappointment for patient. It can breakdown a previously good relationship and provide a platform for criticism...”
- ““Patient not knowing another clinicians and increasing workload of one clinician rather than working in MDT”
- “With high number of pts it's difficult to make it a reality - appts with usual GP might take a long time to be available”
- “Collusion”
- “Lack of knowledge and expertise if patient develops a new condition outside of the clinician's expertise”
- “Lack of other clinician input - fresh approach to an unresolved issue and challenging patients may strain relationship with clinician through high amount of exposure”.

A5.2 Baseline patient survey

A large red graphic element consisting of a triangle at the top and a rectangle below it, with a diagonal line separating the two shapes.

Evaluation of the Increasing Continuity of Care Programme

Baseline Patient Survey Highlight Report -
Valentine Health Partnership

17 December 2019

1 Valentine Health Partnership – Baseline patient survey highlights

1.1 Introduction

As part of the Increasing Continuity of Care Programme Evaluation, patient surveys are being used to gather the views of patients on the principles of continuity of care in general practice. A baseline survey has been undertaken and the second iteration will be undertaken in late 2020. These will inform the evaluation's response to the following evaluation questions focused on workforce:

- Has continuity of care increased for patients?
- How has patient awareness of continuity changed?
- What were the advantages and disadvantages of participation for different patient groups?
- What has been the wider learning about patients' views on continuity of care and how do these vary across different groups?

This short report highlights some baseline findings, relevant to this stage of the evaluation and which may formatively be of interest to the programme and its project sites. Using this data, we have gathered patient views on:

- How important continuity of care is to patients?
- What are the characteristics of those who highly rate the importance of continuity?
- What are the advantages and disadvantages of continuity of care in general practice?

As this survey has been undertaken to gather baseline views, there are questions which have not been included within this highlight report. Instead, these will be used to reflect on how opinions and environments have changed between baseline and future periods over the project.

1.2 Who completed the survey?

Patients were asked to complete the baseline survey. Surveys were shared by online methods via the Project Manager of each project and paper copies were completed by those visiting the practice. The approach to collecting the survey data was managed locally; some practices had designated team members to distribute surveys to patients, some practices placed in the waiting area.

We recognise that whilst this survey has been designed to provide a baseline position, some project sites had already begun to make early progress, thereby potentially altering baseline views. Other evaluation activities will be used to help us to understand the change that has occurred over this initial period.

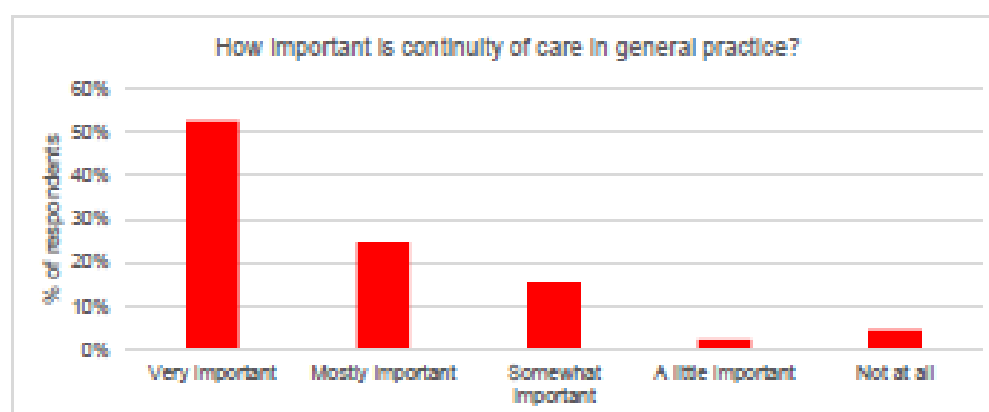
There were 244 respondents to the survey; where 243 were received by paper and 1 was completed online.

1.3 Importance of continuity of care

Patients were asked to rate how important they think it is to have continuity of care within General Practice. This was measured on a five-point Likert scale and ranged from "very Important" to "not at all".

In response, 53% of respondents believed that continuity of care is "very Important", with a further 25% rating continuity as "mostly Important".

Figure 1: Importance of continuity of care in general practice



When delving into how patients with different characteristics rated the Importance of continuity of care in general practice, we would direct you to the programme-level highlight report.

