Increasing Continuity of Care in General Practice Programme

Mixed-Methods Evaluation

April 2022

Increasing Continuity of Care in General Practice Programme

Mixed-Methods Evaluation

April 2022

Issue and Revision Record

Revision	Date	Originator	Checker	Approver	Description
1.0	20/08/21	Dr Emma Sheridan	Brian Niven	Sarah Reeves	Draft Final Report
1.1	07/09/21	Dr Emma Sheridan	Brian Niven	Sarah Reeves	Incorporates Executive Summary
2.0	15/10/21	Dr Emma Sheridan	Brian Niven	Sarah Reeves	Incorporates peer-review comments and amendments
2.1	26/10/21	Dr Emma Sheridan	Chrysa Servou	Sarah Reeves	Incorporates peer-review comments and amendments
2.2	23/11/21	Dr Emma Sheridan	Chrysa Servou	Sarah Reeves	Incorporates final QA amendments
2.3	08/04/22	Sarah Reeves	Sarah Reeves	Brian Niven	Incorporates final programme comments
2.4	08/09/22	Sarah Reeves	Sarah Reeves	Brian Niven	Incorporates Health Foundation Quality Assurance comments
2.5	14/10/22	Sarah Reeves	Sarah Reeves	Brian Niven	Incorporates Health Foundation Quality Assurance comments

Document reference: 407870 | |

Information class: Standard

Contents

Tables

Figures

Executive summary

> It is important to note that this mixed-methods evaluation report should be read alongside individual project reports and the quantitative evaluation report.

Background and context

Pressures on General Practice have long been rising. The workload is becoming more complex and more intense; with a decreasing number of GPs, an increase in part-time working, an ageing population, increasing numbers of patients with complex conditions, initiatives to move care from hospitals to the community, and rising public expectations.

Continuity of care has been a long-standing, core component of high-quality healthcare and has particular relevance in General Practice. From a patient perspective, seeing the same individual GP is easily understood as continuity of care and most research in the field has focused on this doctor–patient relationship (relational continuity). Informational and managerial continuity are also common forms of continuity. Informational continuity is where clinicians have access to up-to-date patient records. Managerial continuity is where handovers between GPs and other members of the primary care team, providing care to a patient, are timely and efficient.

The evidence supporting continuity of care has been published for decades from around the world and linked to various outcomes for patients, doctors and health systems. Examples linked to continuity of care include improved patient satisfaction, reduced accident and emergency use, better compliance with medical advice and reduced hospital admissions[1].

The programme

The 'Increasing Continuity of Care in General Practice' programme was inspired by The Health Foundation research[2] which demonstrated that patients with ambulatory care sensitive conditions, who see the same GP a greater proportion of the time, have fewer unplanned hospital admissions. The research looked at potential opportunities for improvement that could be used to increase continuity at GP practice level.

The primary aims of this programme were to understand whether approaches can be used to increase continuity of care and explore whether increasing continuity of care can improve patient outcomes. It focused on the process of improving continuity of care in practice and aims to understand how different structural solutions, enabling technologies and cultural conditions may increase continuity of care in the General Practice setting.

The programme also explored the relationship between increased continuity and increasing access to General Practice services. The programme set out to identify the possibilities, benefits and unintended consequences of increasing continuity of care in the current context, where the General Practice workforce as a whole is under strain,[3] there is policy pressure to increase timely access,[4] and patients' needs are becoming more complex[5].

---

[1] Pereira Gray D, Sidaway-Lee K, White E, et al. Improving continuity: THE clinical challenge. InnovAiT 2016; 9(10): 635–645.

[2] Barker I, Steventon A and Deeny S (2017) 'Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data', BMJ 356, j8

[3] Davies E, Martin S, Gershlick B, 'Under Pressure: What the Commonwealth Fund's 2015 international survey of general practitioners means for the UK', Health Foundation, February 2016.

[4] NHS England. General Practice Forward View. 2016.

[5] Steventon A, Deeny S, Friebel R, Gardner T, Thorlby R, 'Emergency hospital admissions in England: which may be avoidable and how?', Health Foundation briefing, May 2018.

The programme was developed with the advice and support of the Royal College of General Practitioners.

