Improving Continuity for South Cumbria Patients

Increasing Continuity of Care in General Practice – Final Report

Project Host: Morecambe Bay Primary Care Collaborative (MBPCC)

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Executive Summary

The government decided it was important to be able to see a GP quickly at almost any time of day, seven days a week. Every day it became harder to see your usual GP, as speedy access to care was prioritised and fewer GP appointments were available to book in advance.

The Health Foundation responded to the large body of evidence that showed continuity of care with the same GP had positive outcomes for patients, GPs and services. They awarded Morecambe Bay Primary Care Collaborative (MBPCC) funding to explore how to increase continuity of care in South Cumbria GP practices.

MBPCC recruited local practices and a Quality Service Improvement Facilitator to support practices in improving continuity of care. Because of that, practices were able to identify changes tailored to their practice that they could implement, whilst developing quality improvement skills and confidence to apply them.

In the middle of the project a world-wide pandemic struck causing general practice to change the way it worked, switching to far greater reliance on remote consultations and supporting the national mass vaccination programme. Because of that, direct work on improving continuity paused, although practices involved in the project were mindful of continuity in the changes they were making, reflecting their learning so far. Due to the shift towards increased remote consulting, the project developed additional focus to support the online consultation platform selection locally and across the ICS.

As the project comes to a close we reflect that the original aims and progress were not achievable in the face of a pandemic. Pivoting the focus away from practices at a time of crisis led to an opportunity to develop a great resource, 'The Continuity of Care Toolkit', freely available to all GP practices on the RCGP website. The project had started to make a difference, learned a great deal and has developed many tools to continue to support practices in Morecambe Bay and beyond to increase their continuity of care.

The project's journey shared above is based on the *Pixar* framework, a method used within quality improvement to articulate and share an impact story. It is one of many tools, techniques and approaches of quality improvement that have been utilised within the MBPCC project. This project is based upon quality improvement methodology and has focussed on the six steps of a quality improvement journey advocated by NHSE Quality, Service Improvement and Redesign (QSIR) programme and under pinned by the Model for Improvement (Langley et al 2009). Measuring and understanding the current state, to test and learn in order to develop a future state.

The overall aim of the project was to increase continuity of care for South Cumbria Patients. With objectives to improve relational continuity of care, increase patient satisfaction, reduce hospital use, improve patient flow, improve digital record and practice management systems, and improve clinician's satisfaction with working lives. The project also wanted to utilise digital technology to support and enable greater continuity of care.

The approach taken was to work with five practices (wave 1) covering 50,000 patients, to identify change concepts and enablers, test and learn in order to share and refine the process to spread five more practices (wave 2) covering 100,000 patients in total. The novel coronavirus (COVID-19) pandemic halted the project at the mid-point, but it did not halt the learning and developments that will continue to support improving continuity of care locally as part of the project's legacy plan and shared nationally.

Key learning from the MBPCC project is that a culture and a mind shift towards valuing continuity of care ensures that whatever challenges are thrown at general practice continuity is considered and opportunities are harnessed. Efficient processes of patient and information flow that encourage navigation to a usually seen GP will enable improved continuity of care. Having a strong voice and advocate for continuity within a GP practice will help to drive change. An engaged and tailored approach to improving continuity of care, along with feedback that the changes made are making a difference, support the adoption of sustainability of changes.

All learning from the project has been brought together in a comprehensive Continuity of Care Toolkit for GP practices, to guide them in their own continuity improvement journey. The toolkit is a consolidation of learning from the MBPCC and One Care projects, supporting spread and sustainability.

Other outputs of the project include:

- Morecambe Bay Continuity of Care Dashboard to measure and understand levels of continuity, showing changes over time and can be used to identify improvement focus areas;
- Usual GP modelling and automated change process, an excel spreadsheet to recommend a more appropriate usual GP and model the changes, and a
- Robotic Process Automation programme to enact approved changes.

The pandemic provided opportunity to expand scope and have a wider influence. As a result of an event exploring the impact of digital and review of digital consultation solutions, Morecambe Bay has an involved and engaged local primary care community in the digital agenda aware of its impacts on continuity and relationships. This is supported by increased engagement mechanisms/processes and strengthened governance and leadership across primary care digital in the ICS, all influenced by project team involvement.

The NHS Survey results for four out of the five wave 1 project practices showed significant improvements in the level of continuity reported by patients between 2018 and 2020, whilst in contrast corresponding national and local CCG results saw a reduction in reported continuity. With the onset of the pandemic all wave 1 practices through their response to COVID-19 have seen impact on continuity of care (often positive); these are shared in the report, with before and after comparisons and across a data story.

Project Journey

This project has been led by South Cumbria Primary Care Collaborative and then Morecambe Bay Primary Care Collaborative (MBPCC) following a merger of the two GP Federations in October 2020 within the boundaries of Morecambe Bay Clinical Commissioning Group (CCG). The not-for-profit federation comprises 31 of the 32 practices across the CCG area and a total patient population of 350,256 from the Barrow-in-Furness peninsula, across South Lakeland to the Yorkshire Dales and down into North Lancashire. 28 of the 31 federated practices (216,192 patients) are based in South Cumbria with two of these crossing into North Lancashire. All 28 of the South Cumbria practices were given the opportunity to be involved in the project.

The project approach focussed heavily on quality improvement, with learning shared across the project practices. Following the improvement journey of the six stages of project management as advocated by the NHSE Quality,

Service, Improvement and Redesign (QSIR) programme which is built upon Langley et al's (2009) Model of Improvement.

The original plan was to work in Year 1 (wave 1) with three or four practices with around 30,000 registered patients, identifying and testing ways to improve continuity and learn from the process. In Year 2 (wave 2) applying learning and change concepts from wave 1 to a second set of practices, aiming to cover 80-100,000 patients in total. The project's journey and reflections against the original plan are shared below and depicted within a sketchnote in Appendix 1.

Pre-Project and January 2019 to March 2020

The pre-project phase started in October 2018 with the invitation to GP practices to be involved in the project and advertisement for a project manager with quality improvement experience in December 2018. Whilst practices were recruited and an offer of employment was made in January 2019 at the start of the project, the project manager was not in post to until April 2019, four months behind the planned timescales.

A total of 10 practices were recruited to the project evenly across the two waves. They were selected following a written application and interview, with funding provided to practices to support the release of key individuals to take part in the project. The practices' individual patient populations ranged between 2,876 and 24,938. Four practices worked across more than one site. The project failed to attract practices from the Barrow-in-Furness peninsula; a number of the practices within the Barrow and Millom Primary Care Network were planning a move to a new building and this probably reduced the level of interest in joining the project.

	Wave 1 (Year 1)		Wave 2 (Year 2)		Project Total	
	Practices	Patient	Practices	Patient	Practices	Patient
Expected	3-4	30,000	8-9	50-70,000	12-13	80-100,000
Actual	5	50,021	5	47,254	10	97,275
Funding	£5K + 50p per patient		£3K + 40p per patient		Total cost: £75,829.60	

Note: Patient List Size is taken from June 2021 NHS Digital GP Registrations, those used to calculate incentive was based on April 2020 (wave 1) and January 2021 (wave 2) figures.

Year 1 was dedicated to understanding the different wave 1 practices and their working processes. The project manager regularly visited and worked from the practices, building working relationships and providing hands on facilitation using quality improvement theory, approaches, tools and techniques. Wave 1 practices as part of their commitment to the project were asked to attend quality improvement training via locally run QSIR programme, delivered in part by the project manager as a qualified QSIR Teaching Associate. Three practice staff across two practices attended the five day multi-organisational training with further attendees booked for 2021.

Each practice joined the project for different reasons but with the same goal to improve continuity of care for their patients. The first three steps of the improvement journey identified areas to focus upon. This highlighted the variation in practices' processes, resources and culture. Whilst the focus was different for each of the wave 1 practices, there were some common themes recognised which led to project wide developments in year 1.

Wave 1 Practices		
Practice	Rationale for joining	Area identified
Practice A	Staffing changes making it harder to maintain continuity that is important to the practice	Poor distribution of non-clinical/GP activities impacting on GP capacity
Practice B	Low continuity demonstrated in NHS Survey results	Two systems competing against each other
Practice C	New GPs, falling continuity, desire for a new way of dealing with day to day demand	Alignment of processes to support recent implementation of AskMyGP
Practice D	Passionate about continuity but NHS survey results showed that it had halved since patient list size increased significantly	Processes that hinder continuity (registration and appointment booking)

Practice E	Lost continuity when striving for greater access, feel it would complement the AskMyGP system in place	Support for practice to move out of the neutral zone of transition following external change to AskMyGP before focus on continuity of care

Learning and implementation for wave 1 practices was not complete at December 2019, with three months still to go of their first year. However, there was significant learning to apply, and an accelerated process to define, scope, measure and understand. So, five further practices were recruited to wave 2 in January 2020, beginning their journey in February 2020. The project was progressing well with the ambition to introduce a third wave of practices later in 2020 (not part of the original plan) using action learning sets and the approach taken in the previous waves to support spread.

March 2020 to June 2021

In March 2020 the novel coronavirus (COVID-19) pandemic had reached the United Kingdom and suddenly due to infection prevention and social distancing guidelines had to change the way they operated. When the country entered its first lockdown on March 23rd 2020, wave 1 practices had been part of the project for a year, but wave 2 had only been on board for less than two months. In April the Increasing Continuity of Care in General Practice programme officially paused for six months. A proposal for the project manager to reduce to part-time (0.7wte) hours and to continue background working on the project was agreed with the Health Foundation and enacted, focussing on output development, consolidation of learning and preparation for practice re-engagement.

In October 2020, whilst the country moved into the three tiered system of local COVID-19 alert levels and with nine months remaining of the programme, there was both positivity and apprehension for the project restart. Project risks for the challenges facing general practice were still present. Wave 2 practices were looking to restart their 'define and scope' step and ask staff and patients for their views and experiences using online surveys.

Another turn in events came with the mass vaccination programme becoming a priority focus for GP practices from December 2020. This made it very difficult for project practices to restart the project, however project practices have been mindful of continuity when making changes to their ways of working, seeking wherever possible to maintain or improve continuity. Project plans for a wave 3 were cancelled and face-to-face QSIR training postponed in May 2020 has yet to re-start.

Direct working with project practices ceased in March 2020 and did not restart to any meaningful extent, despite this a number of outputs have been achieved to support a continuity of care legacy plan in Morecambe Bay, these include: A Continuity of Care Toolkit; Continuity of Care Dashboard; Usual GP Modelling Tool; Robotic Process Automation programme; support for Digital First developments across Morecambe Bay.

Continuity of Care Toolkit

MBPCC and One Care following on from a programme workshop in early March 2020, identified the opportunity to collaborate on a resource to consolidate and share learning so far with their respective project practices. Partnership working on the Continuity of Care Toolkit began during the programme pause and continued for the duration of the project driven by the two project managers. The toolkit guides GP practices through a six step improvement journey built upon the Model for Improvement. It shares all the combined learning and resources of two project sites. Originally developed to support both project sites wave 3 practices, it will now be shared nationally on the Royal College of General Practitioners website as well as forming a pivotal role in the localities legacy plans.

Continuity of Care Dashboard

The Continuity of Care Dashboard was designed to support practices to measure their current levels of continuity and allow comparison to other practices in Morecambe Bay. Developed by the Business Intelligence (BI) Team in

the acute hospital trust, it joins a suite of other Qlik Sense dashboard across Bay Health and Care Partners (the local Integrated Care Partnership - ICP). 97% of practices across the CCG signed up to sharing their data, supporting all ICP dashboards. Built with the ability to filter by patient characteristics and measure levels of continuity using consultation history data, it supports identification of target groups and deep dives into why continuity may be lower for particular patient cohorts. Developments and full use within the project timeframe were halted due to BI developer prioritisation of COVID-19 response tasks and EMIS extract issues and by the failed BI procurement of a new extract product in October 2020 which would have been live in January 2021. Working in partnership with the BI team, MBPCC project management time was dedicated to the procurement of the extract product and signing of new data sharing agreement across all GP practices, to enable data to flow into the Dashboard again. This project issue impacted on the inability to support practices model and change the Usual GP (see below) within the project lifetime. The data flow into the Continuity of Care Dashboard was activated at the end of May 2021, enabling the review of project impact on continuity of care and this will play a significant role in the legacy plan.

Usual GP Modelling

It became clear early in the project that the 'Usual GP' field in GP Practice EMIS clinical systems usually reflected the GP the patient was registered with rather than the GP they usually saw. This was a major block to improving continuity and also led to extra work for administrative staff as they had to search the records to identify which GP a patient usually saw. Data extracts from the dashboard were used alongside an excel spreadsheet to model a more appropriate 'Usual GP' i.e. the GP the patient most frequently saw. One wave 1 practice tested the modelling tool and used their project funding to employ a temporary member of staff to manually change 6,000 patient records Usual GP. A reflective Usual GP that is kept up-to-date can support the navigation of patients and their information within GP practices. This enables improved relational and informational continuity of care. During the programme pause, the modelling spreadsheet was developed further and four practices were supported with a set of actions that would allow them to enact 'Usual GP' changes. However, most were unable to undertake this work due to the repetitive and time consuming task to change individual records. This led to the following development.

Robotic Process Automation programme

Programmer time within the local BI team was secured to develop instructions for robotic process automation software to enact usual GP changes on mass for practices. To ensure safe and legal data sharing, information governance was put in place to ensure support to project practices and across Morecambe Bay. The writing, testing and refining of the programme was delayed somewhat due to diverted programme developer time to support mass vaccination bookings and notifications. The refined programme enables one robot to complete 1,500 changes within 24 hours; Morecambe Bay health community has access to four robots allowing 6,000 changes in a 24 hour period. The project's largest practice, from wave 2 completed the testing in March 2021. Further practices will make changes to Usual GP using Robotic Process Automation as part of the legacy plan; this will be given a priority for project practices and the offer will then be extended across Morecambe Bay.