1.4 Preference for a particular GP

In line with the national GP Patient Survey, we asked patients if they had a preferred GP within their practice. Our results show that 73% of patients have a particular GP they prefer to see or speak to; of which 39% of participants had a preference for all appointments with this GP and 34% for some appointments.

Beyond stating whether they had preferred GP or not, we looked to those who have never tried to specifically request an appointment with their preferred GP. Of those who had a preferred GP, 23% had never tried to get an appointment with them.

1.5 How much of a priority is continuity of care in general practice

In keeping with the longstanding debate which recognises the intricate balance of continuity of care and access, we asked patients to what extent they agreed they would wait longer to see their preferred GP. From this, 51% of survey respondents stated that they would agree to wait longer to see their preferred GP; 35% 'strongly agreed' and 16% 'agreed'.

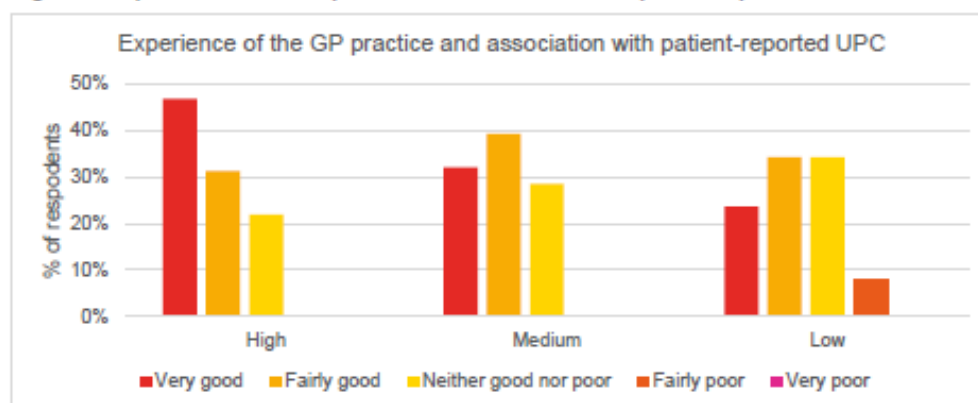
1.6 Association between continuity of care and patient satisfaction with the practice

We posed questions to patients to elucidate a patient-reported 'usual provider of care' (UPC) proxy Index to allow us to assess improvement over the lifetime of the project and also to

understand what other factors are associated with high or low continuity. In keeping with Barker et al., we stratified UPC as low for those with an index of <0.4 , moderate between 0.4 and 0.7 and high continuity >0.7 . We recognise the limitations of comparing this patient-reported proxy with the UPC and despite excluding patients who have one visit to their GP practice, we cannot account for the knowing the length of time that they have been with the practice or the reliability of their information recall.

We note that of all patients who report high continuity, 47% rate a 'very good' experience with their GP practice compared to 24% of those with low continuity. We do recognise that satisfaction may be influenced by a variety of factors, of which continuity may be just one.

Figure 2: Experience of the GP practice and association with patient-reported UPC



1.7 Outcomes of continuity of care in general practice

1.7.1 Ratings of existing benefits of continuity of care

Throughout the literature, there are well-documented examples of the outcomes of continuity of care albeit some more embedded in practice than others. We sought to test these out with patients.

We have populated Table 1 with the proportion of people who agreed that seeing the same GP resulted in the following statements.

Table 1: Ratings of existing outcomes of continuity of care in general practice

	% of patients who agreed ¹
They know my medical history	76%
I feel involved in decision about my care	72%
They are responsive to my needs and concerns	73%
I take an active role in my health and wellbeing	71%
They know me as a person	62%
I know them	65%

¹ (combining 'strongly agree' and 'agree' categories)

1.7.2 Additional patient comments

In a free text box, respondents were able to record anything else that is important to them about seeing the same GP. These comments underwent thematic analyses and the common themes were as follows:

1.7.2.1 Benefits of continuity of care

More efficient use of time

- "He will know my history and save his and our time."

Not having to repeat your story

- "Don't have to keep repeating yourself"
- "No need to explain the issue all over again to different GPs."
- "I don't have to explain myself all the time."
- "When you see the same GP you don't have to retell your medical history, saves time and patients stress/distress."