Introducing the project teams and their interventions

The programme supported five large-scale projects across English GP practices and federations to carry out targeted improvement work to increase continuity in their practices. The five project teams covered over half a million patients and over 45 practices. The initial plan was for the 24-month projects to complete in December 2020; however, a six-month pause period was introduced from April to October 2020 to accommodate the impact of the Covid-19 pandemic and the additional pressures that generated. Instead, four of the projects ran from January 2019 to July 2021, and the project led by Valentine Health Partnership ran from January 2019 to June 2020.

The five project teams funded as part of the programme are:

- Continuity by Design (Pier Health)
- Continuity Counts
- Morecambe Bay Primary Care Collaborative
- One Care
- Valentine Health Partnership.

Across the five projects, there were areas of commonality and difference in the activities that were implemented. Due to the challenges and delays as a result of the Covid-19 pandemic, some activities were still in the process of being implemented or embedded at the time of writing.

There are four key features of these approaches across the project teams:

- **Staff engagement and communication:** to raise awareness of the evidence base for continuity, secure 'buy in' and explore locally how this could be increased
- **Patient engagement and communication:** to raise awareness of continuity, provide information on its benefits and set out what patients can do to request this
- **Patient allocation and workflow improvement:** to increase continuity of care through appropriate allocation of GPs and patients, development of personal lists, and other changes to improve practice processes
- **Measurement and monitoring of continuity**: to locally develop and establish tools, dashboards and other reporting mechanisms against continuity measures for monitoring.

Appendix A provides a case study on each project team outlining the interventions implemented across these four areas of focus.

The aims and objectives of the evaluation

The evaluation of the programme is focused on developing and sharing learning about the process of improvement of each of the five projects and their teams. Two evaluations have been commissioned to capture this learning: this mixed-methods evaluation and a quantitative evaluation to be undertaken by the Improvement Analytics Unit (IAU). The quantitative evaluation has set out to explore whether continuity of care has increased across the practices in the programme and how this compares to the national trend. Therefore, it is important that the content of this report is contextualised alongside the findings of the quantitative evaluation and project team reports.

The mixed-methods evaluation team were responsible for the design and delivery of an evaluation that captures the experience of patients and staff and seeks to understand the underlying interventions implemented by each of the projects.

In doing so, we set out to understand:

- What was done and where?
- How this was done and with what resources?
- What effect this had on continuity, patients, workforce or the system?
- What learning was generated in the processes?

Methodology

The mixed-methods evaluation team undertook:

- Surveys (at the start and end of the programme) with staff and patients across the projects
- Interviews with patients, strategic stakeholders, leaders, and staff in project teams
- Observation of events such as governance groups and project-wide learning workshops
- Analysis of existing data, through the GP Patient Survey (GPPS)[6] and local data or reports.

Limitations and considerations to the evaluation

As with all mixed-methods studies, there were limitations to the evaluation of the Increasing Continuity of Care in General Practice Programme. This evaluation was undertaken based on a Service Evaluation model for the programme. Therefore, the insights described must be taken within the local setting of the projects and their registered population. Caution should be taken when assuming that these findings are transferable and generalisable on a national basis.

The disruption to usual care in general practice during the COVID-19 pandemic meant that the IAU were unable to carry out the original planned quantitative evaluation. Local measures of change in continuity, reported by project teams, have therefore been described within this mixed methods report. This has been supplemented by a quantitative study undertaken by the IAU which provides descriptive analyses comparing trends in continuity of care in general practice nationally to trends in practices participating in this programme.

Impact

Different sources of information from the mixed-methods patient and staff surveys, the GP patient survey and locally collected measures from the project teams have been used to describe the degree to which the initiatives have influenced continuity of care.

The perceived importance of continuity of care increased across staff groups in General Practice:

- The proportion of GPs who felt that continuity of care was 'very important' increased from 16% to 37% (*2019 n=51; 2021 n=30*)
- The proportion of the wider clinic team who thought that continuity of care is 'important' (combining 'very' and 'mostly' responses) increased from 78% to 93% over the course of the programme support (*2019 n=51; 2021 n=14)*
- Responses from the practice management and administration team highlight an increase in the importance placed on continuity of care; 'very important' responses increased from 37% to 54% throughout the formal programme period (*2019 n=147; 2021 n=52).*

---

[6] The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over two million people across the UK. The results show how people feel about their GP practice.