Support for Digital First developments across Morecambe Bay

During the programme pause the significantly increased use of digital consultations prompted requests from individual project practices and the board members of the GP federation to understand which online consultation products would support continuity. The percentage of remote consultations across Morecambe Bay (as depicted in figure 1) has seen a massive change, from 28% in July 2019 to 73% in May 2021, reaching 88% of all consultations with a GP in April 2020.

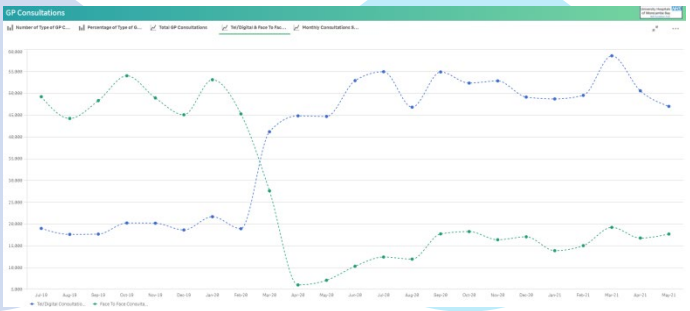


Figure 1: The shift of the total number of face-to-face consultations face-to-face (green line) to remote consultations (blue line) across Morecambe Bay practices between July 2019 and May 2021.

A review of 22 digital solutions available to primary care was undertaken and shared in a reference document for GP practices to understand the products in detail. The review concluded that whilst some products proactively encouraged continuity the choice of product should depend on the practice approach to delivery of care, and patient and information flows through the practice should be considered before implementation of any new digital tool. It also highlighted the need for a more sophisticated suite of online/video consultation products to be available across the Lancashire and South Cumbria (L&SC) Integrated Care System (ICS).

An event on the 19th November 2020 originally organised to disseminate the results and learning of the project was re-purposed to explore the considerations of a digital future for general practice and the impact this would have on continuity of care. 96 primary care colleagues across 26 (72%) of Morecambe Bay's practices attended virtually, with an additional 20 collegues providing supporting roles. Working with the Chief Clinical Information Officer for the Clinical Commissioning Group (CCG) and linking with the Primary Care Digital First team at L&SC ICS to align the digital and continuity agenda. This was the first local virtual event for primary care, outputs of the event were widely shared and a local Digital Design Authority established on the back of the enthusiasm generated by the event.

Following on from this event, ICS Primary Care Programme Board members, seeking independent support with online and video consultation procurement approached the project manager for involvement in two ICS task groups. Approved by the Health Foundation, this expansion of scope has supported the review and co-authoring of proposals for strengthened primary care digital governance and leadership structures and processes, which will enable greater collaboration across the system and engagement with practices.

"MBPCC's contribution to the task groups has been invaluable and pivotal to shape the future model of governance and leadership which will ensure that stakeholders are robustly engaged in the development of our primary and community care digital strategy and associated decision making"

Figure 2: Quote from Peter Tinson, L&SC ICS Director of Collaborative Commissioning

The Continuity of Care project manager has worked with the digital managerial and clinical leads across all five ICPs within the ICS, to lead the development of an online and video consultation engagement and procurement process (figure 3). A process which encourages practices to consider patient and information flow, agree an approach to care delivery, and engage in the decision making process for system-wide procurements that will suit practice need and approach. Thus fulfilling project practices requests and responding to the call for change from those in attendance at the digital event. This involvement will hopefully reduce the barriers that digital products can cause and promote continuity of care during the procurement and implementation processes. Unexpectedly this has led to an important outcome for the project, with application of learning from project practices transferring to the implementation of online digital tools.

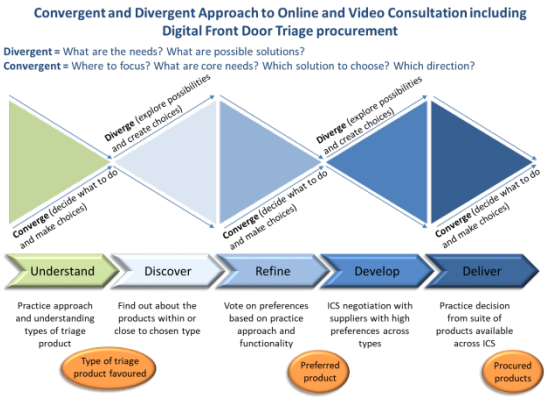


Figure 3: The convergent divergent approach to OCVC engagement and procurement

Impact

The project aimed to demonstrate positive outcomes on continuity of care for South Cumbria patients specifically relational continuity; patient satisfaction; hospital use; patient flow; digital record and practice management systems; clinician's satisfaction with working lives. The project implementation has been heavily impacted by COVID-19 pandemic, and there have been many changes and challenges to healthcare in response that makes it difficult to measure and attribute impact as intended. However, the project's data does tell an important story.

Practice Data Stories

Wave 1 project practice's quantitative data stories are shared in Appendix 2, the table below summaries those stories. Observations are divided into periods before the pandemic (January 2019 to March 2020) to view project change impact, and following (March 2020 to June 2021) to view the practices' response to COVID-19 impact on continuity of care measures (UPC; Usual Provider of Care and CoC index; Continuity of Care Index).

UPC measures how often a patient has seen the same GP (most frequently seen or 'Usual GP' field) over a period of time, the measure is for each patient who has had 2 or more consultations. It calculates who the patient has usually been seeing over a period of time (12 months) displayed as a fractional percentage. For example, if a patient has had 10 consultations and the patient saw GP A, 50% of the time (ABABABBAAC), UPC = 0.5.

CoC Index measures the dispersion of consultations, using the frequency of consultations to each GP. It rewards having fewer GPs which makes it a useful measure for micro-teams. It calculates the number of GPs, number of consultations per GP and total number of consultations to all GPs in a given period (12 months). If the sequence of consultations is AAAABBBC then the CoC Index is 0.32, while if the sequence of consultations is AAAABBCC, the CoC Index is 0.29, both sequences have same UPC (0.50).

Wave 1 Practice	Period	Changes to GP Practice and approach	Continuity of Care Data Observations
Practice A	January 2019 to March 2020	Actions to delegate non-clinical work from GPs identified and some acted upon	Data points sit just below the median but don't appear to decrease.
	March 2020 to June 2021	Total triage model operated encouraged telephone consultations with patients known to GPs; Introduced AccuRx simple triage form	Data points sit clearly above the median line, increasing levels of continuity up until the start of the mass vaccination programme where they begin to fall
Practice B	January 2019 to March 2020	Identified need to reduce to a single system, but practice wary of capacity to move to total triage so did not implement	Data points come from a falling position to consistently sit below the median line.
	March 2020 to June 2021	Implemented total triage system and easy identification of patient request to speak to preferred GP on the day or soon after	Data points dramatically shift above the median line and increases surpassing the MBCCG average which previously the practice sat below.
Practice C	January 2019 to March 2020	AskMyGP implemented in February 2019. Process for receiving clinical test results aligned to new way of working June 2019	Data points rise above the median at the point of AskMyGP implemented beginning to dip when a GP goes on maternity leave in December 2019.
	March 2020 to June 2021	AskMyGP supported total triage but merger with neighbouring GP practice began in July 2020 causing disruption for both sets of practice patients	Data points continue to fall below the median line (but never below CCG average) when the practice merger began until March 2021, from where they begin to rise and potentially recover.
Practice D	January 2019 to March 2020	Usual GP changes to reflect patients existing continuity made in October 2019, actions to encourage navigation of patient or information to Usual GP were not implemented as planned	Data points are on a steady decline, following changes to Usual GP data points hug the median line before starting to fall again.
	March 2020 to June 2021	Total triage using a single list in operation by April 2020, moving more towards patient lists in December 2020	Response to COVID follows CCG average to decline below median line.

Wave 1 Practice	Period	Changes to GP Practice and approach	Continuity of Care Data Observations
Practice E	January 2019 to March 2020	AskMyGP previously implemented in September 2018 had undergone many iterations causing confusion, After Action Review (AAR) of these events undertaken with all stakeholder undertaken in October 2019	Continuity data points look to increase or sit above the median line following the AAR. Data points fluctuate around the median line in the period with the exception of the CoC Index measure which increases from AskMyGP implementation.
	March 2020 to June 2021	Decision to move to a new online consultation system and utilisation of trained care navigator put on hold due to COVID-19	Continuity data points decline or sit below the median line during COVID, but look to be on the rise from January 2021; with changes to nursing workforce to support Long Term Conditions (LTC) and nursing homes supporting GPs.

In comparison, data observation of the combined continuity of practices across all Morecambe Bay show little movement from the median line until COVID-19; where a decrease is seen across all cohorts and measures with the exception of the CoC Index (a measure of continuity with a team rather than individual) for all and frequently attending patients where continuity data points sit above the median line.

The data story of Practice C is shared below in figure 4, demonstrating the richer story measurement for improvement can share compared to measurement for judgement.

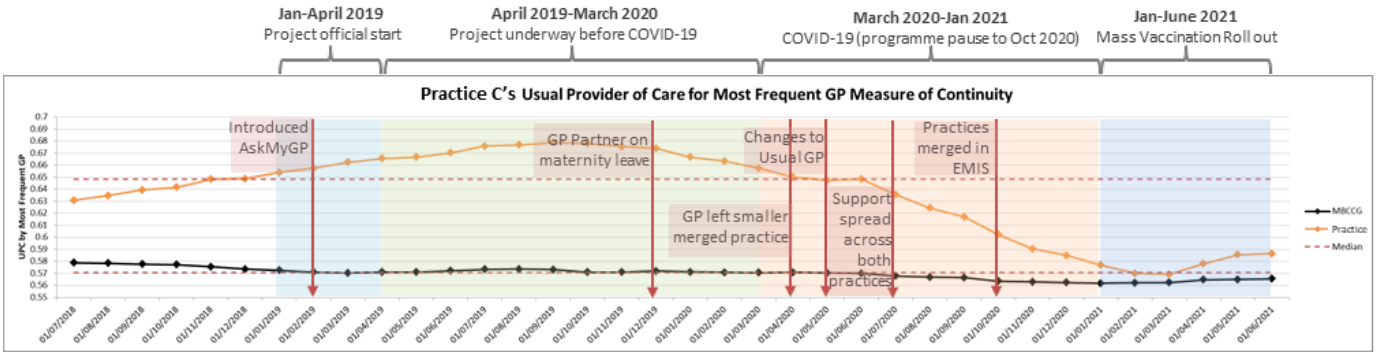


Figure 4: Practice C data story; orange line graph of the current practice population's monthly UPC measure across 3 years with median line, changes within the period annotated and CCG data (black line) displayed as a comparison.

Judgement Measures of Continuity

Comparison of the continuity measures of Usual Provider of Care (UPC) and Continuity of Care (COC) Index at the start and end of the project provide a judgement measure (figures 5 and 6), but mask the changes seen throughout as demonstrated in the data stories in Appendix 2. UPC comparisons show an increase for three of the five wave practices when the CCG decreased. The two practices with a decrease were Practice C; who experienced a practice merger within the period, and Practice D who did not manage to implement the actions to encourage patient and information navigation following changes to 'Usual GP' field and a single list total triage response to COVID-19. Whilst four practices increased COC Index, the same three increased above the CCG.

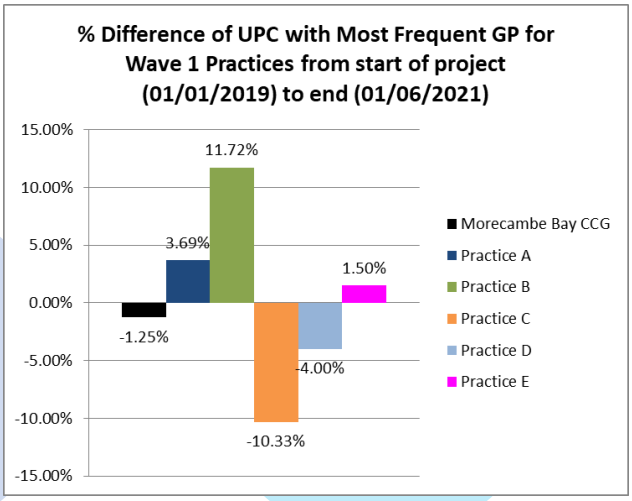


Figure 5: Graphical representation to demonstrate the percentage difference of between UPC at the start of the project to the end.

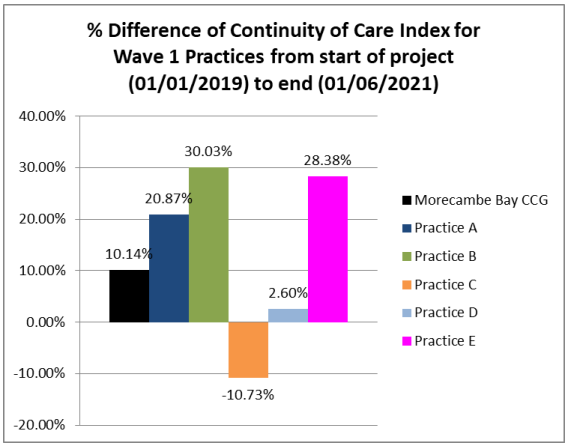


Figure 6: Graphical representation to demonstrate the percentage difference of between COC Index at the start of the project to the end.

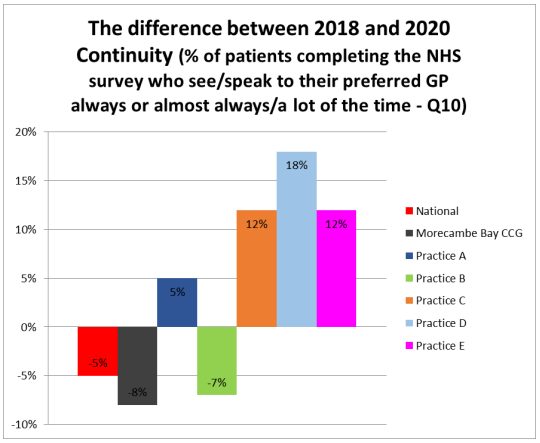


Figure 7: Graphical representation of the difference between the 2018 and 2020 NHS Survey results

NHS Survey Continuity Results

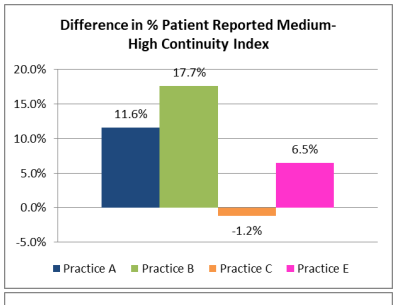
Patients reported low levels of continuity in the annual NHS Survey of 2018 was one of the reasons behind MBPCC application to join this programme, it was also named by individual GP practices.