1.7.2.2 Belief that continuity of care is not required

All GPs are capable to deal with my needs

- "I don't mind because the GP I have met, help me feel very comfortable. With all GPs I meet, I received the same and right treatment "

1.7.2.3 Disadvantages of continuity of care

Access

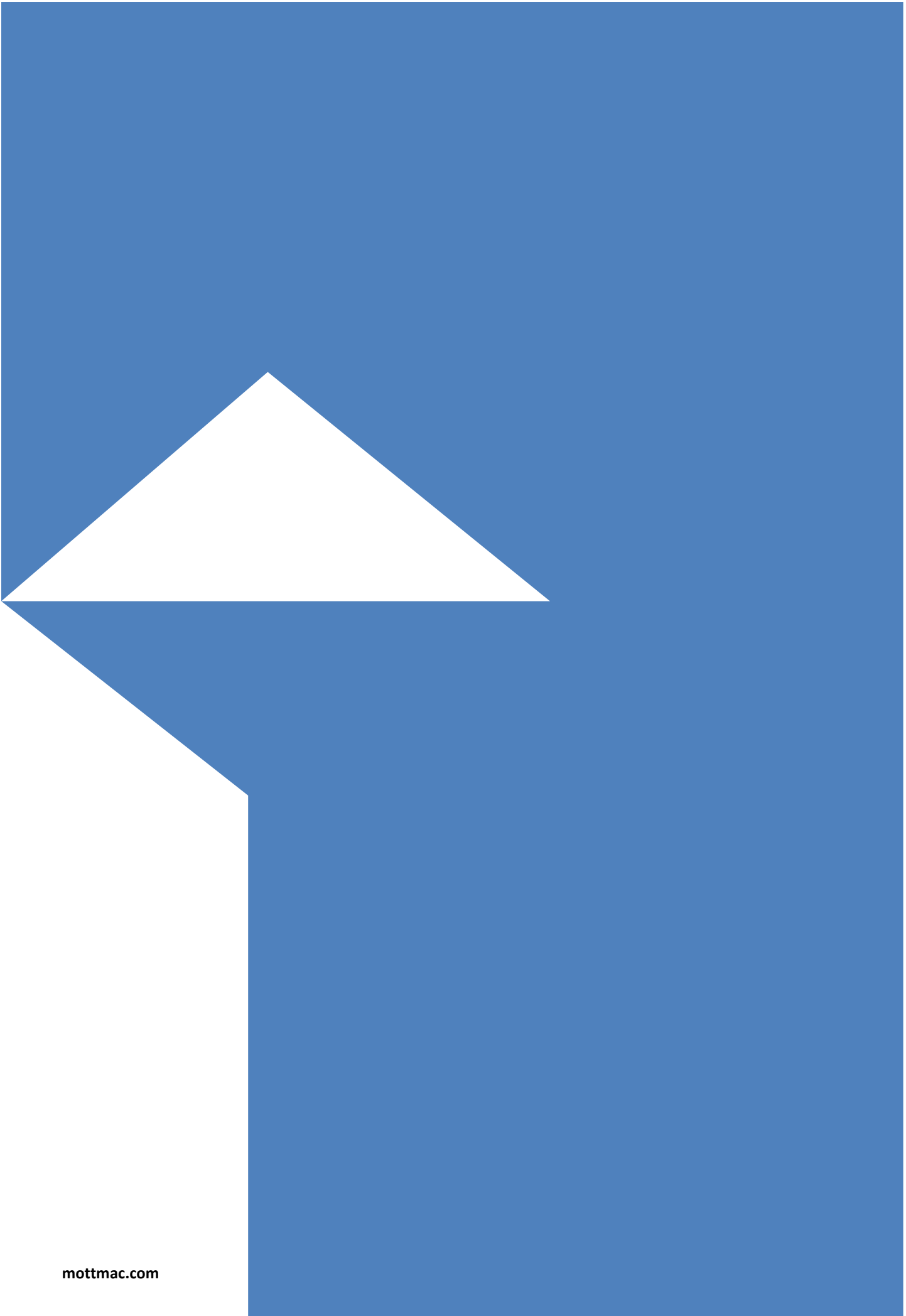
- "Sometimes, I must wait 3 weeks to get an appointment with my GP!"
- "The doctor will ask for you to come back to them back you can't get an appointment."

