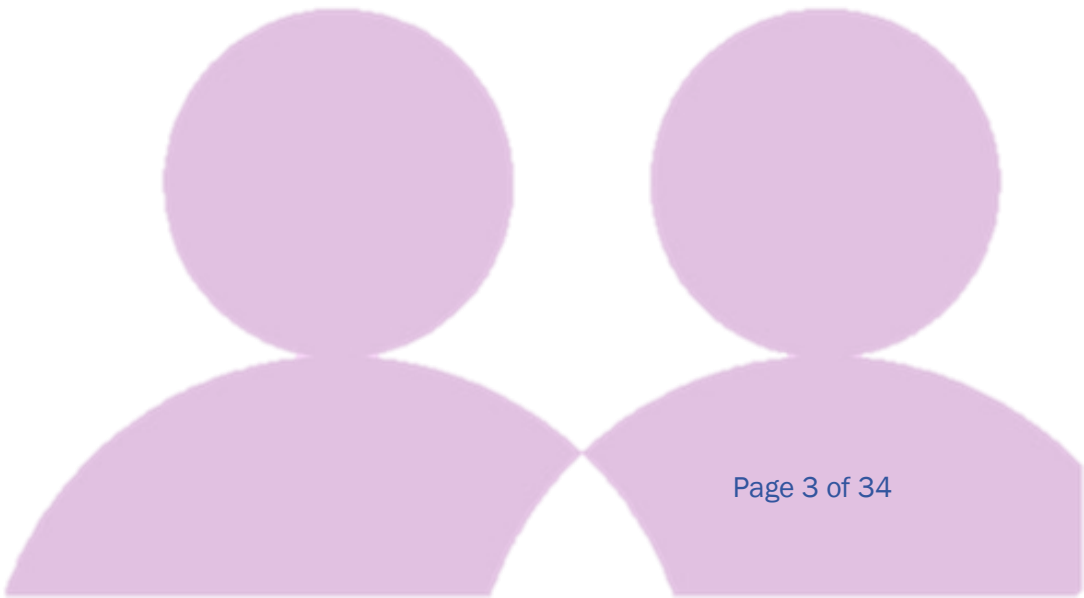
onecare

Continuity of Care evaluation report

June 2021

The Health Foundation

Contents



1. Executive Summary

1.1 Context

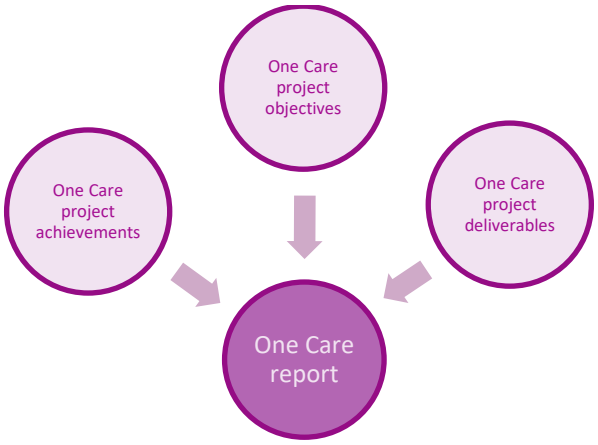
The Health Foundation offered grants up to £250,000 to GP practices and federations of various sizes to carry out targeted quality improvement work to increase continuity of care in their practices. Five sites were selected, and One Care was one of those sites.

One Care is a Community Interest Company. It represents and supports 77 GP practices across Bristol, North Somerset, and South Gloucestershire (BNSSG). Using the grant from The Health Foundation, the One Care Continuity of Care project was established.

The outcomes of the project were:

- shared learning between the practices.
- development of a tool to enable practices to measure continuity.
- a co-produced Resource Toolkit.

This report is an evaluation of the One Care Continuity of Care Project.



The One Care project objectives were:

- More personalised care and satisfaction for patients.
- Increased job satisfaction for staff

The One Care Project ran from January 2019 to June 2021. This timeframe included a 6-month pause by The Health Foundation between April and October 2020 in response to the Covid-19 pandemic.

The One Care Project supported 23 practices to improve their continuity of care, with a focus on relational continuity between GP and patient. It had a full-time project manager, Julia Martineau, a GP clinical lead, Dr Jacob Lee, and a Steering Group with membership drawn from practices participating in the One Care project and support from One Care colleagues.

Using continuity of care measures, the project found 22 of the 23 participating practices had improved continuity of care by up to 15%. This was achieved in parallel with the pressures of Covid-19 and the mass vaccination programme. Their 6-step approach is shared in the Resource Toolkit. The practice that did not make a measurable improvement was only 3 months into their journey at the time of the data extraction.

1.2 Key achievements

The key achievements of the One Care project were:

	Key achievements
1	**Maintained engagement with 23 practices** to improve their continuity of care despite the challenges of the Covid-19 pandemic and mass vaccination programme.
2	**Developed the One Care Usual GP measuring tool** to provide an easy-to-use way for practices using the EMIS clinical system to measure their continuity of care.
3	**Harvested the extensive knowledge and learning** from the participating practices.
4	**Co-authored a 6-Step Resource Toolkit** to share the learning by participating practices.
5	**Worked with patient groups** in the practices raising awareness of why continuity of care is important. There was high level of engagement from patient groups.
6	**Created high quality communication products** with input from patients and Bristol, North Somerset, and South Gloucestershire (BNSSG) Health Watch. Branding was specifically designed for the One Care project. It was used on the patient information leaflets, poster and animation and made available to other continuity of care sites.

7	**Actively worked on networking** between practices, between the 5 sites taking part in The Health Foundation Continuity of Care programme and across wider networks, linking with academic colleagues with an interest in continuity of care including Bristol and Amsterdam Universities.
8	**Actively promoted continuity of care** BNSSG and have shared our learning nationally and internationally through the participation at The Health Foundation webinars, and workshops, the Royal College of GPs conference and a presentation to WONCA (World Organisation of Family Doctors) 2021 Europe conference.

The One Care project successfully:

- **enabled practices regardless of their different constituent make up** to improve continuity for their patients.
- **delivered a continuity of care project at-scale** across a large group of practices.
- **raised the profile** of continuity of care with both patients and staff.

In working collaboratively with 23 practices across BNSSG, and with The Health Foundation and the other project sites, the One Care project's legacy is:

- a Continuity of Care **Usual GP Measuring Tool** enabling practices to measure their own continuity of care.
- A **Resource Toolkit** which shares the learning and ideas from participating practices. It was co-authored with another Health Foundation continuity of care site, Morecambe Bay Primary Care Collaborative. It is a 6-step approach with 42 practical resources and 39 editable downloads.
- **Added to the knowledge** about how to improve continuity of care in general practice.
- **Raised the profile** of continuity of care.

1.3 Challenges

The key challenges for the One Care project were:

- **Challenge 1: Individuality of general practice.**
  While practices are similar, they also differ.
  The 23 participant practices ranged from teams with 6 GPs to teams of 32 GPs. The GPs worked between 2 and 8 sessions each week, and offered appointments varying from 10 minutes to 20 minutes.

  There were single site and multi-site practices and it included those with:

- high student populations.
- large population of young families.
- high percentage of patients with long standing conditions.
- high ethnicity, including several with a third of patients from BAME groups.
- a range of deprivations scores from 1 (most deprived) to 10 (least deprived).
- challenges of both rural and inner-city locations.
- challenges of practice mergers and patient redistribution from practice closures.