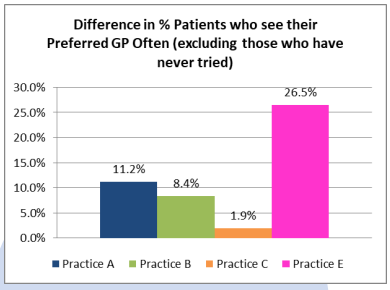
The comparison of the 2018 and 2020 NHS Survey results showed that four of the five wave 1 project practices had a greater percentage of NHS Survey patient responders reporting they saw/spoke to their preferred GP always or almost always/a lot of the time (figure 7). Practice B had a reduced percentage, reflecting the national and local (Morecambe Bay CCG) picture. This practice implemented their changes after the January 2020 survey, in tandem with their response to COVID-19.

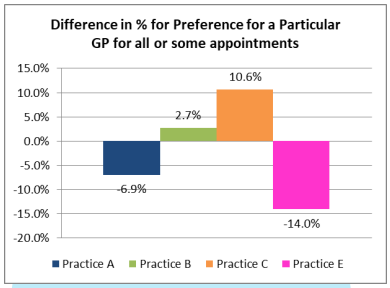
Patient Survey Results

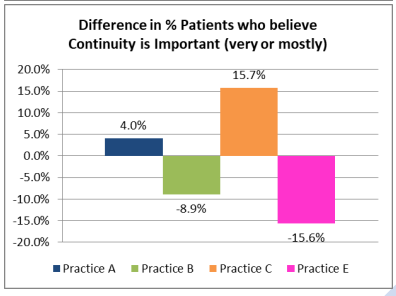
Mott MacDonald, external evaluators of the programme's baseline patient survey for wave 1 was completed in August 2019 by 434 patients on paper or online across all five GP practices, and repeated in April 2021 with 1290 online responses across four of the five practices. Unfortunately Practice D was unable to participate due to PCN responsibilities for mass vaccination roll out.

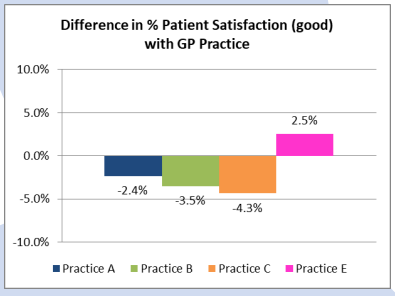
The survey results mirrored the judgement measures of continuity, with patient reported levels of continuity in the past 12 months increasing across the programme for the same three practices, however the across all four practices patients reporting that they see their preferred GP often, which will reflect experiences overall. There have been increases and decreases in preference for a particular GP and the importance of continuity, as the project practices wished to make their changes before advertising and promoting to patients. Changes in patients' satisfaction with their GP practice, between the two surveys were small.











Figures 8-12: Graphical representation of the difference between the baseline and end patient survey results for four of the five wave 1 practices

New ways of working

COVID-19 has changed the way practices operate with 'total triage' and offering remote consultations via telephone, video or messaging platforms. Guidance and information was lacking regarding a clear central direction at the start and often lagging behind prime ministerial announcements, leaving practices, PCNs and federations to make their own decisions. This uncoordinated approach meant that practices responded very differently when setting up new ways of working e.g. total triage, remote working and consultations (figure 14). Some harnessed the opportunity to focus on continuity and others created new processes in haste that had a detrimental impact on it. Practices often lacked timely information to respond and communicate well with their patients causing much frustration and problems, echoed by a patient focus group.

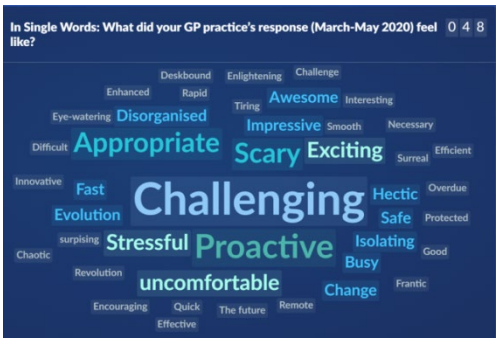


Figure 13: Attendees at the local digital learning event summed up what their GP Practice's response felt like.

Figure 14: Sketchnote depicting the variation of GP Practice's response to COVID in Morecambe Bay (displayed larger in Appendix 1)

For remote consultations, the new way of working had the potential to enhance or disrupt continuity, depending on how practices set up their total triage system. Total triage enables a single flow of patients, with GPs dealing with consultations on the day that they were requested. The process put in place to navigate these requests impacts on whether continuity is negatively or positively impacted. Processes that supported re-active continuity (patients able to request a specific clinician) or pro-active continuity (practice staff directing patients to their usual clinician) maintained or increased continuity of care.

The major increase in remote consulting impacted on relational continuity. As explored at the local digital learning event, clinician's reported that remote consultations felt easier and more appropriate when speaking with patients that were known to them. It was reported as more challenging to build relationships remotely (rather than face-to-face) and to communicate effectively (as communication is 7% spoken word, 38% tone and meaning and 55% body language) over the phone or online. Whilst continuity has supported remote consultations, the challenges with building on relational continuity without some face-to-face contact may lessen the benefits relational continuity brings to remote consultations.

Learning

The Increasing Continuity of Care in General Practice programme was heavily weighted in its initial phases towards learning rather than immediately delivering results. To understand what works and what is needed to improve continuity of care. The pandemic brought disruption but also great opportunity to reflect, consolidate learning and prepare for the future when practices are more able to apply the learning shared.

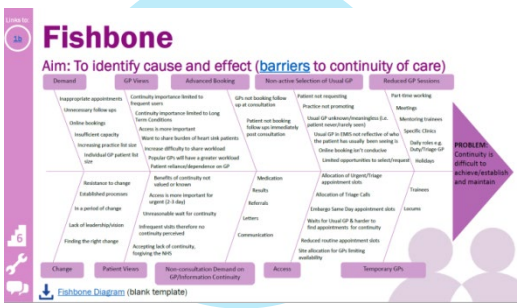


Figure 15: Fishbone diagram available in the Continuity of Care Toolkit (displayed larger in Appendix 3)

Much of the learning from MBPCC's project is shared alongside One

Care's within the Continuity of Care Toolkit. It is a collaborative amalgamation of the best of both projects; the resource outputs, the application of quality improvement approaches to continuity of care, and the learning. Structured to enable GP practices to go on their own continuity improvement journey and apply the combined learning of the two project sites and the many practices involved. It shares the learning of the cause and effect relationship to poor continuity (fishbone diagram, figure 15) and the relationship of drivers and change ideas to support increased continuity (driver diagram, figure 16). The populated diagrams summarise the vast amount of learning that has taken place, exploring the root causes of poor continuity and identifies the drivers which will affect accomplishing the aim to improve continuity of care and the interventions that affect the identified drivers.

Figure 16: Driver diagram available in the Continuity of Care Toolkit (displayed larger in Appendix 3)

Specific areas of learning gleaned from improving continuity and MBPCC's own project journey are outlined below.

Mind-sets and Culture

Human dimensions of change is not to be underestimated, McKinsey's international surveys of global business executives show that more than 70% of the barriers to change are employee resistance to change and management behaviour that does not support the change. This is reflected by the risks and issues logged by the project which included resistance, leadership, transition and engagement. Understanding William Bridges (2017) phases of transition (figure 17); the internal/psychological process people go through to come to terms with the external change was extremely useful in supporting two of the GP Practices.

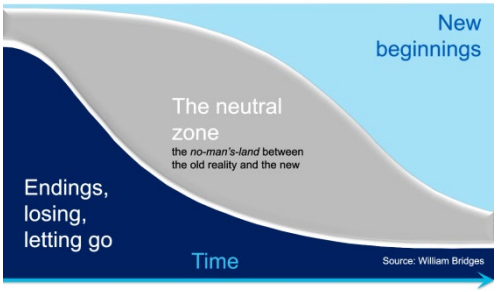


Figure 17: William Bridges (2017) 3 phases of Transition adapted by QSIR

One practice was stuck in phase 2 (the neutral zone) where the old ways had ended but the new ways were not fully operational. Critical psychological adjustments take place in this phase, a period of flux when things can be confusing and disordered. There is a danger that if this temporary phase is not managed properly, consensus easily breaks down and the level of discord rises, teamwork is undermined, as is loyalty to the organisation itself - It can also be used as an opportunity, as restraints on innovation are at their weakest. Used for reflection to experiment, embrace problems as openings for new solutions, and resist the push for premature decisions/closure, the opportunity can be harnessed. The project could have concluded that the practice was not in a position to participate in the project, but chose to learn from this challenge and support the practice to manage this phase, being mindful of continuity when encouraging reflections, direction and change. An After Action Review with all stakeholders to reflect, learn lessons and identify an agreed way forward supported this practice to be in a better place to improve continuity of care.

Another practice displayed informational and emotional/physiological levels of resistance (figure 18) in the early part of phase 1 (ending). The GP practice was fearful/defensive of changing their practice approach and losing the access they had worked hard to establish. Support was provided regarding demonstrating possible total flow systems. The change was implemented as part of the total triage response to the pandemic; the practice ensured a continuity focus, navigating patients to preferred GP and a move to deal with patients on the day or soon after. The pandemic crisis enabled the practice to implement

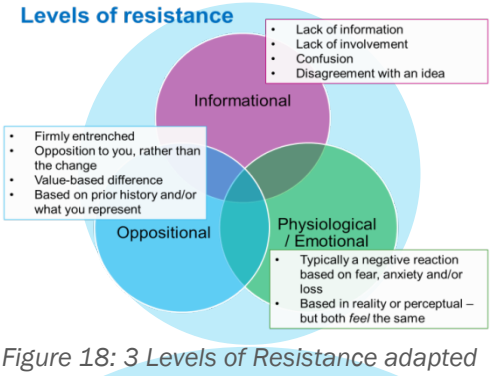


Figure 18: 3 Levels of Resistance adapted from Rick Maurer (2009) by QSIR

previously resisted change.

A continuity mind set has enabled GP practices to consider/be mindful of continuity in the changes they have made in response to the pandemic and in the planning for recovery and restoration. This is demonstrated in practices' continuity of care levels; improving from the start of the pandemic or bouncing back, the two wave 2 practices set up their total triage in different ways. Practice H (figure 19) operated total triage from a single list, whereas Practice F (figure 20) asked their admin staff to look at the consultation history and where possible navigate patients to the GP who had the most contact to support remote consultation.

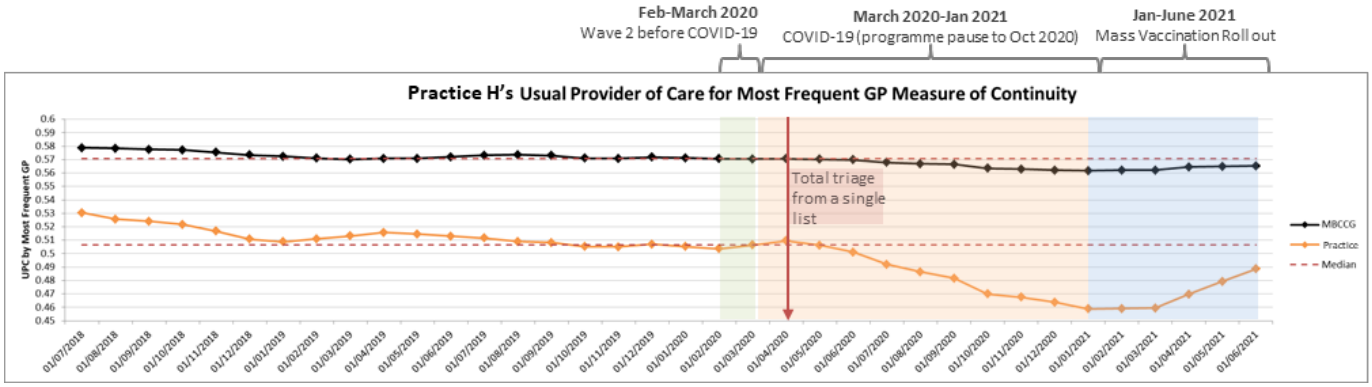


Figure 19: Practice H data story; orange line graph of the current practice population's monthly UPC measure across 3 years with median line, changes within the period annotated and CCG data (black line) displayed as a comparison.

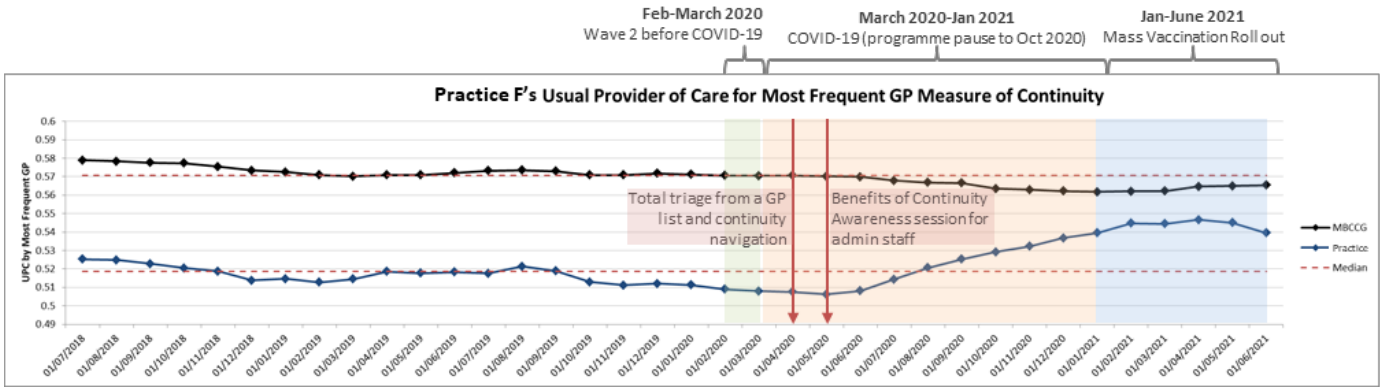


Figure 20: Practice F data story; blue line graph of the current practice population's monthly UPC measure across 3 years with median line, changes within the period annotated and CCG data (black line) displayed as a comparison.