Lack of consistency in approach

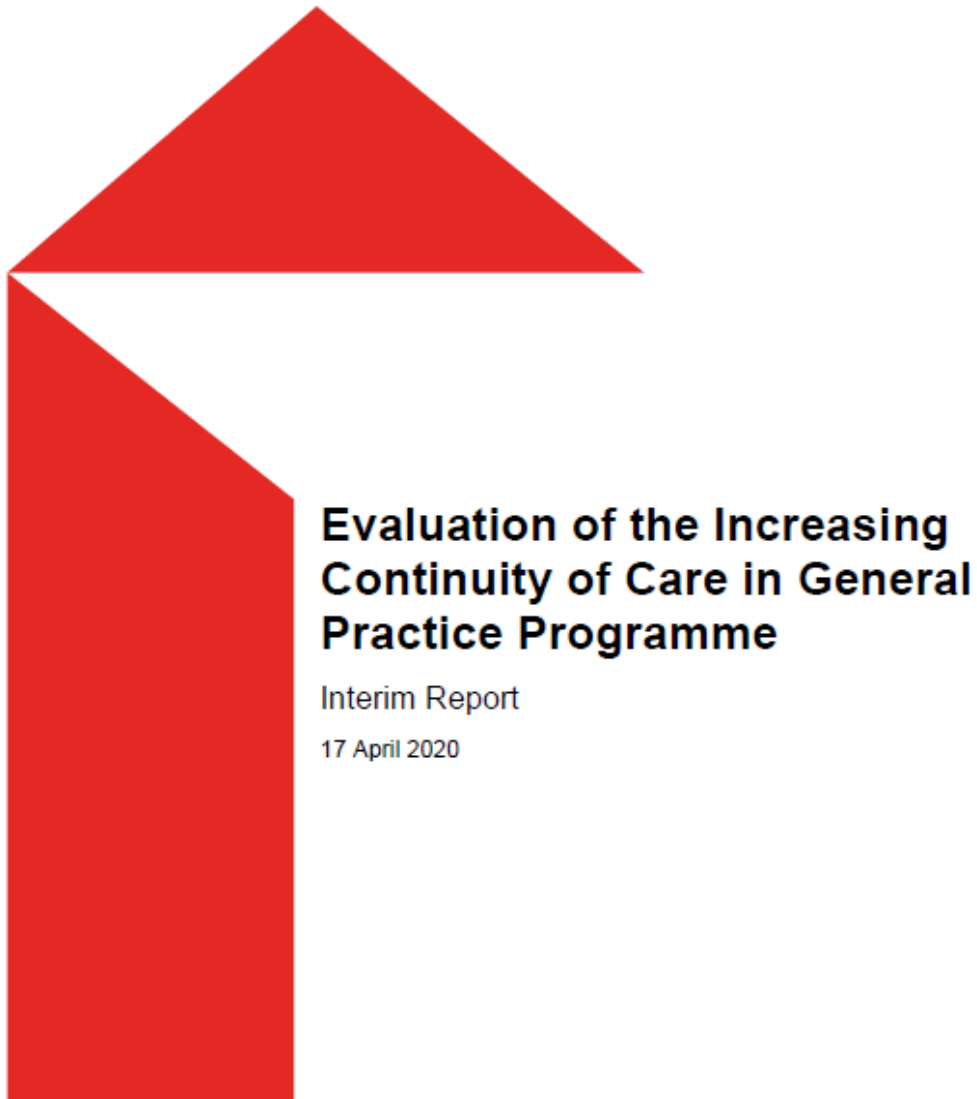
- "I feel that some doctors are more thorough than others, I have been told two separate things by two different doctors."

Resources

- "Doctors don't stay long enough to have the same GP."



A5.3 Interim evaluation report April 2020



10 key findings included below.

For full report please click here: [HYPERTEXT LINK NEEDED](#)

YES


That's great
– so you
have an

Ten considerations for implementing continuity of care initiatives

These early insights have been used to inform ten considerations for those looking to increase relational continuity of care in general practice. These have been important factors across most project sites, at this stage of the programme. Readers are reminded to please consider these within the context of their own practice or PCN.