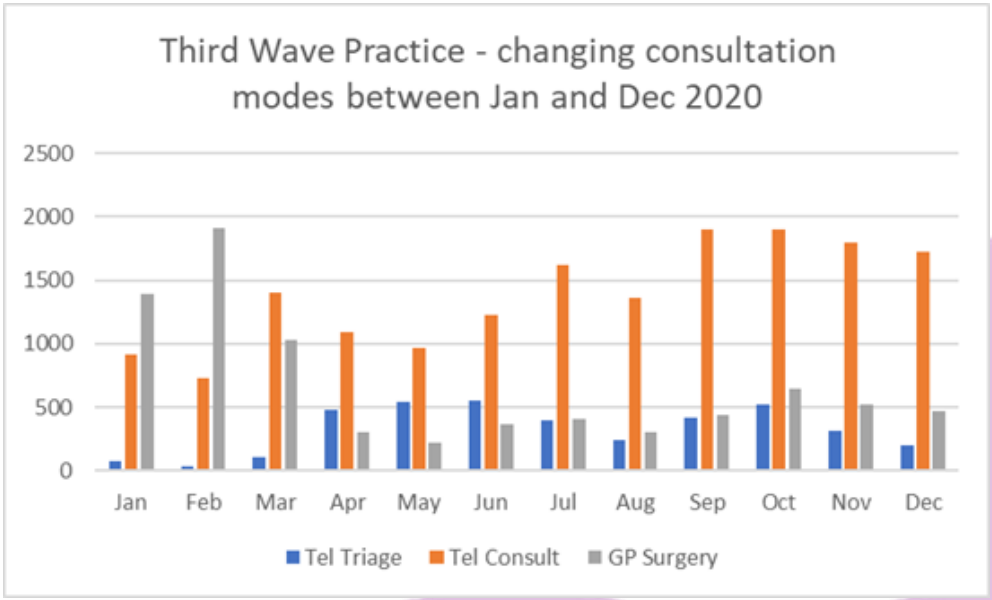
During the project, there was an increase in patient numbers across the participating practices of 12,611.

The Resource Toolkit recognises practice differ and should be flexible to accommodate those differences.

- **Challenge 2:** The **Covid-19 pandemic** impacted on general practice and disrupted the delivery of the Continuity of Care One Care Project and wider programme from late February 2020. The disruption continued through the remaining project lifecycle impacting in 3 main ways:

  - The GP consultation mode changed quickly from being face-to-face appointments to consultations by telephone and online. The speed of change for one Practice is illustrated in the graph below. The measuring tool was adapted to support the change.

    Graph 1: graph showing the change in consultation modes at one practice.



- The mass vaccination programme put significant pressure on general Practice and in turn limited their capacity for working on continuity of care. Practices adjusted their continuity of care plans to align with constraints.

- Two Practices withdrew from the One Care Project due to competing pressures of Covid-19. However, another practice decided to join the project in the third wave.

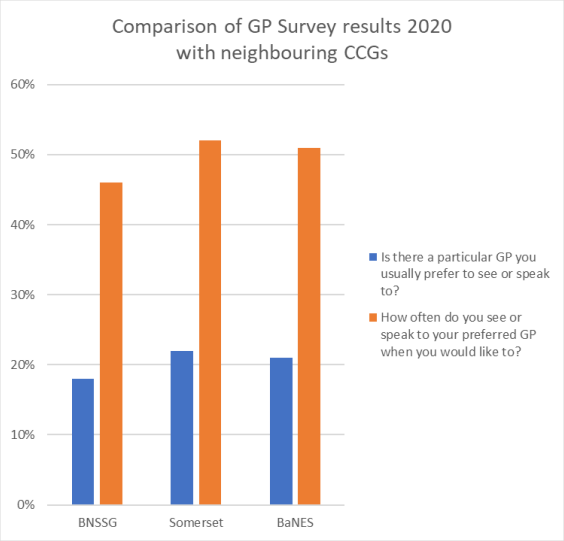
- The impact of the pandemic on GP practices (including a change in operations, Covid-19 related staff absence and general public fear) was reflected in a study by a group of organisation within BNSSG CCG. It found that between April 2019 and April 2020 there was a rapid shift to remote GP consultations during the pandemic from around 30% to around 90%[1]. Dr Becks Fisher's GP perspective on COVID-19 [2] also highlights the impact of adaptions in general Practice in response to the pandemic.

- **Challenge 3**: There is an ongoing balance for general practice between patient **access** and continuity of care.

    - At the initiation stage of the One Care Project there was a Citizen's Panel survey (Autumn 2018) conducted by BNSSG STP Healthier Together. It reported 64% of respondents valued getting an appointment quickly more than they valued seeing a doctor they knew very well.

    - In addition, when comparing BNSSG with neighbouring CCGs in 2019-2020, BNSSG respondents were less likely to have a particular GP they preferred to see, and less likely to see or speak to their preferred GP. It suggests the One Care project was therefore very timely for BNSSG practices.

Graph 2: The graph shows GP survey results 2020 for BNSSG compared with two neighbouring CCGs.

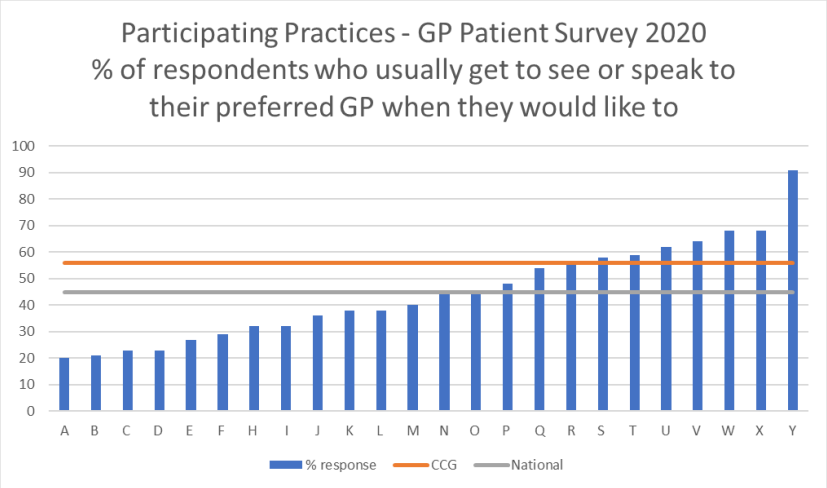


In working with practices, both staff and patients, including surveys pre and post the project, there is good evidence that access and continuity of care are equally important.

- **Challenge 4:** There was a **lack of data** available on levels of continuity of care**.** The only data throwing any light on continuity of care was the GP Patient Survey. The GP Patient Survey assesses patients' experience of GP practices, and the results are published by Ipsos MORI on behalf of NHS England [3].

    - The GP Survey 2020 asked respondents if they usually get to see or speak to their preferred GP when they would like to. The results for the Practices participating in the One Care Project are shared in the graph below. It shows a wide variation between the Practices, with the lowest performing Practice having 20% of respondents able to contact their preferred GP and the highest performing Practices scoring 90%. The average for Practices across BNSSG is shown together with the national average.

Graph 3: This graph shows the wide range of GP Survey results for 2020 for the practices participating in the One Care project.