In addition to this direction Practice F also request some support in May 2020 to increase awareness of the benefits of continuity, which developed and tested the Diamond 9 activity within the Continuity of Care Toolkit.

By changing mind-sets (culture) towards continuity it will underlie behaviours and outcomes as described in Keller and Price's 2011 Discovery Model (figure 22). GP practices with a lead individual with a strong voice and an advocate for continuity helped to drive change and influence others. Role modelling is one of the four levers of the influence model introduced by McKinsey & Company in 2003 (figure 23), which support the changes of mind-sets. This learning and theory is the rationale for advocating champions of continuity of care within the Continuity of Care toolkit.

Figure 21: The sketchnote depicting the outcome of Practice F's staff awareness session on the benefits of continuity of care (displayed larger in Appendix 1)

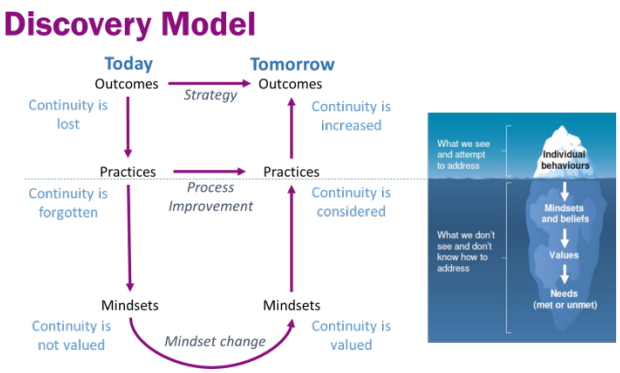


Figure 22: Discovery Model applied to a continuity of care culture

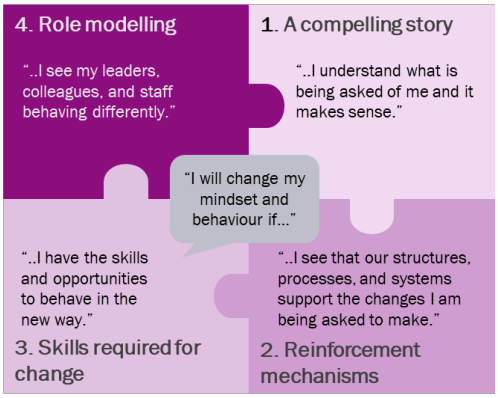


Figure 23: The 4 levers of the influence model (McKinsey & Company 2003)

Measurement for Improvement

As soon as it was known the programme quantitative evaluation planned to collect data retrospectively to measure impact, the project explored continuity of care measurements for improvement; to understand if the changes that were made resulted in improvement. There has been a great deal of learning regarding the different measures of continuity, the explanation of which is shared within the Continuity of Care Toolkit. The project struggled to find a dynamic measure of continuity of care that would support the use of Statistical Process Control (SPC) Charts, for project practices to use to know the changes they made were making a difference.

Usual Provider of Care against most frequent GP (UPC MFGP) and Continuity of Care (COC) Index are process measures, measuring contact with a usual GP or GP team over 12 months and assumes relational continuity will be improved with increased proportional contact. These measures have been used in research to evidence the benefits of continuity. The MBPCC project has used UPC MFGP and COC Index as a judgement measure when comparing a practice's performance in comparison to other practices/between patient cohorts or before and after change. The Continuity of Care Dashboard collects four years of consultation data to plot a measurement of continuity of care over 12 months, at monthly intervals, enabling a run chart to be used as a measure for improvement. As each data point includes 11 months of the data within the previous data point, it cannot be displayed in a SPC Chart; it also means that improvements are not dramatic – more rolling hills than spiky mountains. Observations on the data can be made but the lack of independent data points means shifts and trends conclusions cannot be drawn.

St Leonard's Index of Continuity of Care (SLICC) can be used within SPC charts; with unrelated data points over a 2 year period, as each data point is the total of consultation with Usual GP divided by total of consultations for a given month. This measure has been added to and displayed in SPC Charts within the dashboard by practice and individual GP across Morecambe; in readiness for a time when the Usual GP field is more reflective of whom the patient consults with. An additional monthly measure, the proportion of consultations with the most frequently seen GP across a 2 year period, for patients who had 6 or more consultations in the past year is also being tested (figure 24).

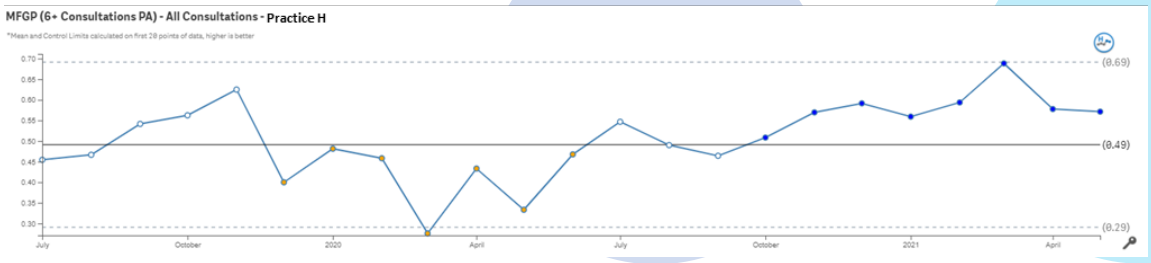


Figure 24: Practice H UPC MFGP over 2 years, for the patient cohort who have had 6 or more consultations in the past year displayed in a Statistical Process Control (SPC) Chart within the Morecambe Bay Continuity of Care Dashboard, currently under testing

As two of the wave 1 project practices used an online consultation platform separate to their clinical system, it was decided early in the Dashboard development that data extraction needed to be from consultation history as opposed to the clinic diary; and to count, face-to-face, telephone and online consultations. This early decision enabled the dashboard to continue to measure of continuity of care despite the changes to general practice COVID-19 brought; a monumental shift to remote consultation and reduced use of clinic diaries, which were replaced by total triage lists.

The Dashboard's measures of continuity follows the patient's experience as it utilises the consultation history (not the clinic diary) capturing continuity from the patient's perspective. The displayed GP practice's measure of continuity is the combined total of the patients registered with them. Large numbers of new patients e.g. GP merger or neighbouring practice closure can therefore have a huge impact on the displayed level of continuity for a GP practice, as consuming the patients' past continuity levels (whether high or low) with their previous practice are now subsumed into their new practice's measures and will impact on the overall level of continuity provided over the past 12 months. The use of this as a judgement measure must therefore be used with caution, requiring an understanding of any patient list changes etc.

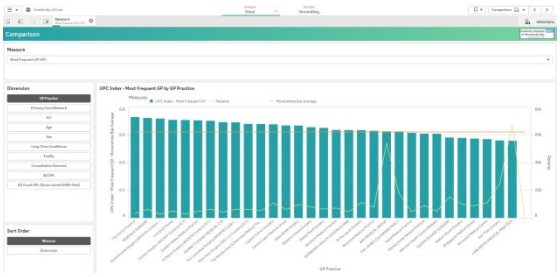


Figure 25: Morecambe Bay Continuity of Care Dashboard's Comparison sheet, displaying 31 practices levels of continuity

The development of the Morecambe Bay Continuity of Care Dashboard has enabled CCG wide, PCN and practice views of the levels of continuity with the ability to instantly filter and drill down to patient cohort and individual levels. Whilst the dashboard negates the need for practices to pull their own data, the impact of incorrect data within the Dashboard's was major risk to project delivery and key performance indicators. Risks were logged and mitigated to ensure data validity, reliability and accuracy. An issue not predicted was the ceasing of all data flow from EMIS to the Continuity of Care Dashboard, resulting in considerable unanticipated work by both the project manager and BI team to rectify. This highlighted how valuable data is to supporting improvements to continuity of care and the project's reliance on the Continuity of Care Dashboard.

Patient Engagement

It is through greater engagement that patients' influence as a stakeholder can be increased. Listening to patients' experience provided an insight from a different perspective. Focus groups enabled a greater understanding of behaviours and the impact that lack of and high levels of continuity had. It reinforced and mirrored the findings drawn from understanding the processes within GP practices, and provided compelling stories to influence others (a lever within the influence model, figure 23).

Many of the known benefits and challenges of continuity were shared by patients; the most surprising view commonly shared by patients was the acceptance that the NHS often struggled to deliver ideal standards of care. Continuity was seen as an ideal that wasn't always possible, when you received it you were grateful but when you didn't there was great acceptance of the challenges general practice faced. Revealing that patients could be easily persuaded to accept consultations with different GPs, reducing their level of continuity.

"I think it's important but I don't think it's practical. For the numbers of people that keep coming in for the number of doctors that they have got here, you can't see the same person every time. If 50 people want to see Dr X it would be impossible"

Figure 26: Quote from a patient who attended a focus group

When developing the Continuity of Care toolkit, both project sites were keen to include a refined version of the programmes patient and staff survey designed by Mott MacDonald. Lessons learned on survey design were shared by Mott MacDonald for its refinement for MBPCC wave 2 practices (as they were not included in the programme level mixed methods evaluation). Survey design and analysis is time consuming and following the design principle of making the improvement journey as easy as possible for others, templates were designed (figure 27). The wealth of data from the surveys analysed at practice level is immensely powerful, it is unfortunate this level of data was not shared to project practices earlier.

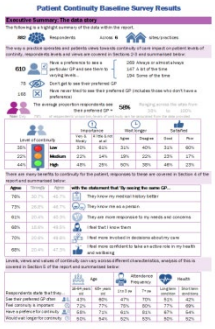

Patient Continuity Baseline Survey Results

Figure 27: Patient Survey Analysis Template, a downloadable resource within the Continuity of Care Toolkit

Tailored Approach

Morecambe Bay GP practices all have EMIS as their electronic patient record system, they all serve patients who live in South Cumbria or North Lancashire, however each practice is unique; their processes, workflow, care delivery model, staffing levels and culture vary significantly. The project adapted the approach within the improvement journey framework for each practice. The measures of continuity, process mapping, and feedback from patients and staff all supported the identification of changes to make, and were different for each practice.

Wave 1 Practices		
Practice	**Measure and Understand**	**Changes identified**
Practice A	• High levels of continuity • High patient satisfaction • Patients willing to wait for continuity • Exhausted GP workforce • GP control over workflow	• Efficient non-clinical processes staff could support and reduce clinical input safely
Practice B	• Low levels of continuity • Challenging clinic diary set up • Poor access to routine appointments • Wasteful and problematic appointment booking process • Instant access to urgent consultations and manipulation of the urgent system by patients • Double handling of patient consultations	• Move to a single system with a single patient flow
Practice C	• AskMyGP system implemented and working well • Information flow processes not complementing new way of working	• Efficient test results communication process • Usual GP changes to support patient and workflow navigation
Practice D	• Time pressured appointment booking system which discouraged continuity to protect partners time • Misunderstood registration process • Feeling of unbalanced workload	• More efficient appointment booking process • Balanced patient list • Pooled GP registration list
Practice E	• Loved and loathed AskMyGP system by patients and staff • Constant phase of flux and change, inconsistent communication and operation • Non-clinical workforce without a voice	• After Action Review of AskMyGP as a system, its implementation and commitment to listen to the learning • Clear vision and direction for the future

The learning from wave one allowed the scoping process to be accelerated for wave two practices. There were key enablers such as an updated 'Usual GP' EMIS field that would support navigation to continuity, but the individual way practices operate means this process cannot be short cut. Change concepts (the original plan hoped to identify in wave 1 and apply to wave 2) cannot simply be adopted en masse; GP practices must go on their own continuity improvement journey. The six steps within the Continuity of Care Toolkit enables GP practices to adapt their approach to suit their population, processes and workforce. This is the rationale for the

toolkit; a guide with supporting resources not an advocated list of changes, every practice is different and their starting points will vary.

Navigation and Flow

Scoping during wave one didn't just help identify possible changes for individual practices it identified common enablers. A 'Usual GP' field reflective of who the patient usually consults with and its fair distribution across the GPs in the practice would support navigation of patients and information to enable improved relational and informational continuity, and equity of workload which would improve patient flow and clinician satisfaction.

For staff to navigate information and patients to the GP they had most contact with, it was common practice for staff to view the patient's consultation history. There is a field clearly displayed on patients' records named 'Usual GP' which ideally should support navigation to a GP responsible for the patient's care. However, none of the project practices believed the 'Usual GP' in EMIS was reflective of who the patient usually consulted with, it was therefore was not relied upon and was often ignored. This additional effort to view consultation history was identified as an obstacle to continuity.

A key output of the project has been the development of a process to identify and maintain the 'Usual GP' field so that it better reflects which GP a patient usually sees and who therefore has overall responsibility for their care. Extracts of data from the Continuity of Care Dashboard, a formula based excel spreadsheet modelling usual GP changes to reflect existing continuity, and a Robotic Process Automation programme to then assign the correct GP to the 'Usual GP' field in EMIS, will assist Morecambe Bay GP practices make changes on mass to their Usual GP field across individual patient records.

It was discovered through process mapping the patient registration process, that the different fields for 'Usual GP' and automated 'Registered' GP within EMIS was commonly misunderstood and exacerbated the underuse of 'Usual GP' as a field to support continuity of care. The 2004 GP Contract recommended that each practice should have a single list of patients and Primary Care Support England (PCSE) support a pooled registered GP list. However, only one third of Morecambe Bay practices have a central code from PCSE for this process to be in operation. A pooled registered GP list has and will continue to be encouraged across Morecambe Bay to support the 'Usual GP' field as an enabler for continuity of care and for efficient processes to allocate Usual GP on patient registration.