1

PRIORITISE




Do you have knowledge of the evidence base and benefits of continuity of care in general practice?

Yes. This is a great starting point. Keep up to date on latest developments from this programme via The Health Foundation, the RCGP blog and the continuity of care community Basecamp.

No. Take a look at The Nuffield Trust's evidence review which compiles previous work to understand how continuity of care benefits patients and staff. Then, keep up to date on latest developments from this programme.

2

LEADERSHIP




Do you have clinical leaders who are passionate about continuity of care?

Yes. Great! Clinical leadership has been important in the context of this programme to build and sustain momentum, as well as helping to navigate emerging challenges.

No. General Practice is balancing many priorities at the moment and having a strong leader who can help to keep focus on continuity is important. If this isn't you, consider if there someone in your practice, Federation or PCN who could help to drive this?

3

CULTURE




Do you have a collaborative working environment?

Yes. This will give you a good basis for discussion. This programme has found that it is important to involve all staff and give them time to discuss the impact that changes may have on them and how they work.

No. The involvement of all staff has been an important factor for practices involved in this programme, supporting them to design and implement approaches to enhance continuity, as well as measure progress. Consider formal or informal opportunities to build collaboration and allow staff to integrate and understand each other's roles within the practice.

4

CULTURE




Do you have experience in making improvements in the practice?

Yes. This gives you a good foundation to work from. Consider undertaking formal quality improvement training, such as QIQR courses, to build on your experience to date.

No. Start by creating a shared vision and consider the use of improvement methodologies or accessing some improvement support locally through your PCN or CCG. Find opportunities to reflect on current practice at regular team meetings/training sessions.

5

RESOURCES




Can you protect time for management and organisational influence of the project?

Yes. The project sites involved in this programme have benefited from a project manager, clinical leader, and in the most part, backfill for staff time. Local champions in each practice have also been useful.

No. You may need this to drive this ambition and make far reaching changes. Consider whether there may be opportunities to apply for funding to support this via your Federation or PCN, or through interested practices coming together. In the meantime, consider potential 'quick wins' and their relevance to your practice. This could include changes to scripts for administration staff who are talking to patients and the adaption of simple patient communication materials others have used.

6

RESOURCES




Can you protect time for staff training and implementation?

Yes. You may wish to use this time to educate, train and troubleshoot challenges with staff.

No. Consider opportunities to create this, for example by utilising some protected learning time or part of an existing practice meeting. Also look out for toolkits emerging from those involved in this programme as they could be adapted to your local context. Having a local champion to manage and promote this locally may also be useful.

7

SYSTEMS




Do your systems currently reflect the 'responsible GP' for your patients?

Yes. Good – this has provided a good foundation for practices involved in this programme and you will need to monitor and update this regularly. Also ensure you create a fair share of patients across doctors and the sessions they work.

No. You may need to review this and update your records. Project sites within this programme have created 'matching tools' or undertaken manual reviews of this. It will also be important to consider the process for allocating a 'responsible GP' for new registrations going forward.

8

SYSTEMS




Do you measure continuity of care?

Yes. All five project sites have found this to be important to allow them to understand current performance and track change over time. You may want to also consider alternative measures and explore local variation.

No. Common measures are the UPC or SUCC. You may want to set up a monitoring mechanism with a good baseline period. This can be a useful tool in helping to engage stakeholders initially and to allow them to see the impact of any changes you make locally.

9

ENGAGEMENT




Do you engage or communicate with your patients about continuity of care?

Yes. With so much focus on access and resources, this provides a useful basis to build from. Consider whether there are new audiences or alternative modes you could use to extend your reach?

No. Discuss locally how this could be approached, potentially through your PPG or perhaps via a patient champion. Consider the modes of communication you could utilise, as well as the messages you would like to promote.

10

LEARNING



Do you have a network to discuss ideas, challenges and solutions for improvements?

Yes. Great! Consider opportunities to share your learning and please join the debate on RCGP's continuity of care community Basecamp.

No. This can be useful to troubleshoot and learn from the experience and expertise of others. Consider established networks PCN/Federations or local Quality Improvement teams. There may also be likeminded or similar practices locally you could do this with together.

26 November 2019