Continuity of care remained as a strategic priority throughout the Covid-19 pandemic

- More specifically, 60% of respondents ranked increasing continuity of care in their top 3 strategic areas: 63% of GPs, 46% of the wider clinical team and 62% of practice management and administration teams *(n=90)*.

Project teams described an increase in continuity of care measures locally

- Each project team has undertaken its own local analysis of measures of continuity. At a project level, continuity measures have experienced small improvements or have been maintained. Section 4.3.1 provides detailed commentary on these measures.

Mixed-methods survey highlights an increase in patient-reported continuity of care measures

- Patient-reported continuity of care increased from 0.58 in the baseline survey to 0.64 in the summative survey (*2019 n=713; 2021 n=982)*
- When categorised into those with low, medium and high continuity, there was no change in the proportion of patients who had high continuity over time. However, there was an 11% shift in the proportion of patients with a low continuity index into the moderate category.

Availability to see or speak to the preferred GP over the programme period and throughout the Covid-19 pandemic varied

- Over the programme period, 21% of patients found it easier to see or speak to their preferred GP and 30% described that there was no change, whilst 49% of patients described it to be more difficult *(n=1458)*
- Reasons for finding it easier included changes to practice systems and ways of working, often linked to interventions implemented locally as part of this programme. Patients also described taking ownership of the process and having knowledge of how to request continuity.
- Reasons for finding it more difficult were often aligned to the use of online platforms, the resources and workload of staff and total triage systems implemented as part of the Covid - 19 pandemic.

Project teams were able to maintain levels of patient-reported continuity compared to the national picture, without detriment to timely access

- In 2018, the GP Patient Survey showed that 49% of patients in the practices involved in the programme saw their preferred GP 'Always or almost always/A lot of the time'. This was comparable with the national picture. Over time however, the national figure reduced to 45% in 2020, while for the programme practices, this figure remained at 49% (*2018, n=1399; 2020, n=1354).*
- For those practices which showed the greatest improvement in continuity, further analysis of the GP Patient Survey on patient satisfaction with the available General Practice appointment times, demonstrates that these practices do not always experience reduced patient satisfaction with access. Patient perception of timely access in these practices, where patient-reported continuity has been improved, show little difference compared with the national trend.

Benefits and consequences of increasing continuity of care

Project stakeholders described benefits and consequences for patients

- Patients were perceived to be more informed about continuity of care and how to achieve it
- The doctor-patient relationship enabled co-production and shared decision-making
- Those who found it easier to see or speak to their preferred GP felt that the GP was more responsive to their needs and concerns
- Patients were more inclined to be proactive in self-care
- Patients who found it easier to see or speak to their preferred GP in the past two years reported having greater overall satisfaction with their practice
- When asked, 61% of patients would be willing to wait longer to see or speak to their preferred GP
- The culture shift towards continuity has resulted in some patients becoming *"disgruntled"* when they prioritise rapid access over continuity
- The prioritisation of continuity within practice principles had led some patients to feel that they had lost their ability to choose between access and continuity of care.

Project stakeholders described benefits and consequences for the workforce

- Increased staff satisfaction was reported across the programme for both clinical and non-clinical staff. This was linked to a number of reasons:
  - Through managing their own patients, their results and care pathway, without the stress of trying to piece together the decisions or thought process of a colleague
  - Finding it easier to manage clinical uncertainty without referring to another service
  - Increased sense of professional responsibility
  - Improved quality of consultations which enable GPs to find it
  - Improved collaborative working across colleagues both within and across practices within the project
  - Specifically, in the Valentine Health Partnership project, 73% of staff surveyed said the increased continuity achieved through the project had made their working life easier or not affected it *(n=30)*
  - Whilst we were unable to evidence it quantitatively, there was a belief that there were fewer patient complaints received from patients
- Adhering to and implementing continuity-focused processes has caused challenging conversations and additional stress for reception teams and care coordinators
- A **more evenly distributed workload was noted across the clinicians in a practice**. Reducing variation in workload has resulted in some GPs noting a reduced workload, some an increasing workload and others having no effect.