- The inability in being able to measure continuity of care led to the One Care project developing the **Usual GP Measuring Tool** to provide each practice with baseline continuity of care measures. These measures were a key part in engaging and motivating Practices on their continuity of care improvement journey.

2. One Care Project Journey

2.1 Infographic

2.1 A summary of the One Care project journey, with the key activities and highlights:

onecare CoC project journey

Referenced in local CCG documents and HealthWatch

Continuity of care in response to project activities

Jan - June 2019
Engage with practices and onboard

1 Oversubscribed, needed 400K patients

2 Steering group set up 24 practices recruited in three waves

June 2019 - March 2020
Develop resources, share learning, start CoC improvement journey

3 **April - Oct 2020**
Collate and produce resource toolkit

Developed a CoC measuring tool

April 2020
Start of project pause

Being able to measure continuity is important

Co-authored with Morcambe Bay a 6-step resource toolkit

COVID-19 period of pause

Oct 2020
End of project pause

4 **Oct 2020 - June 2021**
Re-energise project and reinvigorate practices

23 participating practices (2 left, 1 joined)
Ongoing work during COVID-19
Impact of COVID-19 = CoC more important

5 **April - July 2021**
Network and share the learning

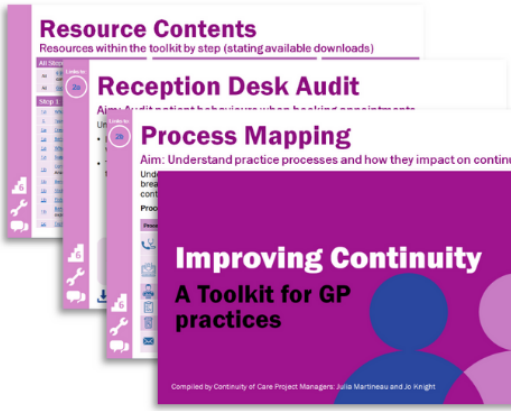
Presentation to RCGP, WONCA, THF, IHI

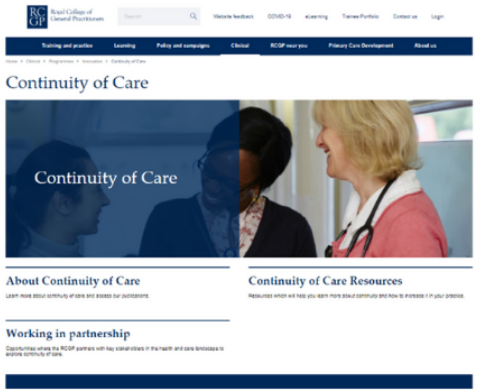
6 **July 2021 - June 2022**
Maintain momentum post-project

Ongoing work – bursaries, champions

7 **Ongoing**
Ongoing work to align national strategy, GP contracts with CoC research and evidence

Practices increased their Usual Provider of Care score by up to 15% over the project lifespan





Each practice is unique, but all are able to improve continuity of care

The Health Foundation

Jan 2019 | Jan 2020 | Jan 2021 | July 2021 | June 2022

2.2 Continuity of Care measures

Throughout the report, the participating practices share their continuity of care activities. More in-depth Practice Journeys are included in the Resource Toolkit. Practices are anonymised with both letters and numbers.

What is the One Care Usual GP Tool?

It is a tool to enable practices to measure continuity of care at both practice and GP level. It was developed by One Care and was an important part of the project.

What measures are used by the One Care Usual GP Tool?

The Usual GP Tool has two ways of measuring continuity:

1. Usual Provider of Care (UPC) is a measure of how often a patient saw a GP.
   The GP is either:
   a. The GP the patient saw the most often (referred to **UPC Most Seen**)
      or
   b. The GP the patient saw the most often AND is the GP named in the patient's record as their usual GP (referred to as **UPC Usual GP**).

   The calculations use the frequent attender patients (those who consulted 9 or more times in the 12-month period) because the UPC calculation requires at least 2 consultations.

2. St Leonard's Indicator of Continuity of Care (SLICC) is a measure for a group of patients and is useful to practices moving towards personal lists.
   The Tool provides a SLICC score by calculating how often the patient sees the GP who is named in their patient record.

   The Tool gives a SLICC score for two groups of patients:
   a. Frequent attender patients (those who consulted 9 or more times in the previous 12 months).
      Patients who consulted less than 9 times in the previous 12 months.

   A useful comparison of UPC and SLICC measures is provided by Sidaway-Lee[4].

What are the key benefits and limitations of the measures?

Three of the four measures in the Usual GP Tool rely on the Practice ensuring the patient record includes the correct GP name. The exception to this is UPC 'Most Seen' GP. It does not rely on the GP name being correct on the system and because of that this measure often gives a higher continuity of care score. For a practice just beginning their continuity of care journey, the UPC

'Most Seen' is a good indicator to focus on because it shows the informal level of continuity of care within the practice, and they can build on it.

In addition to UPC and SLICC, there are other measures of continuity of care but at the present time there is not a generally accepted or widely used method of measuring continuity of care. For practices wishing to update the patient record with the correct GP name, this is currently a manual process, and the estimated effort is 1 hour to update 100 patient records. Future automated processes are likely, and it is hoped clinical systems, such as EMIS, will adopt these.

Why is the practice list grouped by consultation activity?

The practice list is grouped by how often the patient has consulted with their GP. This enables:

- Usual Provider of Care scores to be calculated.
- An opportunity to balance consultation activity and workload evenly across the GP team.

There are 8 groups of consultation activity, and these are set out below. The table also includes the range of results from the participating practices which provides a useful benchmark. For example, the number of Frequent Attenders in the participating practices ranges from 4% of the practice list to 14% of the practice list.

Consultation Activity Groups	Range from 2020/21 results
Patients who consulted with a GP 9 or more times in past 12 months. (aka Frequent Attenders in the One Care Project).	4% to 14%
Patients who consulted with a GP less than 9 times in past 12 months	39% to 55%
Total number of patients who consulted at least once in the past 12 months	43% to 63%
Patients who consulted at least once between 1 and 3 years ago	8% to 30%
Patients who consulted at least once between 3 and 6 years ago	3% to 10%
Patients who consulted at least once between 6 and 10 years ago	2% to 10%
Patients who have not consulted in at least 10 years.	4% to 22%
Total number of consultations used by Frequent Attender patients	31% to 63%

Practice 21 ran the tool which showed their Practice had a high number of frequent attenders and these frequent attenders consumed 63% of the total consultations. This was the highest score across all the participating practices. The Practice needed to reduce the level of consultations being used by frequently attending patients and believed continuity of care was being key in making that happen. They attached flags to the patient records, updated the usual GP field and, with the support of the Reception Team, these patients were directed to their usual GP. The work is ongoing. The practice runs the Tool monthly and the data is reviewed by the GP team.

Resource Toolkit: Using EMIS to promote continuity and Usual GP Tool

The Usual GP Tool can be adapted to measure continuity of care for a cohort (e.g., palliative care, learning disabilities), rather than the whole practice list.

How does a practice use the frequent attender consultation activity?

The Tool lists all the Frequent Attenders (patients who consulted with a GP 9 or more times in past 12 months) together with the names of the GPs they have seen in the past 12 months.