As shared by Tammes et al in 2019 findings into the named GP scheme for older patients; simply having a named GP doesn't result in improved continuity of care. Updating the Usual GP field is an enabler to navigation of patients and information flow. Improvements that: increase staff encouragement of continuity; increase the number of patient choosing continuity; create efficient systems and process that support continuity are also needed to reinforce the changed Usual GP. Without this ongoing and proactive approach, the 'Usual GP' field will become out-of-date and any temporary increases in continuity will not be sustained.

Quality Improvement

Knowledge and experience of applying quality improvement (QI) tools, techniques and approached have been invaluable to the project. Whilst the project has funded this expertise, GP practices wishing to undertake their improvement journey do not need this level of experience. It is shared in the Continuity of Care toolkit which imparts that knowledge, experience and application to continuity of care.

The original plan was to train practice staff in quality improvement so they would feel better equipped to lead improvements. The project did not achieve the levels of QI trained staff intended due to the pandemic. However, when delivering facilitated sessions the project manager shared knowledge and coached primary care staff in that activity.

Figure 28: NHSE Quality Service Improvement and Redesign training and tools have been used throughout the project.

The principle of learning from wave 1 to apply to wave 2 was followed; the plan was based on application of change concepts but resulted in application of process. As this project has relied upon QI knowledge and experience of the project manager, it may have detracted from the ownership of leading the improvements within the practices despite having a clinical and operational (and in wave 2 administrative) champions within the practice. This could have been mitigated by a project manager with both QI and primary care experience but the lack of individual's with such a skill set was a gap previously identified by the project's clinical lead, Dr Hugh Reeve when co-authoring the report, *Innovative Models of General Practice* (Baird et al., King's Fund, 2018). As the project progressed from wave 1 to 2 the application of the QI journey to primary care was better understood and the processes accelerated. The ambition to add a third wave in January/February 2021 would have tested out a coaching model using a guide/plan, QI training and action learning set approach in its delivery. Without the break in the programme to consolidate and reflect on learning with time to collaborate and produce the Continuity of Care Toolkit, the guide/plan due to launch for wave 3 would not have been as comprehensive. The planned wave 3 approach and the Continuity of Care toolkit forms the basis of the legacy plan which will aim to increase QI knowledge and improvement leadership within primary care whilst improving continuity of care.

Collaboration and Relationships

Collaborations with other continuity project sites have supported the project work and developments, increasingly so in the second year of the project. Our greatest collaboration is with One Care, a project site with a similar concept, approach and like-minded project manager. From idea concepts of waiting room videos to the co-authoring and promotion of a key programme resource, the project managers' skills and competencies have complemented each other to become a productive team. This collaboration was a welcome connection at times of isolation during the pandemic when the project work dramatically changed. There are many benefits of team working, this virtual partnership/team working reaped many including: fostered creativity and learning, idea generation; shared workload; gained new perspectives; utilised strengths; boosted productivity. The Continuity of Care Toolkit would not be the comprehensive resource it is, without the existence of this partnership.

Figure 29: The Continuity of Care Toolkit authors, a collaborative partnership.

The MBPCC project has benefitted from the sharing of knowledge and support from St Leonard's and Valentine project sites, supporting greater understanding of the measures of continuity of care and influencing the developments of the Continuity of Care Dashboard. The inclusion of the St Leonard's Index of Continuity of Care (SLICC) measure and consultation demand data within the Dashboard has been enabled by the sharing and support from the St Leonard's project team and Data Syrup within Valentine project site.

Whilst virtual working relationships worked well for the task focussed collaborations with other project sites, it did not translate as well for GP practice working. Hampered also by the challenges and greater priority of the response to the pandemic, the virtual working relationship with project practices could not replicate the pre-covid working from GP practice sites. Face-to-face working built good working relationships, provided hands on facilitation using quality improvement theory, approaches, tools and techniques, and also enabled ad hoc interactions and observation opportunities. As the project moves into its legacy phase this has been considered, with training, task setting and action learning set approach to support GP practices lead their own continuity improvement journey.

The project managers pre-existing links with the acute trust and clinical commissioning group of has been beneficial to the project. These links have been widened to include primary care and MBPCC, supporting the legacy plan and future Integrated Care Partnership working.

Scope Change

Due to the pandemic the project plan was unable to continue as it intended, it was hoped that with a six month programme pause the project plan would be able to resume, this unfortunately was not the case. During the programme pause the project manager's scope changed to include support for the COVID-19 response and GP Federation work. This maintained links with practices and built a greater relationship with the Federation and board members. A downside to managing additional projects created a challenge to rein the scope back in when the programme re-started after the pause.

Digital featured within the projects award application with the intention to utilise digital technology to support and enable continuity of care, this in fact became a strong element of the project. With the Continuity of Care Dashboard and Robotic Process Automation programme as outputs that support the measuring of and navigation for continuity. Requests from project practices regarding online consultation products aligned to promoting continuity began prior to the pause and heightened with the increased use of remote consultations during the pandemic. The digital solution review, Morecambe Bay's digital learning event, ICS wide digital online/video consultation engagement and procurement process, and strengthened ICS primary care digital governance and leadership proposals have all been possible due to the change in the project's scope. The reduction of direct practice working provided the opportunity, and enabled the project and the Health Foundation to be responsive to the pace of change for the use of digital in general practice and identify the value and impact this will have.

Other changes to scope included acceptance of South Cumbria GP practices to the project where their patients lived outside of South Cumbria. Expansion of a third wave of practices was cancelled following the introduction of the mass vaccination programme; the planned 3rd wave approach forms the basis of the legacy plan.

Spread, Sustainability and Wider Influence

The Continuity of Care Toolkit is a vehicle for spreading the learning locally and nationally. The MBPCC project award has funded quality improvement (QI) expertise, clinical guidance and incentivised participation and involvement in the external and internal project requirements which has enabled the toolkit to be developed in partnership with One Care. GP practices that access the free toolkit hosted on the RCGP website are given the opportunity to utilise and apply the learning, QI tools and resources from both projects.

Sharing

Emerging learning from the project has been shared through-out the project timeline, locally as part of updates to the MBPCC Board and Morecambe Bay CCG Primary Care Committee, and on the MBPCC website. Learning was shared as part of the organisation and facilitation of the November 2020 GP learning event on the topic of a digital future. At a programme level, the MBPCC project has shared learning with the other project sites and more widely as part of the RCGP Learning Webinar on Top Tips in November 2019, naming five practical things practices can do to start their improvement journey which now feature within the Continuity of Care Toolkit.

Learning is shared in the promotion of the Continuity of Care Toolkit nationally at conferences, webinars and planned events. This has and will include: RCGP conferences (February and October 2021); regional Q Networks; QSIR Teaching Associates and Colleges forums; submissions to Institute for Healthcare Improvement workshop delivery and Health Service Journal Awards.

Legacy Plan

As the project was unable to complete planned delivery as it was intended due to the pandemic, the Health Foundation provided the opportunity to utilise project underspend (~£16K). MBPCC has developed a legacy plan to support sustaining the project's impact locally. The legacy plan will see support continue and widen to all GP practices in Morecambe Bay to enable them to make improvements to their levels of continuity of care, and increase the knowledge and application of quality improvement skills. Aligned to the Hive (the local Continuous Quality Improvement Strategy), links between secondary and primary care will also continue to be strengthened.

MBPCC and its board are committed to supporting continuity of care and foresee it being a core element of its vision for the future of primary care against the backdrop of system reform. This vision for general practice; capturing what is important to general practice in Morecambe Bay, will be explored with GP practices at a learning event in July 2021. The event in addition to sharing the learning from the project will support practices to reflect on the changes to general practice resulting from the pandemic. This will support restoration and recovery using the Royal Society for Arts (RSA) Future Change Framework. The *Understanding crisis-response measures matrix* within this framework (figure 29), encourages differentiation between one-off crisis actions and interventions that have longer-term potential, and between innovations resulting from new activities and those enabled by putting a hold on business and bureaucracy as usual.

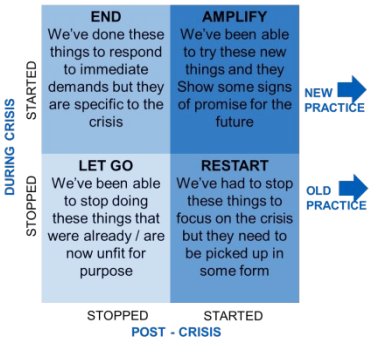


Figure 30: Understanding crisis-response measures matrix adapted from the RSA by QSIR

Wider Influence

Wider influencing and engagement has already started to take place across Morecambe Bay, within practices, PCNs and into the ICS. Expansion of the project scope has enabled linkage of continuity of care with the general practice core digital offer, supporting at ICP and ICS level to promote patient and information flow to the right person at the right time in the right place. The Online/Video Consultation engagement and procurement process shared with practices asks for their help to engage with the process, their staff, patients and ICP digital leads. To reflect and understand their needs and approach for the future through a number of activities, these activities will also support restoration and recovery as general practice finds the right balance of remote consultation for their practice and patients. The evidenced benefits of continuity such as impact upon secondary care use and efficient uses of resources across the healthcare system will also support system restoration and recovery.

"This project has increased awareness of the value of continuity far beyond the pilot practices. More than that, it has encouraged a wider debate about the role of digital solutions around the relationship between patients and clinicians."

Figure 31: Quote from Dr Tim Reynard, Joint Chief Clinical Information Officer for Morecambe Bay

The Health Foundation

Programme Support

Regular update calls with the Health Foundation starting as verbal update become online virtual updates; this enabled sharing visually some of the work being carried out locally. The MBPCC project manager provided project highlight report for each update to outline progress, achievements within the previous month, risks and issues causing problems and planned actions for the future. This was not a requirement but the structure to the meeting was beneficial to project.

Support with local events (alongside a few project sites providing additional support), has been much appreciated assistance and a chance for MBPCC project to share local level working beyond the regular updates.

Whilst there was some connection between the project manager and programme leads to raise and escalate issues. Greater connection and clarity would benefit both programme and project level, with stronger links to the advisory group and risk and issues management.

Learning and Sharing Encouraged

The focus on learning the Health Foundation has fostered has been beneficial for the outputs of the project. The six monthly report writing very much encouraged reflections and it has been a great opportunity to be involved in the programme.

The workshops organised by the programme's Learning partner the Royal College of General Practitioners (RCGP) have been a useful vehicle for networking, collaboration and sharing. The RCGP clinical lead for continuity's promotion of outputs instigated a lot of the fantastic sharing opportunities we have been involved in, though this has generated unanticipated demands on capacity. The RCGP's support for promotion and sharing of major outputs has been appreciated, the timing of transferred expectations on projects have coincided with final report writing. Recommendations for future programmes are to consider what outputs/sharing opportunities are anticipated from the programme, their schedule and identification of support required to prepare the outputs for wider sharing. To provide greater levels of support at these points, with emphasis at end of the programme when outputs are often generated.

Sharing across all project sites has been facilitated to great effect by the Health Foundation and the RCGP. Whilst sharing of concepts and approaches has been encouraged, the mechanism did lead to some concerns that those who invested time and efforts to trail blaze new methodologies may not receive the proportional credit. Clearer ground rules on sharing across projects and stakeholder wide agreement on collaboration or co-opetition could mitigate the risks and foster collaborative working and pollination of ideas.

MBPCC have benefitted from sharing and cross working with reciprocal sites. Collaboration and shared learning could be further encouraged in future programmes which look to benefit from this approach. Sharing project plans and ambitions at the start of a programme, alongside the information of people involved and their contact details would enable greater understanding and earlier connections. Support systems (networks and regular meetings/touch points) for project managers to encourage discussion and sharing progress on equal footings are now enabled greatly by the advert of virtual meeting platforms.

The *Basecamp* forum was established to provide a cross project site network, this started well but lost momentum, possibly due to the pressures caused by the pandemic.

Evaluator Support

The MBPCC project utilised the support of Mott MacDonald (mixed method evaluators) in developing a focus group agenda, learning lessons to refine patient and staff surveys for wave 2 and the Continuity of Care Toolkit. This partnership working has benefitted both parties. A similar relationship with the quantitative evaluators unfortunately was not possible.

In developing the Continuity of Care Toolkit Mott MacDonald shared MBPCC raw data and their analysis, to have received this level of data much earlier in the project would have added to the value of the qualitative data collected, it could have been used to better understand patients views and their perceived levels of continuity at a practice level. It is recommended that external evaluators offer and projects request this wealth of raw data, and where possible external evaluators are commissioned to provide this data to local teams in an analysed format.

Project sites, were not actively supported to develop their own quantitative measures by the programme which is an area to consider improving; for future programmes. Where there are key measures within the research base that would span and support projects, help with this would be valuable. The Quantitative evaluation planning and implementation appears from MBPCC perspective to have taken place in isolation to the local projects. At the time of this report, the quantitative evaluation protocol is unknown.

Opportunity Welcomed

MBPCC would like to express its gratitude for the opportunity to be involved in the project. Continuity of Care will continue to be supported locally with the legacy plan, by the GP Federation and the advocates this project has inspired. MBPCC hope that their input will have in some way contributed to the greater understanding of how to maintain and improve levels of continuity of care for patients across the NHS.

References

Baird, B., Reeve, H., Ross, S., Honeyman, M., Nosa-Ehima, M., Sahib, B. and Omojomolo, D., (2018). Innovative Models of General Practice. London: Kings Fund. Available at: https://www.kingsfund.org.uk/sites/default/files/2018-06/Innovative_models_GP_Kings_Fund_June_2018.pdf [Accessed on 25 June 2021].

Bridges, W. and Bridges, S. (2017). Managing transitions. Making the most of change. London: Nicholas Brearley Publishing.