Project stakeholders described benefits and consequences for the system

This area of interest was more difficult to extract learning, compared to patients and the workforce, and system benefits and consequences may likely be more evident longer-term. Nevertheless, through engagement with project leads and practice staff, we can describe that there has been:

- **Strengthened links with local Patient Participation Groups (PPGs)**
- **Better understanding from teams of their practices and their data**
- **More efficient and streamlined practice processes**

- More efficient use of consultations, particularly for remote consultations, *"the massive increase in remote consulting that has occurred caused by the Covid-19 pandemic has only emphasised further to me the importance of continuity of care for patient safety and practice efficiency".* This was supported by local survey data which showed that 76% agreed that it made it **easier to provide follow up by telephone or video consultation** *(n=30)*
- There was a suggestion that early evidence has shown shorter consultations for patients of which were 'continuity patients'
- Local data from the Valentine Health Partnership suggested that patient who had achieved continuity with their usual GP more than 50% of the time had fewer attendances at A&E and urgent care.

Implementation of continuity of care initiatives

The context of each project team was different and their approach to implementation varied as a result of this. It is important to recognise that project teams also started from different positions in their continuity journey.

The figure overleaf highlights the key contributing factors for success and categorised by their link to the patient, workforce, practice, project or programme.
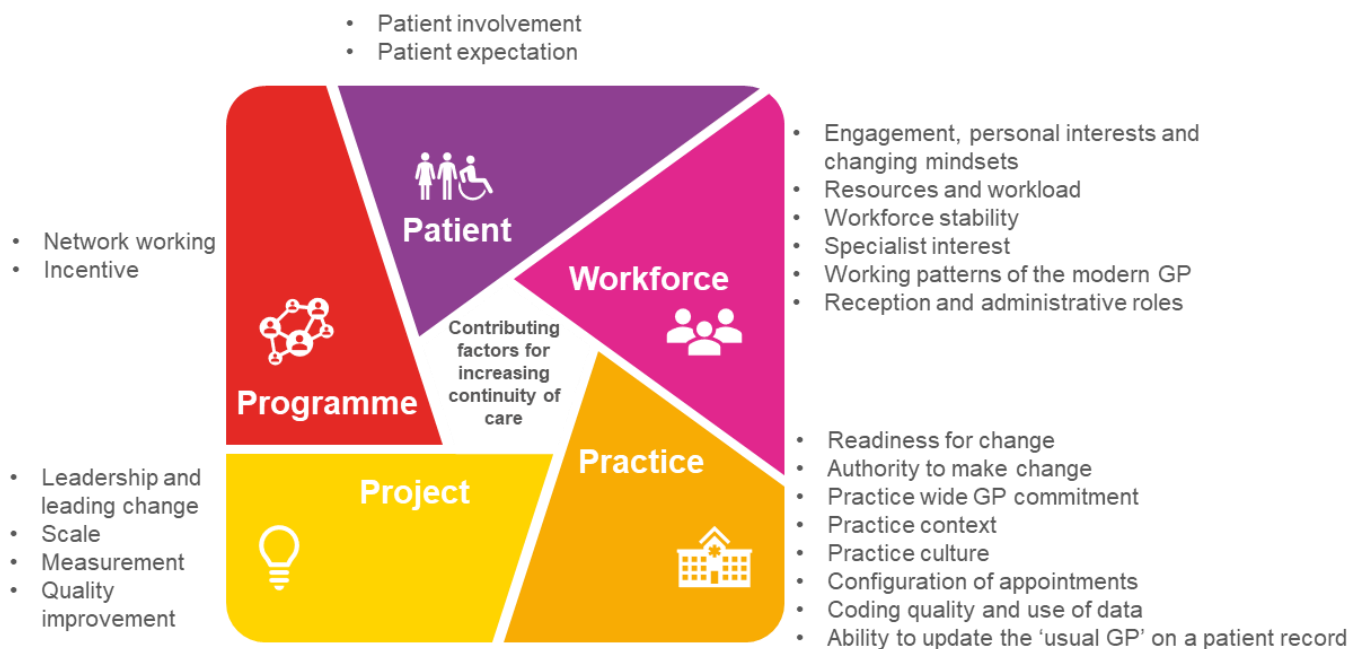
In the main body of the report, these factors are also considered in two categories: 'factors relating to the process of change in General Practice' and 'factors relating to the delivery of continuity'.