Practice 7 reviewed the frequent attender patients with a focus on:

1. Patients seeing the same GP but who was not the GP named on the clinical system. Patients with a high number of consultations circulating through the GP team.
2. The distribution of these patients across the GP team.

The Practice improved continuity by

1. Updating the clinical system with the GP the patient was seeing.
2. Adding a continuity of care flag to the patient record.
3. Adding a reminder for the Reception Team to book the patient with the GP named. .on the system.

These changes improved continuity of care for this group of patients and reduced the risk of delayed or missed diagnosis.

Resource Toolkit: Frequent Attenders Power of 3

2.3 The One Care Project results

Each practice ran the Usual GP Tool to give a dataset for 2019/20 and a dataset for 2020/21. Across the 23 participating practices, continuity of care (as measured by UPC most seen GP) improved for all the practices by up to 15%.

Practice results

Range of results

The table below shows the range of continuity of care results across the 23 participating practices.

Notes:

- The 'Usual GP' is a data field on the EMIS clinical system where the patient's GP is recorded.
- The 'Most Seen' GP is the GP that the patient has seen the most often during the period. This may not be the GP that is named in their patient record and practices are encouraged to update the record.

Measures from the One Care Usual GP Tool	Range of results across all practices in 2019/20	Range of results across all practices in 2020/21	The average improvement by all practices across the 2 years
UPC 'Most Seen = How often the patient sees the same GP.	10% to 66%	25% to 77%	4%
UPC 'Usual GP' = How often the patient sees the GP named on the clinical system.	2% to 64%	7% to 77%	3%
SLICC 'Frequent Attenders' = How often the GP named on the clinical system saw patients who consulted 9 or more times in the 12-month period	9% to 64%	7% to 76%	1%
SLICC 'Other Patients' = How often the GP named on the clinical system saw patients who consulted less than 9 times in the previous 12-month period.	7% to 62%	12% to 76%	3%

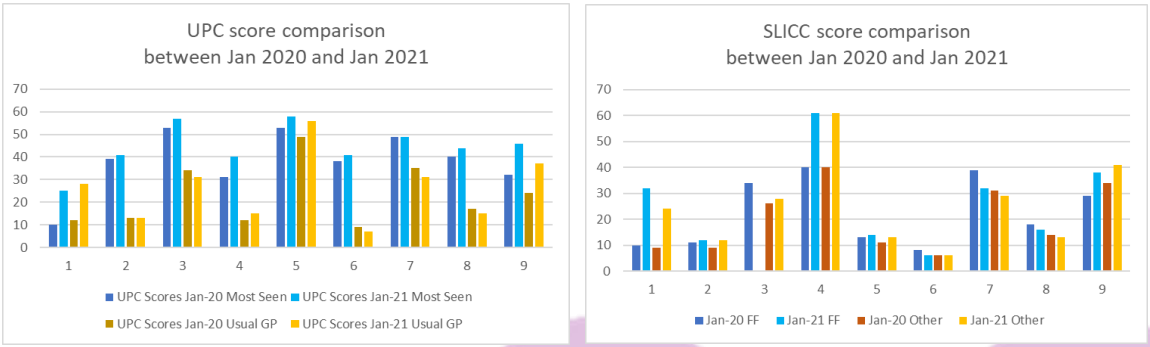
The results show:

- An improvement in the range across the scores.
- The UPC 'Most Seen' is a higher score because it does not rely on the correct GP name on the clinical system.
- The high scores in the range were achieved by Practices with "Personal Lists".
  A personal list means a GP has their own list of patients for whom they are responsible, and therefore the patients on that list have a GP they see for most of their consultations. Personal Lists could be viewed as the gold standard for continuity of care because it supports the development of trusting relationships between patient and GP.
- The project view was practices should aim to achieve 50% UPC 'Most Seen' as a starting point.

Data comparison

The graphs below compare the results for the 9 practices who joined the project in September 2019 as they had the best opportunity to improve continuity prior to the pandemic. In the comparison below the data from January 2020, prior to the first Covid-19 lockdown, is compared to data from January 2021 during the pandemic and when the mass vaccination programme was underway.

Graph 4: The graph compares the continuity of care scores between 2019/20 and 2020/21 for the 9 practices who joined the project in September 2019.



The UPC 'Most Seen GP' measure is the only measure showing improvement across the 9 practices.

Measures that rely on the correct GP name on the clinical system is a time-consuming process for a practice to correct. Practices may be interested to learn about programmed robotic process automation software to change individual patient records on mass which has been developed by the Morecambe Bay Primary Care Collaborative project and is explained in their report.

Patient and staff survey results:

Patient and staff surveys provided a mechanism to measure patient and staff satisfaction. Mott McDonald undertook the surveys on behalf of The Health Foundation. The surveys were done before the One Care Project started and repeated towards the end of the Project. Mott McDonald have produced their own Report, but it shows both GPs and patients make their own judgement on which consultations they think require continuity of care. The headlines for the One Care Project were:

- 82% of staff responses saw continuity of care as 'very important' for all patients.
- key hurdles were delays or restrictions in patient being able to book an appointment (33% of respondents).
- the top two advantages of continuity being to build trust, confidence, and a good relationship (44%) and having better patient knowledge (41%).
- 50% of patients who responded saw continuity of care as 'very important' with 25% saying it was 'mostly important'.
- 79% of respondents said they had a particular GP they prefer to see or speak to.
- 63% of those responding said they had a 'very good' experience with their GP practice.

The patients rated the benefits of continuity and below are the key responses scoring above 70%:

- They know my medical history 86%.
- I feel involved in decisions about my care 82%.
- They are responsive to my needs and concerns 77%.
- I take an active role in my health and wellbeing 77%.
- I feel that I know them 77%.
- They know me as a person 76%.

Talking with patients

Practices found taking time to talk with patients in the waiting room gave helpful insights from a patient's perspective.

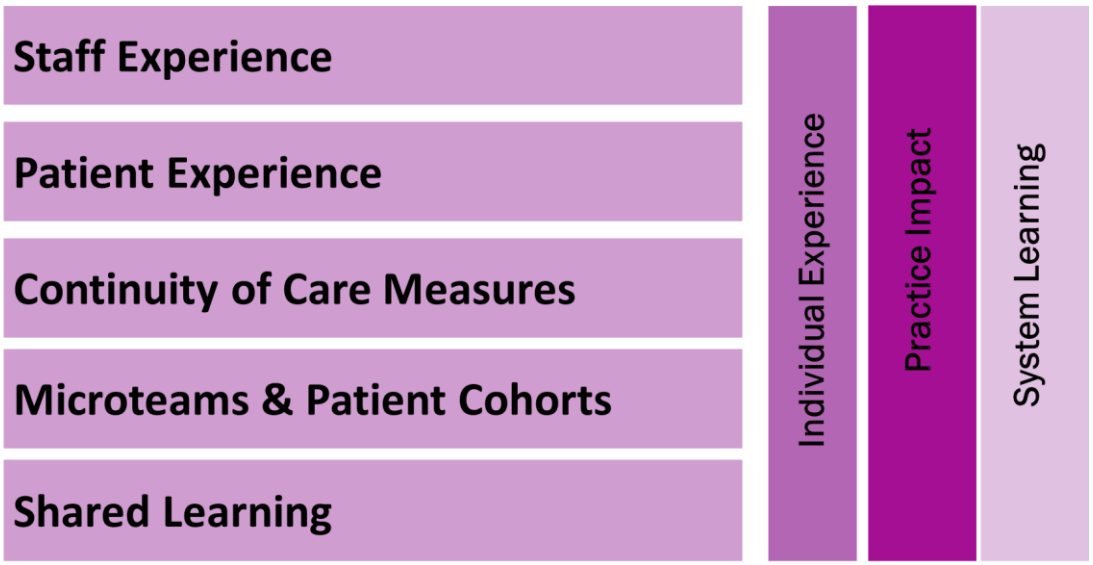
Practice 7 found a difference between what patients viewed as an acceptable wait for a routine appointment and what patients saw as an acceptable wait to see their usual GP. The results were shared with the Practice's Participation Group and with staff as it helped support the Practice's ambition to improve continuity of care.