Keller, S. and Price, C. (2011). Beyond performance: *How Great Organizations Build Ultimate Competitive Advantage*. New York: Wiley.

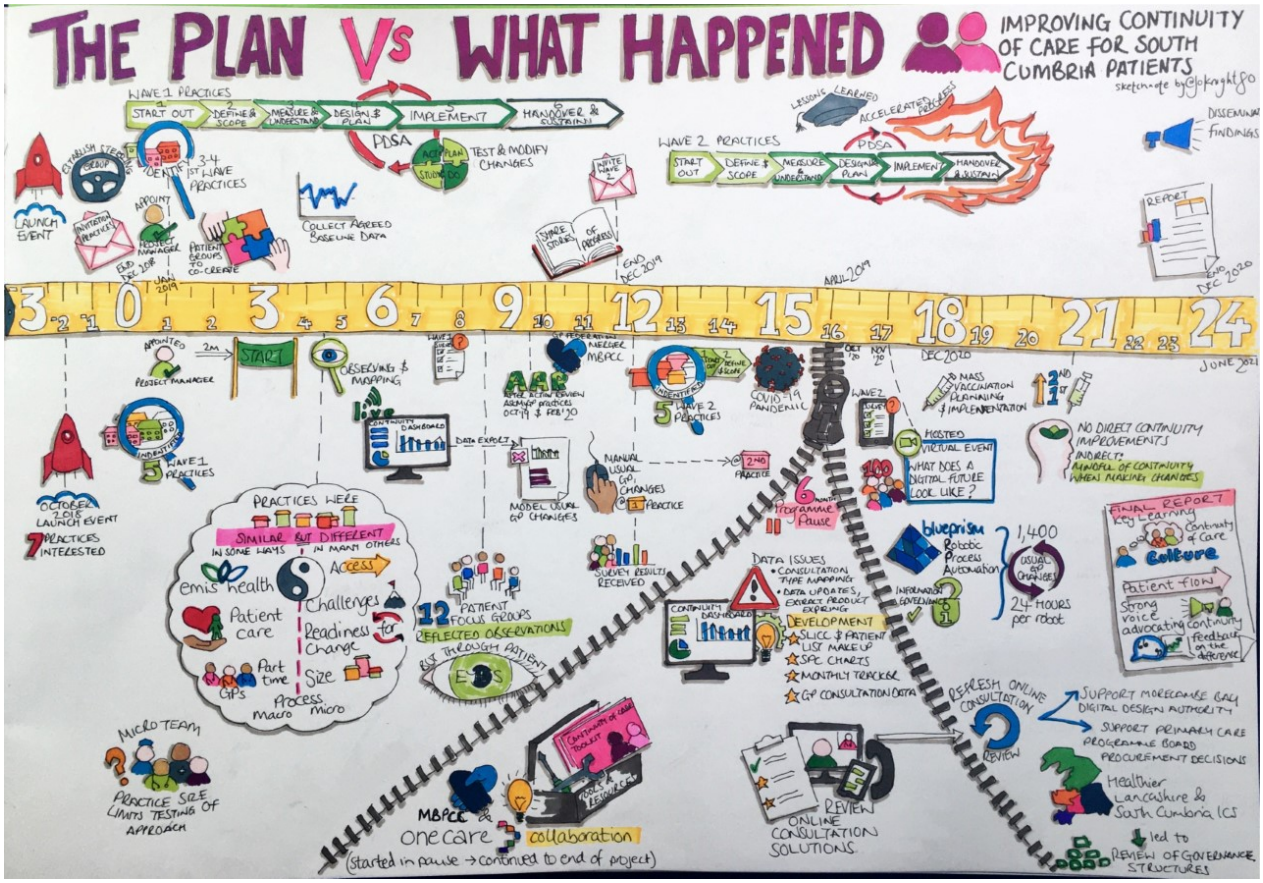
Langley, G., Nolan, K., Nolan, T., Norman, C., and Provost, L. (2009). The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers.

Maurer, R. (2009). Introduction to Change Without Migraines. Available from: http://www.rickmaurer.com/wp/wp-content/uploads/2010/12/Intro-CWOM-tm-final.pdf [Accessed on 25 June 2021].

Royal Society for Arts, Manufactures and Commerce (2020). Future Change Framework. Available from: https://www.thersa.org/approach/future-change-framework [Accessed on 25 June 2021]

Tammes, P., Payne, R., Salisbury, C., Chalder, M., Purdy, S., and Morris, R. (2019). The impact of a named GP scheme on continuity of care and emergency hospital admission: a cohort study among older patients in England, 2012–2016. Available from https://pubmed.ncbi.nlm.nih.gov/31548353/ [Accessed on 25 June 2021].

Appendix 1: Sketchnotes

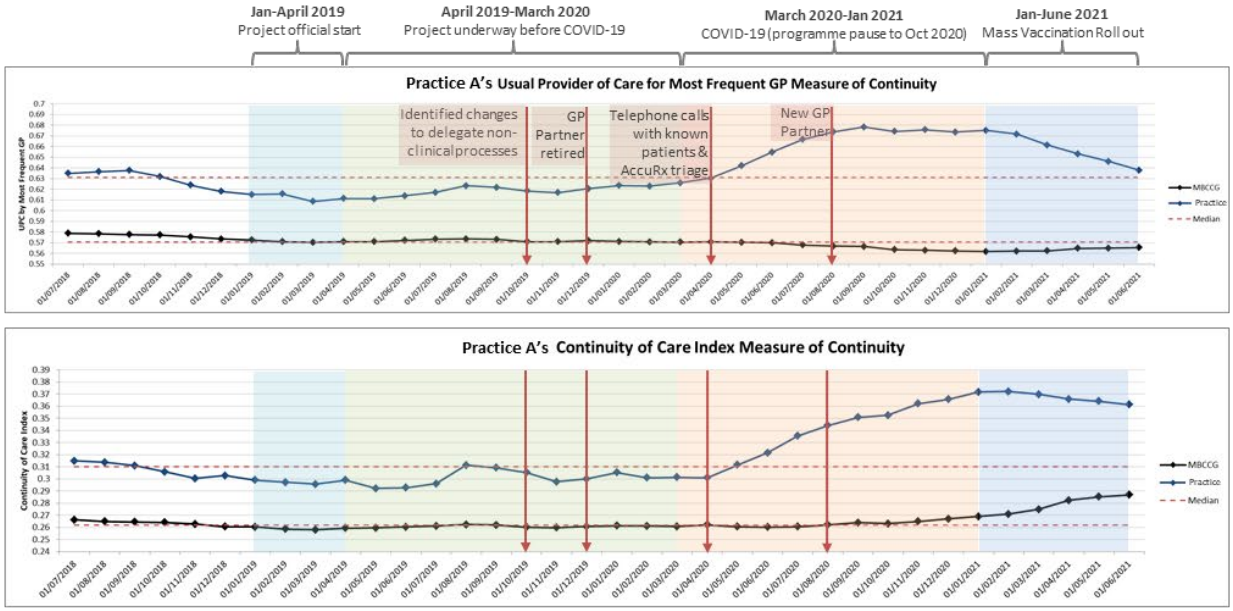


CONTINUITY @ Practice F
THE BENEFITS
HIGHER QUALITY OF CARE
MORE EFFECTIVE COMMUNICATION
ACCUMULATED KNOWLEDGE ABOUT THE PATIENT
GREATER SATISFACTION (PATIENTS & GPS)
MORE TIME EFFICIENT
GREATER TRUST
REDUCES $ USE OF OTHER SERVICES
A&E
GOOD DOCTOR-PATIENT RELATIONSHIP
WE ALSO... think
IT WOULD... REDUCE WORRY
IT'S A... SAFETY NET
IT WOULD BE A... SMOOTHER PROCESS
sketchnote by @bknight80
OUR PART
IN ENCOURAGING & FACILITATING CONTINUITY
CHECK NOTES
& PROACTIVELY SUGGEST
EASIER IF 'USUAL GP' HAS CORRECT
ASK THE PATIENT
WHO THEY SAW LAST
SHARE THE BENEFITS
WITH THE PATIENT (SELL IT!)
IF PATIENTS AREN'T FUSSED SHARE HOW IT'S GOOD FOR THE GPS
MAINTAIN GOOD AVAILABILITY
SO PATIENTS DON'T HAVE TO SETTLE FOR DIFFERENT GPS
DIRECT ACTIONS
TO THE GP THE PATIENT IS SEEING

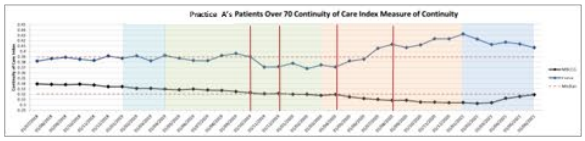
Appendix 2: Wave 1 Project Practices Data Stories

Practice A

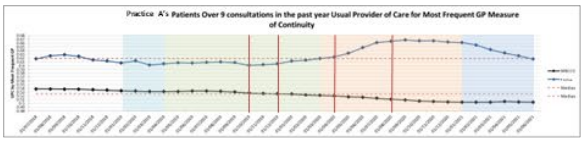
Practice Population



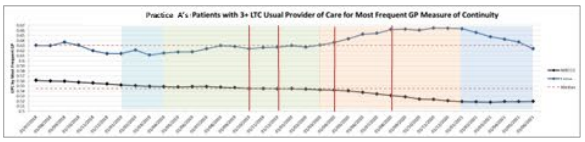
Patients 70 years old or above

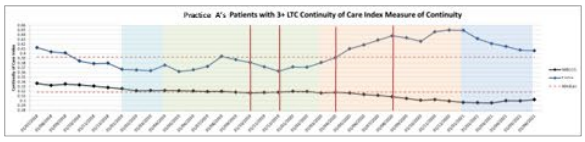


Patients who have received 9 or more consultations in the past year

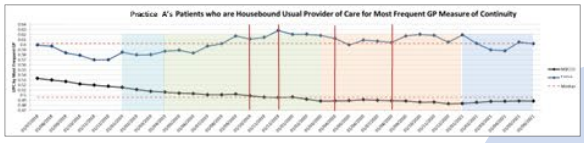


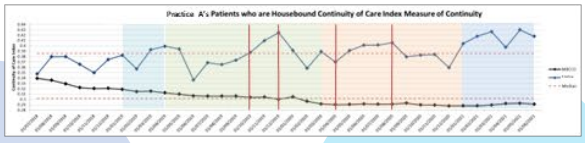
Patients with 3 or more Long Term Conditions



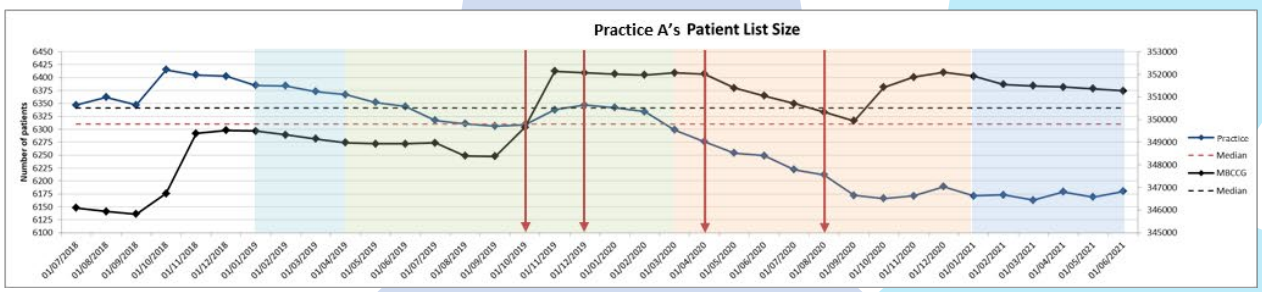


Patients who are housebound



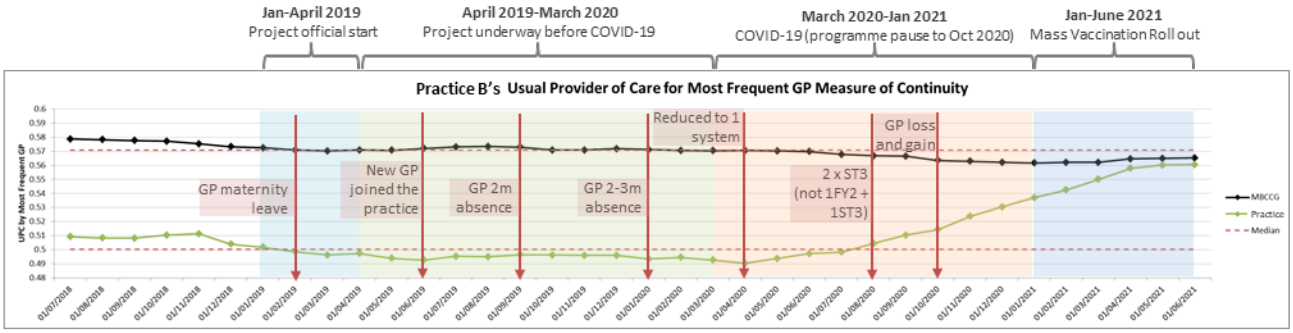


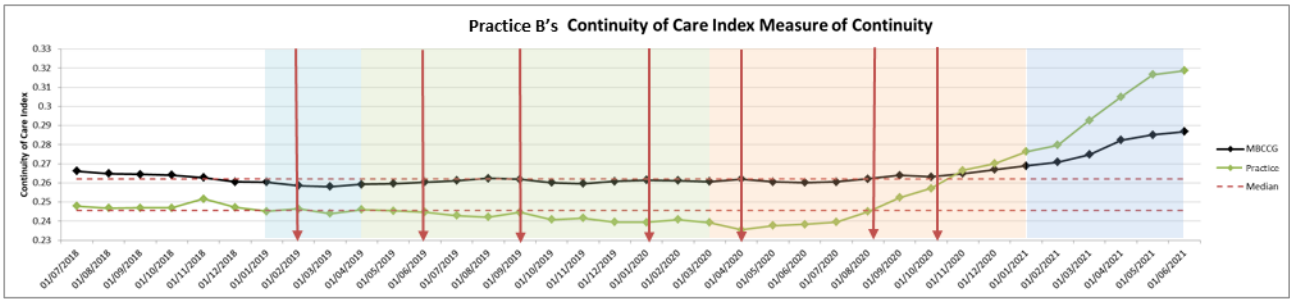
Changes in Patient Population Numbers across the time period