Resources required to implement

Bringing together the contextual factors and key ingredients for success, the resources that have been required in project teams includes:

- A balance of people with the right skills and influence to facilitate change at both a project and practice level Building on a solid understanding of the evidence relating to continuity of care. Sharing evidence with practices about what is known about continuity and the benefits associated with this helped to generate buy-in from teams within the local practices and created local discussion

- Creating shared expectations. Whilst the programme can be described as GP-led, many of the day-to-day process changes were the responsibility of non-clinical teams. It has therefore been important to involve the workforce from across the practice
- An ability to share continuity measures and enable practices to track their progress over time
- A structured approach to working with practices to enable change. This has varied across projects but the resulting toolkit (developed by the One Care and Morecambe Bay projects) for use by others, outlines a six-step process that is underpinned by a QSIR methodology.

Evidence of spread activities and successes

Here, we highlight successes of how the implementation or awareness of continuity of care initiatives spread over time. We focus on two arms of spread:

- Spread within the project teams
- Spread beyond the project teams.

Within the project teams	Beyond the project teams
A simple representation of this is in the projects who took a **'wave' approach**; Morecambe Bay and One Care used the learning from wave one practices shaping their approach in the wave two practices	As part of the learning support, RCGP hosted and delivered two waves of **webinars on lessons from the programme**
Through sharing learning and successes, those **previously absent practices expressed an interest** in becoming involved with activities to promote and increase continuity of care	The Health Foundation produced a **blog** describing 'four lessons from the frontline'
Towards the end of the formal programme period, there was a greater interest from practices to **share learning and initiatives with their PCN**	**Conferences** have been an avenue where work of the programme has been showcased, through the RCGP conferences, WONCA, Health Services Research UK and Evaluation Society conferences
We have observed spread beyond the PCN but to Federation levels in Morecambe Bay, where the project team will have hosted two **federation-wide sessions on continuity of care**.	The Continuity Counts team have published a number of **journal articles** to share their learning
Learning workshops run by RCGP provided the project teams with an opportunity to come together to learn from one another	The projects sites were highly commended in a **nomination for a Health Service Journal Award** focused on changing culture. This raised awareness of the programme with a wider audience
To support more ad-hoc discussions and sharing, a **forum was set up within the Basecamp** platform	Members of the Morecambe Bay team became involved with linking continuity of care with the wider General Practice core digital offer and 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 networks developed across the project teams resulted in **visits between teams**	
Through interactions between project teams, it was clear that there was **cross-pollination and spread of ideas**. Over time the 'menu' of approaches to increase continuity became similar across teams, yet still nuanced in each context	

Programme legacy

One of the key outputs from the programme funding has been the **development of the Improving Continuity Toolkit for GP practices**, led by two project teams and supported by

RCGP. From the outset, One Care had planned to develop a toolkit to share knowledge of the interventions and the steps taken in implementation. Through the programme's network, traction was built in the shared learning specifically between the One Care and Morecambe Bay projects. This was accelerated by the 'pause period' of the programme, where the two project managers continued to develop the local projects – whilst also supporting wider Covid-19-related activities in their respective Federation, CCG, or Trust. Together, they brought experiences of continuity initiatives in over twenty practices: spanning across different geographies and each with their own contextual challenges, such as rurality, deprivation, and experience of making improvements locally. Insights and tools from the mixed-methods evaluation were included in the toolkit.

Another target for the legacy of the programme is the developing conversation with stakeholders from the electronic patient record system providers. It is clear from the work of the programme that measurement is key; however, this often becomes a manual or "offline" task for members of the practice team. Given that the data inputs originate from within the systems (such as EMIS and SystmOne), those associated with the programme are exploring the feasibility of building in a one-stop, simple measurement tool within the system itself.

New learning gleaned from evaluating the Increasing Continuity of Care Programme

Throughout the evaluation, much learning has been gathered from local teams about continuity of care and lessons from implementing initiatives to increase it. New areas of learning which evolved from the Increasing Continuity of Care in General Practice Programme include:

- An emerging role for episodic continuity in General Practice (where a patient interacts with the same health care professional for an episode of time or care)
- Continuity of care remained a priority through the Covid-19 pandemic
- The importance of continuity of care in remote consultations
- Continuity of care and timely access are not opposing principles
- Increasing continuity of care can be beneficial to others in the practice beyond GPs
- Multi-disciplinary micro-team working hadn't gained the traction that was expected
- Measurement of continuity of care is key
- Learning about measuring continuity for practices at different stages of their continuity journey.