Resource Toolkit Reception Desk Audit.

Overall, what is important is the relationship with a GP who knows the patient history, gives consistent advice, takes responsibility and action, and trust and respects the patient.

3. Learning

The **learning** from this One Care Project will be covered from the following perspectives:



3.1 Continuity matters to GPs

This was demonstrated by the high level of interest from Practices wishing to participate in the One Care Project. The majority who participated maintained their commitment in the face of unprecedented and challenging times in general practice.

The table below is extract from Gray[5] and summarises the advantages to GPs of greater continuity of care.

Advantages for GPs	Details
Accumulated knowledge	GPs gain more knowledge about their patients and use it
GP satisfaction	Personal knowledge and good doctor-patient relationship
Patients easier to work with	Patients disclose details, have better compliance, follow advice
Efficiency in administration	Reception staff are clear on workflows
Forgiveness	A strong patient-doctor relationship means errors are forgiven
Professional audit	Personal lists enable audits on GP performance

A GP view

Dr Anna Graham is a GP Partner at Horfield Health Centre who shared her thoughts which align with the advantages tabled above.

"Continuity is very important to me. I have been working in the same Practice for 15 years. We have personal lists. I know my patients well and they know me. This works for patients. I start in the middle of their story, not at the beginning each time. I understand their wider world having known them over many years. I think I make better joint decisions which can include doing nothing because of the trust I have built up over this time. For my own ability to get the job done and get home, I find seeing the results and letters about my own patients I can do quickly because I ordered the tests and know why I made the referral. This also helps with my learning, finding out about new treatments and following this up with the same person. It is hugely satisfying as a role. If I make a mistake, I apologise, and the patients forgives me. In the Practice the way we manage work is very clear. I cover my patient's queries and provide cross cover. This helps the wider team with who to ask and where the buck stops".

3.2 Practice staff support continuity

but it needs the GPs to decide that is the priority for their practice and to explain the benefits and rationale to colleagues and patients. This is supported by having a clear policy to support continuity of care.

3.3 Patients value continuity

This was evident at Patient Participation Groups and through patient surveys. The discussions around continuity were very positive, with most patients who took part in the discussion sharing the view that continuity of care should be in place for all routine appointments. Patients contributed to the development of the communication material, including the wording in the patient leaflet and the development of a PPG resource which is included in the Resource Toolkit.

A patient view

Dr Jill White is Chair of The Family Practice Patient Group (PPG) and has been involved with the continuity of care One Care Project at the Practice. Dr White invites PPGs to get involved and

"Recommends PPGs take up the Continuity of Care Tool Kit, to better understand what is meant by Continuity of Care and in so doing increase their confidence in supporting their Practice. It is proven that Continuity of Care develops better outcomes, saves GP time, and makes the patient feel more confident about their well-being and treatment. PPGs can support the key messaging on continuity of care and members can share their experience to help the Practice identify how current processes in the Practice may be working against continuity".

3.4 Being able to measure continuity is key

The Steering Group worked with the One Care Digital Team to develop the One Care Usual GP Measuring Tool. The details are provided at 2.2.

3.5 Continuity is important for urgent consultations

Although the focus is usually on routine appointments, as this side steps the access versus continuity of care debate. There is growing recognition that continuity across urgent consultations is also important.

Practice 12 looked at ways to improve continuity of care for urgent consultations because they believed a lack of continuity of care in urgent consultations contributed to a delayed diagnosis. Unfortunately, the pandemic interrupted this work but another Health Foundation site, the Valentine Project, explored this prior to the pandemic and their findings are shared in their evaluation report.

Resource Toolkit: Valentine Report

3.6 Each practice journey is unique

Practice journeys are unique and are made up of different constituent parts and experiences. It means how they set out to improve continuity of care will differ although all will cover one or all of the following: staff training, patient education, adaptations to the clinical system and changes to processes. These differences found in practices means some caution is needed when comparing continuity of care results across practices. It is useful to be able to benchmark data but also to be cognizant of the multitude of other factors that come into play.

This project's focus was relational (GP-patient) continuity however with the onset of the pandemic Practice 11 moved to episodic continuity (Patient sees the same GP for the duration of a particular condition/treatment). Moving to episodic continuity enabled the practice to continue to improve continuity of care, despite the pressures of the pandemic and the changes to their working processes. The Reception Team were key to the process. They checked patient records and guided patients to consult with the same GP for the same condition/treatment. The Practice saw an increase in continuity of care scores with:

- *UPC most seen increasing from 35% to 41%*
- *UPC usual GP increasing from 16% to 19%*

Resource Toolkit: Reception Team Guide and using EMIS to promote continuity.

3.7 Patient turnover impacts on continuity of care

Patient turnover impacts continuity because how long a patient remains with the Practice impacts on continuity of care. The number of patients joining and leaving each year is an important statistic and the range of churn across the participating Practices was 13% to 35%.

Practice 22 was disheartened to learn there was only a small improvement in the continuity of scores when they reran the Usual GP Tool. The Practice had been working hard on continuity and anticipated their scores would be aligned with a nearby Practice. The Practice had not considered the impact of churn. The practice demographics means over a third of patients join and leave the practice each year. It was therefore unlikely they could attain continuity of care scores like a Practice with a more stable population. Sometimes there are immovable barriers to what can be achieved.

Resource Toolkit: comparison of Bristol practice results

3.8 GP team stability impacts on continuity of care

When a GP leaves or joins a practice, it impacts on continuity of care for the patient.

Practice 8 had a significant number of changes to the GP team including GP parental leave and a GP leaving the practice. This meant that patients saw a different GP, meaning lower continuity of care. A process was put in place so the Reception Team could update the usual GP field when a patient contacted the practice. The practice also tried to use the same locum cover.

Resource Toolkit: using EMIS to promote continuity

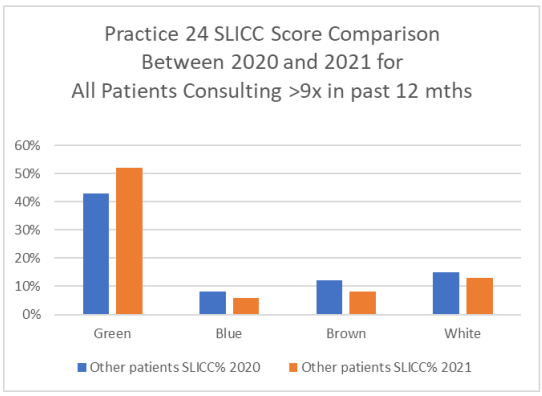
Practices may also consider using the same locum for extended absence to improve continuity of care for patients.