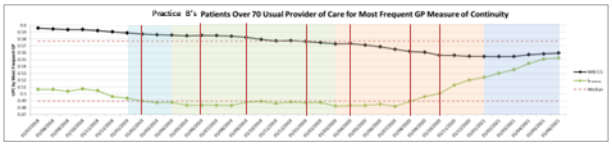
Practice B

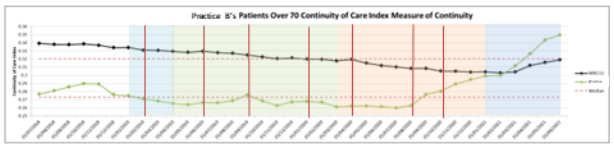
Practice Population



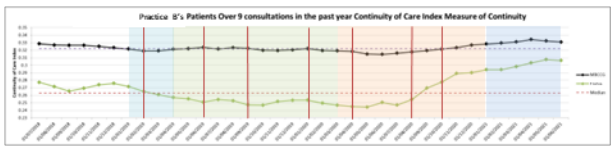


Patients 70 years old or above

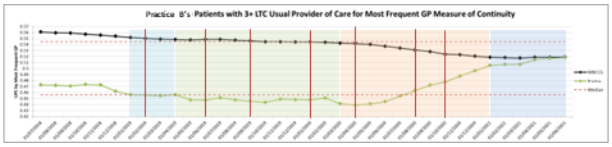


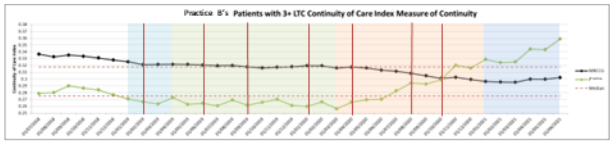


Patients who have received 9 or more consultations in the past year

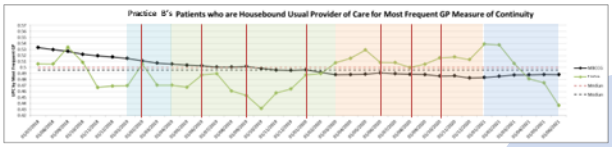


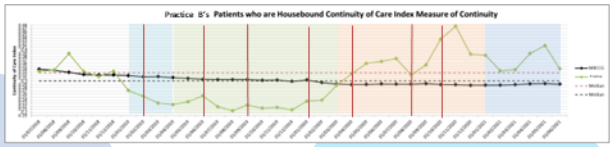
Patients with 3 or more Long Term Conditions



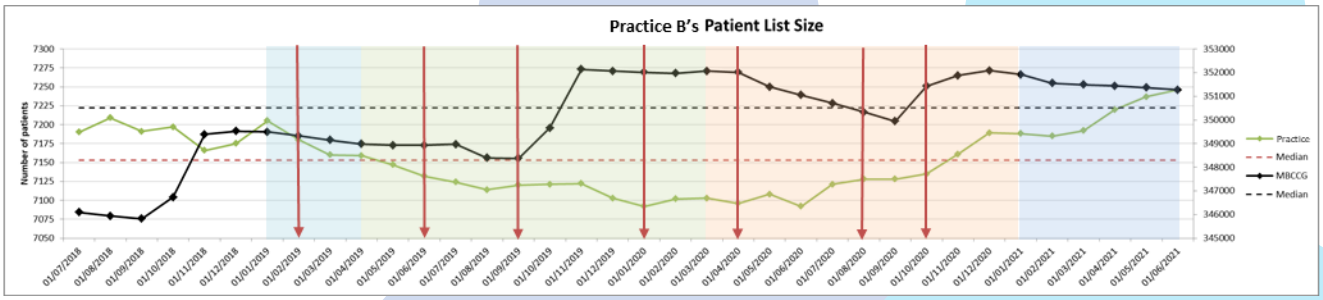


Patients who are housebound



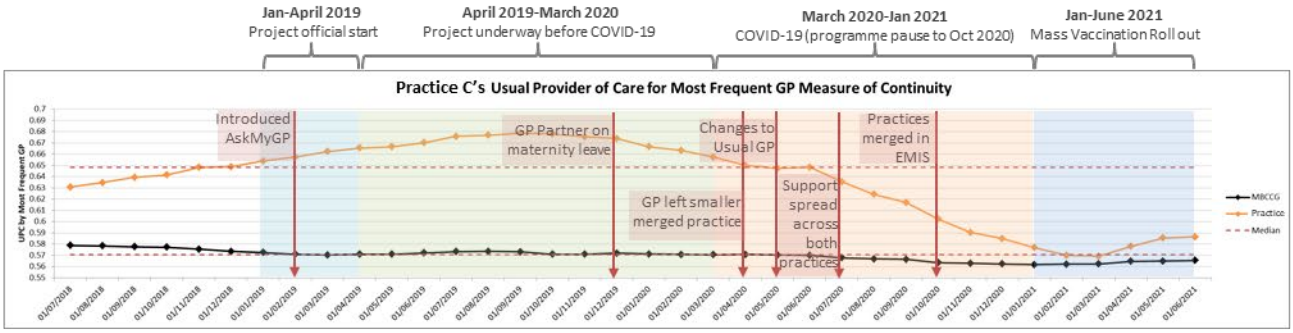


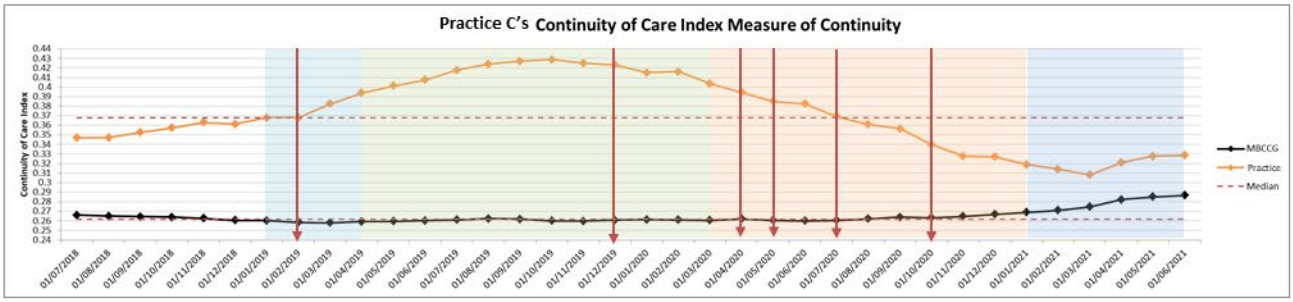
Changes in Patient Population Numbers across the time period



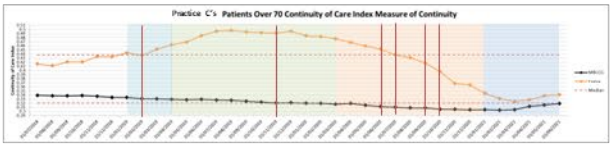
Practice C

Practice Population



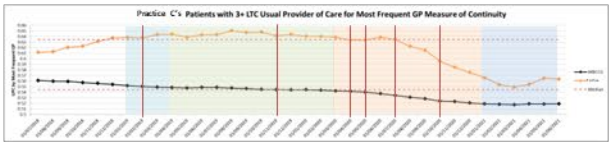


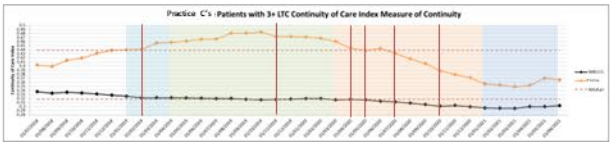
Patients 70 years old or above



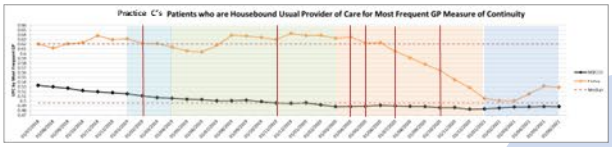
Patients who have received 9 or more consultations in the past year

Patients with 3 or more Long Term Conditions

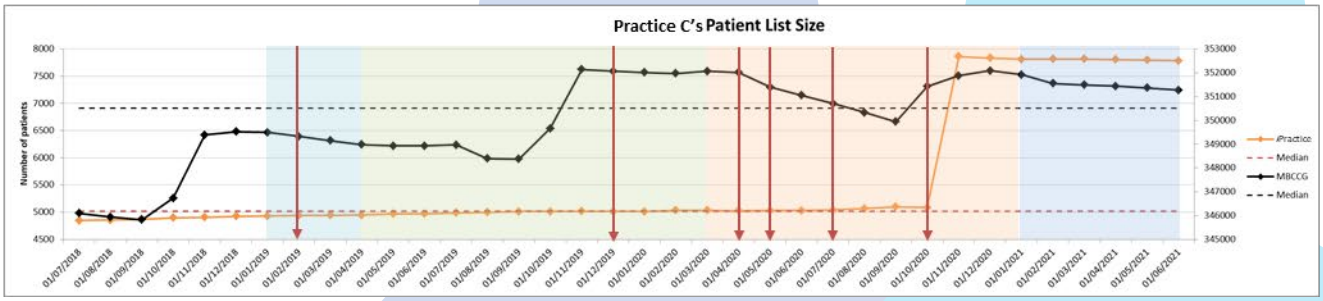




Patients who are housebound

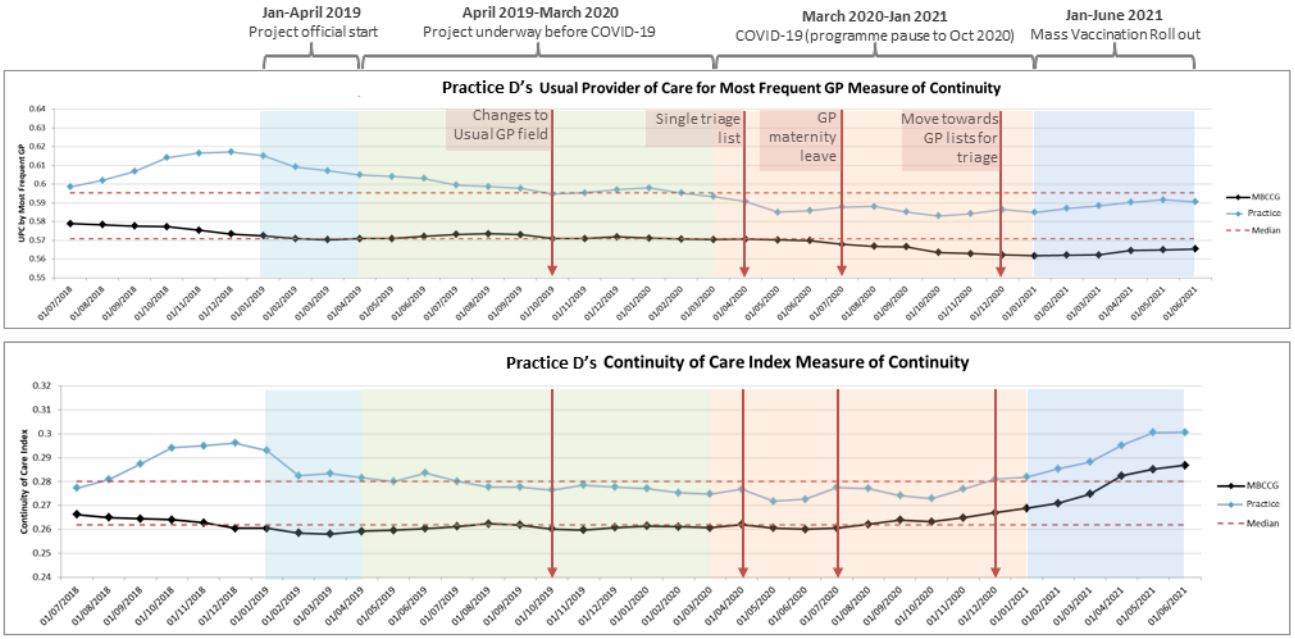


Changes in Patient Population Numbers across the time period

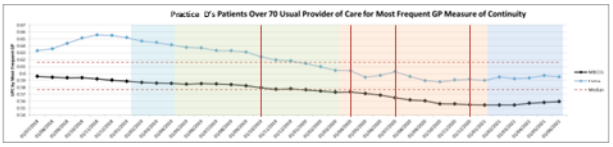


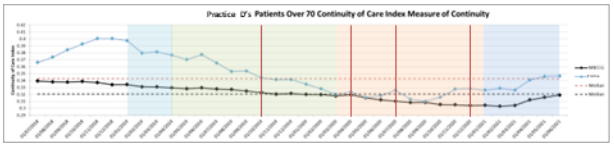
Practice D

Practice Population

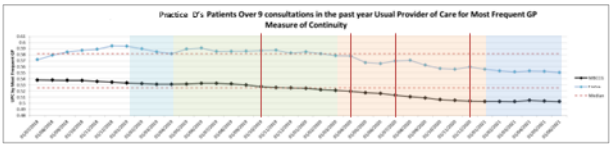


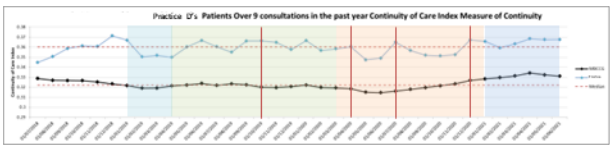
Patients 70 years old or above



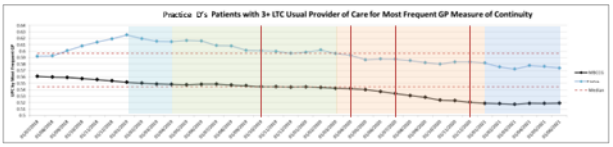


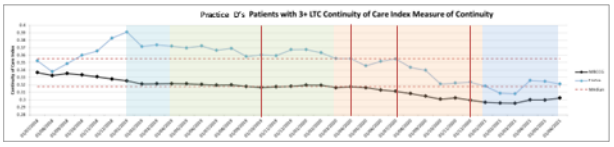
Patients who have received 9 or more consultations in the past year