Concluding remarks

The 'Continuity of Care in General Practice Programme' aimed to explore the potential for general practice to increase continuity of care for its patients and improve their care. This mixed methods evaluation set out to capture the experience of patients and staff and sought to understand the interventions implemented by five project teams awarded funding by The Health Foundation to increase continuity of care in General Practice.

Over the period in which this programme has been undertaken, General Practice has been through a period of rapid change and challenge. Nonetheless, the evidence presented within this report highlights that **benefits can be achieved through increasing continuity of care for both patients and the primary care workforce** within the practices involved in this programme.

It must be noted that **there were some challenges through implementation**. In comparison to the patients and the workforce, there was limited evidence that had shown benefits or consequences to the wider system through the mixed-method evaluation. It may be that these will come to fruition beyond the formal programme period.

Locally reported measures of continuity, at a project level, suggest that **levels of continuity have been maintained or have experienced some improvements**. Our patient-reported continuity of care index also suggested that those practices with existing high and medium levels of continuity were able to maintain this, and, for those with low continuity, this had increased over the formal programme period. Given the context in which practices had been working, it can be observed that **this is in contrast to the national trend**, in which patient reported continuity across England has decreased, although it is not possible to attribute this to the impact of the programme.

In individual practices where locally reported levels of continuity have decreased, this is thought to have been influenced by a lack of consensus in the prioritisation of continuity between the GP partners, an inability to implement project interventions, as well as practice changes which have impacted measurement, such as a merger.

A range of improvement interventions were implemented and sat across a number of core themes: staff engagement and communication, patient communication and engagement, patient allocation and workflow improvements and the measurement of continuity of care. Of the interventions implemented by practices, those which best withstood this period **combined embedded changes in ways of working and processes, as well as bringing about a cultural shift towards a continuity culture**. Measuring continuity can be complex but it can be an important first step in enabling improvement.

The evidence base for continuity of care is widely established, however, this programme has been valuable in enabling practices to implement different approaches to increase continuity of care. This mixed-methods evaluation has contributed to the continuity of care evidence base; showing that both **longitudinal and episodic continuity of care can be beneficial,** and that continuity of care **does not need to come at the expense of timely access**.

The programme has also brought new insights which are valuable in advocating for continuity and its relationship with national priorities such as access and relationship-based care. The Continuity of Care Toolkit highlights 'what can be done' and holds practical tools to facilitate the implementation of continuity of care improvements.

This programme moves forward the conversation about continuity of care in General Practice from 'why continuity' to 'how continuity'. The work of the mixed-methods evaluation indicates that implementing interventions to increase continuity of care is achievable and that it *can* be done in the challenging landscape of General Practice.

1   The role of continuity of care in General Practice

Pressures on General Practice have long been mounting. The workload is becoming more complex and more intense; coupled with a decreasing number of GPs, an increase in part-time working, an ageing population, increasing numbers of patients with complex conditions, initiatives to move care from hospitals to the community, and rising public expectations.

Continuity of care has been a long-standing, core component of high-quality healthcare with particular relevance in General Practice. The evidence supporting continuity of care has been published for decades from around the world and linked to various outcomes for patients, doctors, and health systems. Examples linked to continuity of care include improved patient satisfaction, reduced accident and emergency use, better compliance with medical advice, and reduced hospital admissions[7].

The significance of improving continuity was highlighted by a study from The Health Foundation which indicated that a higher continuity of care, determined by the Usual Provider of Care (UPC) index, is associated with lower avoidable hospital admissions[8]. Therefore, increasing continuity of care holds much potential to improve patient outcomes in primary care and throughout the system.

One of the main challenges in General Practice stems from balancing the expectation and desire for rapid access to care and continuity of care. The belief is that demand for rapid access can make continuity of care difficult to achieve, something that is made harder still by changes to professional working patterns, larger practice sizes and out-of-hours care. Practices are finding it increasingly difficult to recruit and retain GPs; fewer GPs are choosing to undertake full-time clinical work with more opting for portfolio careers or working part-time. Collectively, this presents as an additional challenge to improving the continuity of care.

Measures of patient experiences, such as the GP patient survey, provide some insights as to how continuity of care has changed over time. In the 2020 GP patient survey, half of patients reported having a GP they prefer to see, and of these, 22 per cent 'always or almost always' get to see this GP. This has steadily over time declined from 42 per cent in 2012.