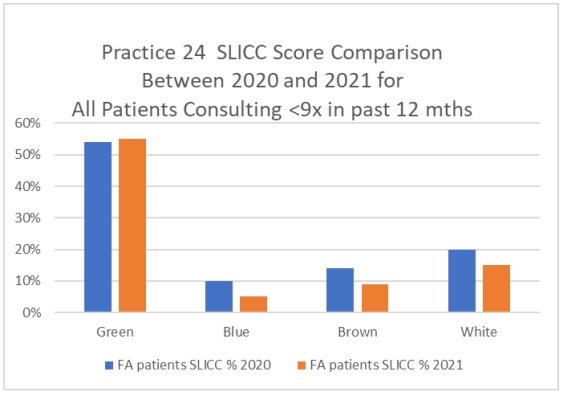
3.9 Learn from the practice team

Learn from the practice team by finding out who is achieving the best levels of continuity in the practice.

At **Practice 24**, they found one of their GPs, Dr Green, was achieving much higher continuity of care compared to other members of the team where continuity of care was falling. (See graphs below). The team looked at what Dr Green was doing to encourage continuity. Dr Green always reminded patients to book their next consultation with her and took time during the consultation to check she was the named GP on the clinical system so any correspondence for the patient was sent to her.

Graph 5: The graphs show the results for Practice 24, comparing the scores for some of the GPs at the practice. Dr Green had significantly higher SLICC scores than colleagues and the practice spent time understanding the factors at work.

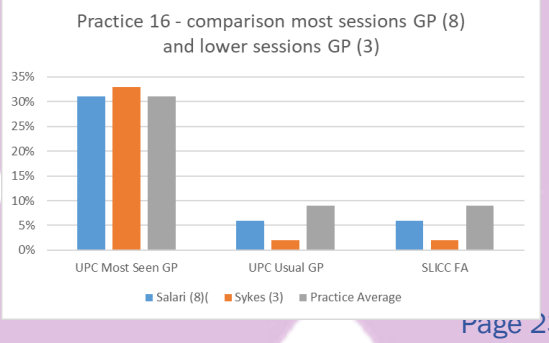




3.10 There is not an optimum number of GP sessions

GPs working a low number of sessions can achieve good rates of continuity which suggests it is the processes practices put in place to support continuity which is important.

Practice 16 has a GP working 3 sessions who achieved a similar continuity of care score (UPC Most Seen) to their GP colleague working 8 sessions.



3.11 A good starting point is to work with a cohort

The Resource Toolkit recommends starting small working with a cohort has been an approach taken by many Practices.

Practice 3 focused on improving continuity of care for palliative patients, and continuity of care improved both for the cohort, and for the Practice list by 2%.
Resource Toolkit: Cohorts that benefit.

Practice 18 focused on learning disability patients, doubling the continuity of care for this cohort within 6 months, together with an improvement at the Practice of 4%.
Resource Toolkit: GP Practice Story

It is not possible to show there is a causal relationship between working with a cohort and achieving an improvement of continuity of care across the Practice list, but it seems possible they are linked. Practices working with a cohort need staff to understand the importance of continuity and will have made changes in how patients are navigated so it seems reasonable to link the two. Perhaps more importantly, the positive results motivate the Practice to do more.

Practices focusing on a cohort, can adapt the Usual GP Measuring Tool to measure continuity of care. The Usual GP Tool Guide shows how to set it up.

3.12 Personal lists are the highest level of continuity of care

Personal lists support GPs to build trusting relationships with their patients. Personal lists mean test requests, results and letters are passed to the named GP, even if another GP colleague has seen the patient and ordered a test. It can however also mean personal choice is limited. Variations on personal list include where another GP completes an episode of care following up on the results for that episode, but there remains a named GP with overall responsibility for the patient's care.

Practice 23 operates personal lists and achieves high levels of continuity (77%). The GPs work a minimum of 6 sessions per week and all work across 4 days to provide better access. All the GPs work on Mondays and Fridays. Patient churn was around 11%. GP recruitment was relatively easy and is believed to be linked to continuity of care giving greater job satisfaction and greater patient satisfaction and consequently decreasing workload.

Resource Toolkit: GP Practice Stories

3.13 Microteams may be an option

Microteams offer an opportunity to provide the patient with care from as few GPs as possible. This is supported by information sharing and a consistent approach in the care of a patient.

Several practices trialled a GP Buddy approach. This meant the patient was given two GPs. Most consultations were with their usual GP but if the usual GP was unavailable, the patient consulted with the GP Buddy.

Practice 4 found setting up the GP Buddy approach with 2 GPs required a considerable amount of preparatory work and included discussions and decisions on:

- The criteria for agreeing which GPs would buddy up.
- How GP buddies would share information and update each other.
- The administrative processes eg all test results sent to the Allocated GP even if ordered by the GP Buddy.
- Informing patient of the pilot and their Allocated GP and GP Buddy.

The approach appeared to be working well but unfortunately the pandemic interrupted the pilot.

Resource Toolkit: GP Practice STories

One practice begun a trial of the Microteam approach, but it was interrupted by other events.

Practice 13 were keen to improve the patient experience by improving relational continuity. A major hurdle was the GP team worked a low number of sessions which meant that patient waiting times for consultations were long and increased significantly when a GP was absent. The practice approach was a microteam of 4 GPs and a nurse. The pandemic interrupted their exploration of this approach which will need reviewing with the change to the National GP Contract which requires a patient to have an accountable GP. (Section 7.7B)

Resource Toolkit: Microteams

3.14 Reception team are key to continuity

The link between receptionists, appointment systems and continuity of care (Freeman[6]) found the receptionist influence was small in relation to other factors ultimately decided by the doctors. However, this may be changing. This project has found the support of the reception team is vital to improving continuity of care. Locally, care navigator training has changed the reception role and requires staff to be clear on practice policy and process and supported improvements in continuity of care.

Practice 2 has more than doubled their continuity of care scores for the whole of the Practice list. Their Reception Team have been key in their success. At the initial meeting about the Project, the Reception Team recognised that continuity would improve workflow and make their job easier so were as committed and as enthusiastic as their GP colleagues.

Resource Toolkit: Reception Team Guide

Measure	2019-2020	2020-2021
SLICC Frequent Attenders	10	25
SLICC Other Patients	12	28
UPC Most Seen	10	25

3.15 Awareness of competing priorities

Awareness of competing priorities and how that impacts on continuity of care. For example, there is a drop in continuity of care if the GP takes holiday.

At Practice 10 one GP found his continuity of care scores fell sharply because he had taken on an additional clinical role during the pandemic and was doing less sessions:

Measure	2019-2020	2020-2021
SLICC Frequent Attenders	40%	17%
SLICC Other Patients	32%	16%

3.16 The practice list size may be factor

Research by Barker[7] suggests patients from larger Practices (at least 7 full-time equivalent GPs) are on average 4% less likely to see the same GP than those at medium sized Practice (4-6 GPs) and 11% less likely than at small Practices (1 to 3 GPs). The results from the One Care Project appear to support Barker's findings with smaller Practices achieving greater continuity although this may also be linked to being single site practices.