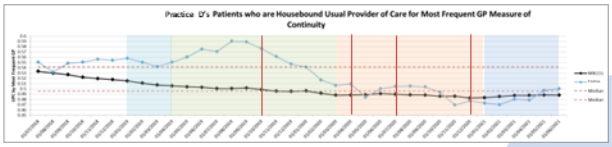


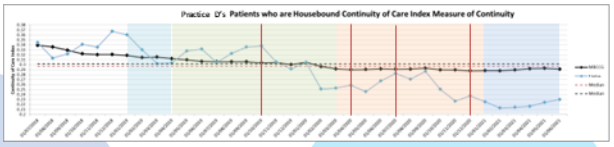
Patients with 3 or more Long Term Conditions



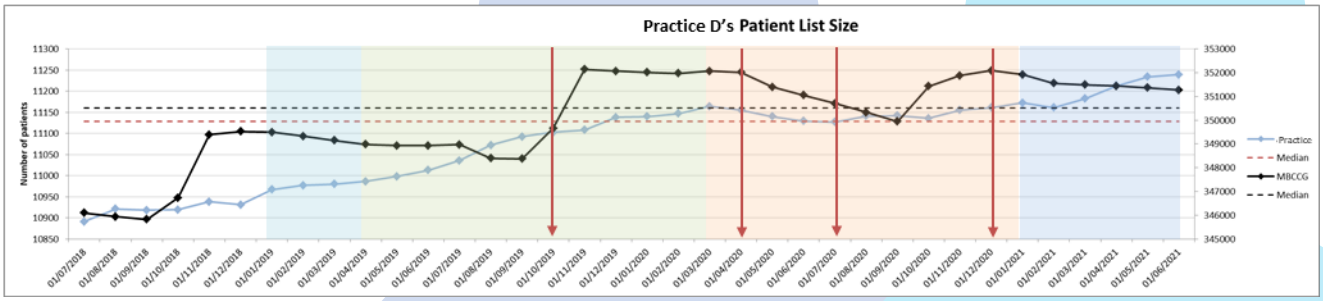


Patients who are housebound



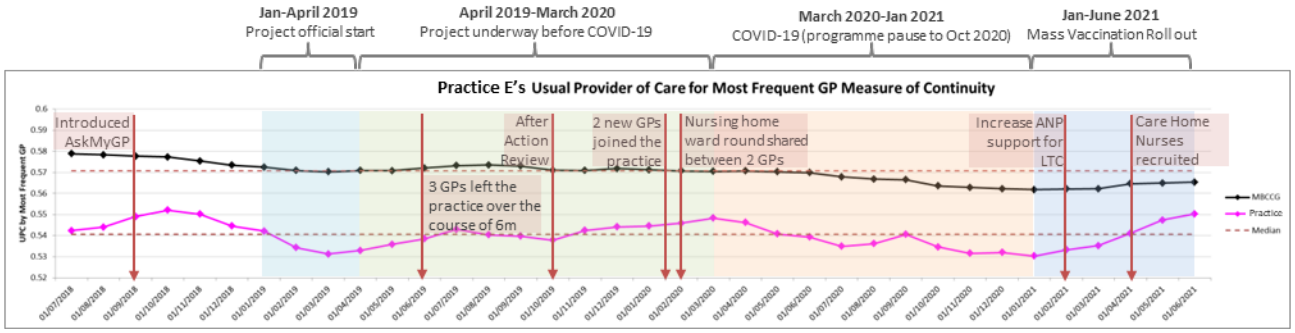


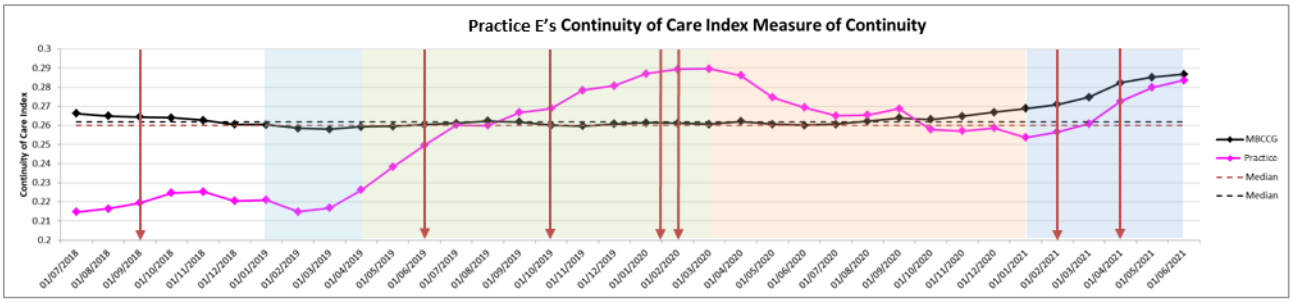
Changes in Patient Population Numbers across the time period



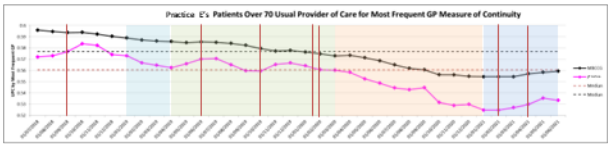
Practice E

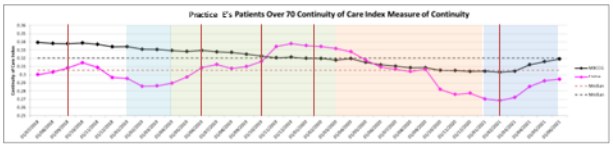
Practice Population



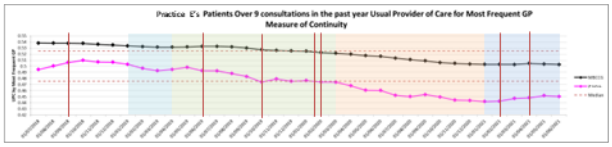


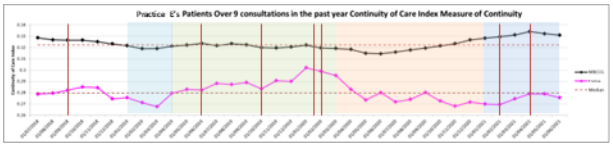
Patients 70 years old or above



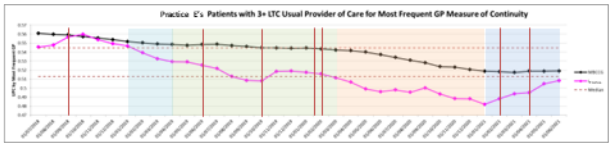


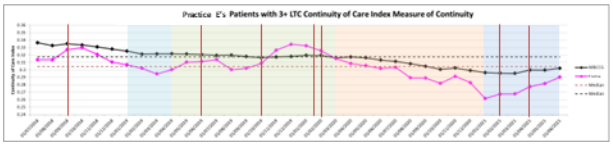
Patients who have received 9 or more consultations in the past year



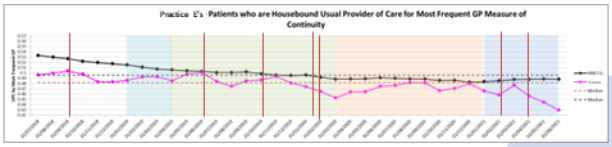


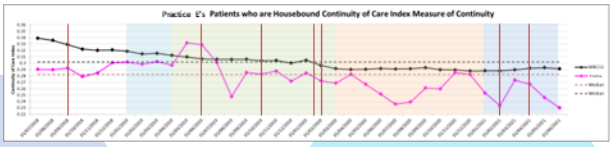
Patients with 3 or more Long Term Conditions



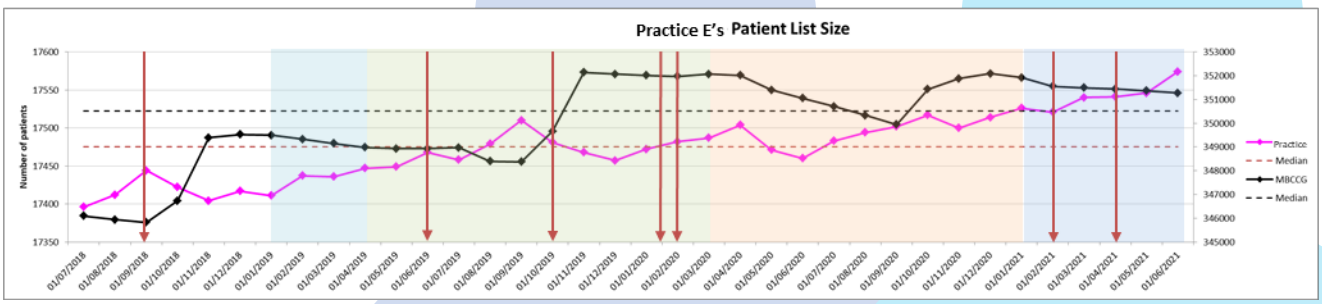


Patients who are housebound





Changes in Patient Population Numbers across the time period

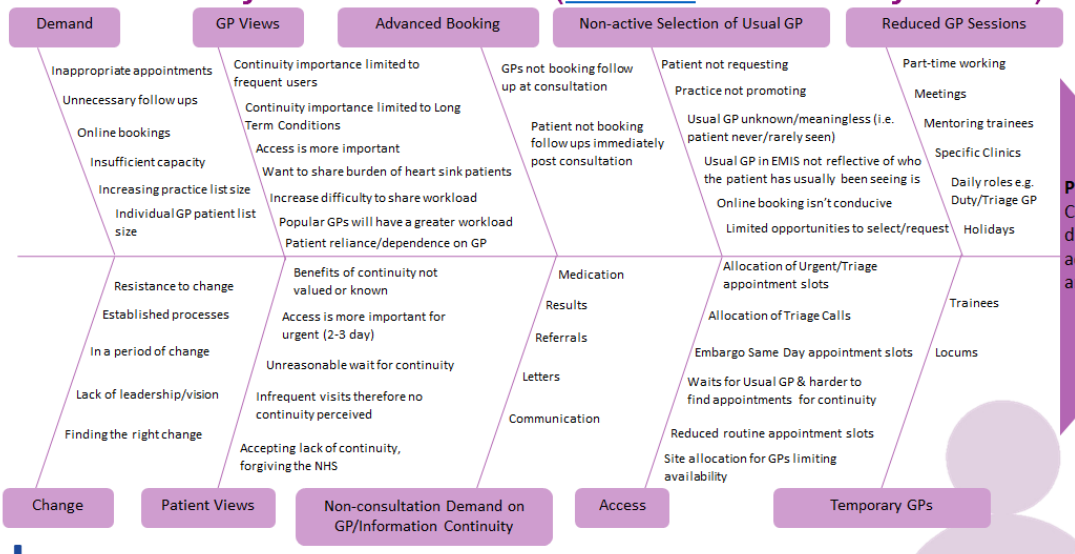


Appendix 3: Continuity of Care Fishbone and Driver Diagrams

Links to: 1b

Fishbone

Aim: To identify cause and effect (barriers to continuity of care)

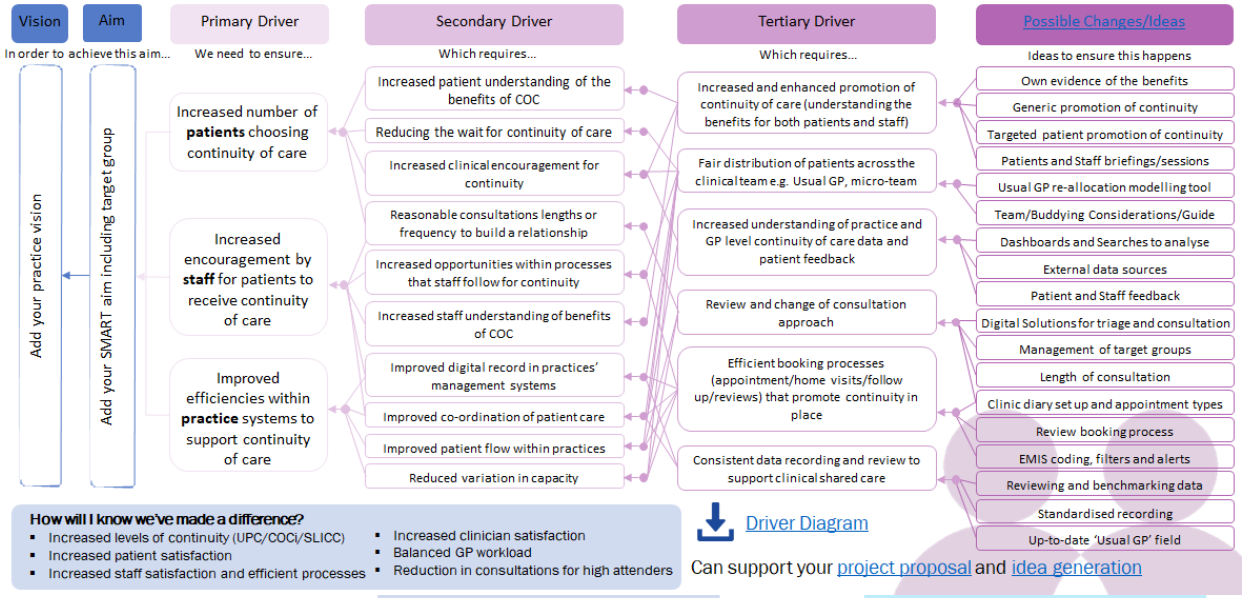


Fishbone Diagram (blank template)

Links to: 2c

Continuity Driver Diagram

Aim: Share the drivers for continuity of care and links to your aim



Driver Diagram

Can support your project proposal and idea generation