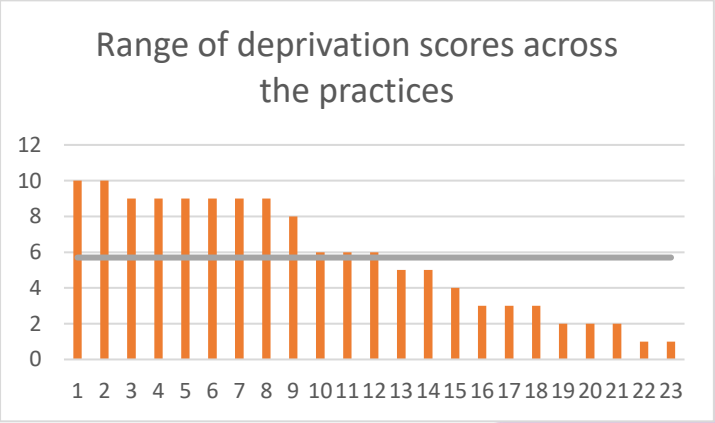
The average list size for the participating Practices in the One Care Project was 15,725 patients. This is double the average list size in 2015. It reflects the amount of change in general practice with mergers and redistribution of patients in recent years which in turn impacts on continuity of care.

Informally it seems higher levels of continuity can be achieved by larger Practices, including those that are multi-site, but they need the supporting systems in place.

3.17 Good levels of continuity can be achieved in deprived areas

There is a wide range of deprivation scores across the participating practices as shown in the graph below (source: phe.org.uk/profile/general practice). Two practices achieving good levels of continuity are in areas of high deprivation. This was achieved by being clear on their policy and processes for maintaining continuity of care coupled to an ongoing training programme and regular audits. It suggests that processes that support continuity of care negate the impact of deprivation.

Graph 6: shows the range of deprivation scores for the practices participating in the project.



3.18 The adverse effects are outweighed by the positive

The adverse effects are outweighed by the positive benefits of continuity of care. Most of the research is clear and compelling that continuity of care is beneficial for both patients and staff. However, there is some research that continuity of care may have an adverse effect and it is useful to be alert to those risks.

1. A fresh pair of eyes
   Research found that when a patient consulted with an unknown doctor (a fresh pair of eyes) with symptoms of bowel cancer it tended to be identified slightly more quickly. (Wise[8])
2. Risk of delayed diagnosis
   Research found that where there was patient-doctor continuity in the 24 months before diagnosis, it was associated with a slightly later diagnosis of colorectal cancer. (Ridd[9]).
3. Heartsink Patients
   Continuity may mean the GP having to see what O'Dowd termed heartsink patients where the GPs heart sinks when he sees the patient's name on the appointment list. (O'Dowd[10]).
4. Risk of patients becoming dependent.
   Patients seeing the same GP may become dependent on them, particularly the socially isolated.
5. Risk that difficult conversations are avoided because of the familiarity between patient and GP.

The Resource Toolkit looks at these and shares ideas from GP on ways of mitigating each of the risks.

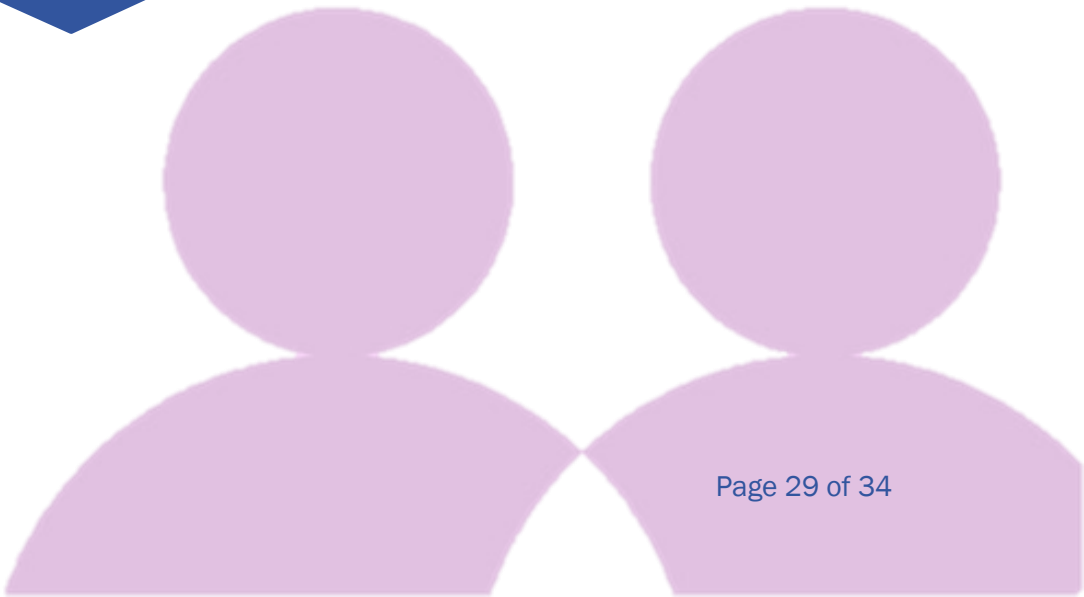
A practice view

Vicki Staatz from The Merrywood Practice shares her experience of the project. The practice joined the project as part of the first wave of practices. The Merrywood Practice is in an area of high deprivation in Bristol. The practice has 7 GPs, around 7000 patients and a high number of children on the list.

"We decided to join the CoC project to develop the work we were already doing to encourage patients to stick with one doctor rather than just the doctor with the shortest wait. We had already spent time with Reception explaining the benefits of CoC both for patients and doctors – one of the key phrases was that the usual doctor 'knows what is normal' for the patient so interventions are likely to be more appropriate.

Being part of the project gave us the impetus and motivation to keep developing CoC and to promote the benefits with patients and staff. We also used CoC to develop our signposting pathways as they are closely linked – in fact we couldn't have done CoC without reviewing signposting as well. We had a good patient meeting as part of the project which involved an excellent game where patients had to identify what they thought the best service was for various health needs! We enjoyed seeing what other practices were doing (there were huge variances in approach) and we enjoyed explaining what we were doing! We had already done quite a lot of work in setting up 'usual GP' flags on patient records.

It was clear everyone has the same dilemma – patient access versus CoC. It is difficult when the messaging centrally is that access is more important. We were really delighted to see the increase in patient percentages who said they normally got to speak to their usual doctor in the GP national survey. We are also finding that CoC is an incentive in recruiting GPs – if we can show it is important to us, it is something they like. We feel we made lots of little changes that make a difference to CoC rather than one major change. This was easier to implement and maintain for both staff and patients.



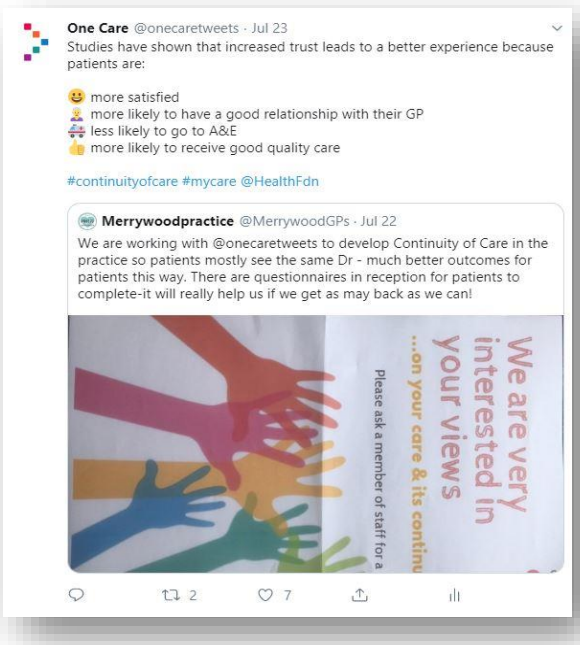
4. Spread and sustainability

4.1 Building on local support

The One Care CIC has incorporated the continuity of care One Care Project into its work programme. Information on the One Care Project has been included in bulletins and updates to Practices and the One Care Project has presented at One Care events.

One Care has a patient group, with patient members drawn from all 77 Practices and this was utilised to canvas patient views both for the One Care Project and by Mott McDonald for the continuity of care programme.

The One Care communications team set up a continuity of care page on the intranet (TeamNet) and has set up a page to host the Resource Toolkit and library.



4.2 Sustaining support

Due to the impact of Covid-19, it was not possible to undertake all the work that was originally anticipated. This meant there is some surplus funding. The Health Foundation have agreed that this funding is offered to Practices who have not yet begun their continuity of care improvement journey. Practices are invited to apply for a £500 bursary to support them in improving continuity of care with One Care providing support.

4.3 Creating momentum

The One Care Project generated a continuity of care momentum which the Steering Group is keen to maintain. It is anticipated that improving continuity of care will continue once mass vaccination work is completed. Many GPs believe that continuity of care is even more valuable now, in a time when most consultations are being done by telephone/online.

4.4 Engaging with patients

Patient education and engagement was a key part of this project. A well engaged Patient Participation Group (PPG) can help both steer and support a practice.

4.5 Delivering a similar One Care Project at scale

The One Care Project worked across 23 Practices, and demonstrated that continuity of care can be delivered at scale. For organisations considering running a similar scaled project, the Steering Group's key messages would be:

1. Employ a project manager to motivate and maintain momentum. Practices have competing priorities, so a gentle nudge is sometimes needed. The project manager also facilitates sharing learning and networking.
2. Provide some management resource and a clinical lead at a PCN or federation level.
3. Assign both a clinical lead and an operational lead within the practice to drive the improvement and to be the conduit between practice and project.
4. If a Practice is committed to improving continuity of care, the indicative timetable of activities over a 12-month period is:
    - **Month 1 & 2** – Use the 6-step approach set out in the Resource Toolkit and begin by understanding what continuity of care is, the barriers in your practice and what you would like to achieve. Find out the view of staff and patients views using the surveys in the Resource Toolkit.
    - **Month 3 & 4–** Consider how your Practice could improve continuity of care, using the ideas from other practices shared in the Resource Toolkit. Decide on your approach and set out your plan.
    - **Month 5** – Take a baseline measure of continuity using the Usual GP Measuring Tool.
    - **Month 6, 7, 8 & 9** – Put the plan into action and begin the PDSA cycle.
    - **Month 10** – Rerun the Usual GP Measuring Tool and compare to baseline measures.
    - **Month 11** –If the PDSA is successful expand upon it. If not try a new PDSA.
    - **Month 12** – Share your learning and achievements with others via the RCGP continuity of care website.

5. Wider influence

The One Care project would like to put forwards some suggestions on system and policy changes and recommendations that would support continuity of care.

5.1 Access vs. continuity of care

The One Care project has found the focus on rapid access to consultations is generating systems and processes that work against continuity. It misdirects patients and reception teams into thinking access overrides continuity of care. A major component of this programme was the education of patients and staff in understanding that waiting to see the same GP can be more beneficial for both patient and GP than seeing a different GP quickly.

The recent GP contract sets out a requirement for each patient to have a GP they usually see and is accountable for their care. This change to the contract is welcomed as it supports continuity of care. The next useful step would be the ability to measure adherence to this requirement thereby putting continuity of care on an equal footing with access. The subsequent step would be to focus access targets on urgent appointments and to prioritise continuity of care for routine appointments where appropriate.

5.2 Technology enablers

The Usual GP Tool highlighted a need to provide a way of measuring continuity of care using the GP clinical system.

In addition, there is a requirement that all commissioned digital tools enable continuity of care to be optimised. For example, NHS Apps such as eConsult should be designed to promote and support continuity of care by allowing patients to see their 'usual GP' and to book a appointments with their own GP.

5.3 Educating GPs and patients

GPs*:* It is suggested that training for GPs includes a module on continuity of care, sharing the research and the benefits of continuity of care to them and to their patients. The training should include how they can actively promote it.

Patients*:* The communication material developed as part of this One Care Project has provided information to patients but a national public campaign to educate patients on the benefits of continuity of care would inform and encourage the behaviour change needed by patients.

5.4 Expanding the research

There is a wealth of research giving clear and compelling evidence on the benefits of continuity of care. The research indicates continuity of care leads to better patient outcomes, a decrease in patient consulting with their GPs and less admissions to hospital but more is needed, especially

when it comes to health outcomes (Maarsingh[11]). As was noted by Freeman[12], studying the effects – including costs and benefits – this is work that should be expanded by the government who should test the value of continuity of care on a larger scale and over a greater length of time.

5.5 Consultation modes

The new way of working with increased telephone consultations will impact on continuity of care in ways that are not yet understood. The quality of the relationship between GP and patient and the sense of knowing each other is important (Freeman[11]) but can this be achieved with telephone consultations. If most consultations are now by telephone, how many are needed to establish a relationship would seem a continuation of the earlier work by Ridd[13].

BNSSG CCG guidance to practices is patients must be seen face to face prior to a referral to hospital with some exceptions including patients who have had continuity of care. The CCG recognises continuity of care provides in-depth knowledge of the patient, but the longer telephone consultations remain the main consultation mode, the more research is needed to understand the impact.

5.6 New roles in primary care

The changes in general practice include new roles such as social prescribers to support the work of general practice. The patient will be seen by members of this wider team, as and when appropriate, although the GP will retain overall responsibility for their patient. This is a new challenge to the provision of continuity of care. There is little work on 'team continuity' and so it is currently unclear how this expanding multi-disciplinary team will function and impact on continuity of care.

5.7 Future engagement and hopes

One Care will continue to work with practices to improve continuity of care and to contribute and to support work that continues to promote continuity of care. We hope:

- The participating Practices continue their continuity of care improvement journey because they recognise the value of it.
- The Health Foundation programme demonstrates the culture and ethos of continuity of care is worth investing in.
- The work with patients continues to snowball and they actively consult with their usual GP.
- The evidence of why continuity of care matters has been showcased by The Health Foundation programme and it acts as a catalyst to inform strategic conversations.

6. Acknowledgements

Thank you to the 23 participating practices who embraced the project, maintained their commitment despite the challenges in general practice and who have shared their learning and stories in the Resource Toolkit.

Thank you to the dedicated Steering Group members; Dr Richard Berkley, Linda Branch, Dr Kim Hyunkee, Dr Nicola McGuiness, Emily Nicholls, Dr Douglas Redpath, Vicki Staatz, and Jose Tarnowski. They have been wholehearted in their support in promoting the project, exploring, testing, and sharing ways of improving continuity of care and provided the 'steer' to the project.

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