1.1   Types of continuity

It is important at the outset to define continuity of care and various dimensions of continuity covered by this broad term. From a patient perspective, seeing the same individual GP is easily understood and is therefore what is frequently described as 'continuity'. Similarly, most research in the field has focused on relational continuity and as a result, has dominated much of the narrative. However, continuity of care can be considered across three overarching domains:

- **Relational continuity:** Where clinicians develop a therapeutic relationship with patients that spans various health care events, resulting in the accumulated knowledge of the patient and care that is consistent with the patient's needs.

  Terminology for subdomains of relational continuity have evolved and include:

---

[7] Pereira Gray D, Sidaway-Lee K, White E, et al. Improving continuity: THE clinical challenge. InnovAiT 2016; 9(10): 635–645.

[8] Barker I, Steventon A and Deeny S (2017) 'Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data', BMJ 356, j8

- ○ Longitudinal continuity: Where a patient interacts with the same health care professional for a long period of time
- ○ Conditional continuity: Where a patient interacts with the same health care professional for matters relating to a specific condition
- ○ Episodic continuity: Where a patient interacts with the same health care professional for an episode of time or care.
- **Managerial continuity:** Where handovers of care between clinicians, teams and organisations are timely and efficient, and patients' needs, and preferences are respected and met at every step in their journey. A key example of a method to provide managerial continuity is through 'micro-teams', where small multidisciplinary teams are responsible for the care of a cohort of patients[9]
- **Informational continuity:** Where clinicians have access to accurate, up-to-date, patient records and patients are not required to repeat their symptom history to multiple clinicians.

Unsurprisingly, relational, longitudinal continuity with one individual has dominated the literature as this appears to reflect the stereotypical doctor-patient relationship. However, within debates on continuity of care, there are diverging opinions on what type of patient interaction constitutes a meaningful interaction and contributes towards the doctor-patient relationship. While some argue that only face-to-face communication serves to build the therapeutic relationship, others argue that digital communications, such as email and text messaging, can play an important role. New ways of working, driven by remote consultations, through the pandemic increase the need to open up a wider debate about how we measure continuity of care.

1.1.1   Terminology

Terminology to describe the "responsible GP" varies across the continuity of care community and includes:

- Usual GP
- Preferred GP
- Personal GP
- Accountable GP.

To maintain an element of consistency, we will use "responsible GP" when discussing programme-level insights but apply project-specific terminology within the case studies. However, the terminology in survey tools was based on the "preferred GP" and in line with existing national collections such as the GP Patient Survey. Where insights are based on survey data, the term "preferred GP" is applied.

Further definitions can be found in the Glossary in Appendix B.

1.2   Measurement of continuity of care

Continuity of care has been measured, predominantly in General Practice research, in a number of different ways. The Usual Provider of Care (UPC) index[10] is the most widely applied measurement for relational continuity and calculates the proportion of a patient's consultations that take place with the same GP, although not necessarily a chosen or preferred GP. Requiring more than two consultations to generate a measure, however, calculating the UPC for health patients may take several years

---

[9] Risi L, Bhatti N, Cockman P, et al. Micro-teams for better continuity in Tower Hamlets: we have a problem but we're working on a promising solution!. *Br J Gen Pract*. 2015;65(639):536. doi:10.3399/bjgp15X687025

[10] Breslau N, Haug MR (1976) Service delivery structure and continuity of care: a case study of a pediatric practice in process of reorganization. J Health Soc Behav 17(4):339–352

More recently, the St Leonard's Index of Continuity of Care (SLICC) has been developed which calculates the percentage of consultations that occur with each patient's named doctor (as at that point in time)[11]. Focusing on the consultation rather than the patient as the unit of measure, the SLICC can be applied in a shorter time frame than UPC. Both UPC and SLICC focus on the patient-to-individual clinician relationship, typically the GP, and are less useful (without adaptation) to micro-teams, for example.

Where the micro-team approach is implemented, the Bice-Boxerman measurement (also referred to as the Continuity of Care Index) can be applied. This quantifies the index based on the number of consultations with the clinicians who belong to a patient's allocated clinical 'team'.[12] Project teams have also developed their own measures, for example, the Own Patient Ratio.

The GP patient survey and other measures, such as the Cover Index[13] and consultation data from insurance records[14], have also been used to quantify continuity.

However, it is worth highlighting that these measures do not quantify the strength or effectiveness of the doctor-patient relationship. Informational and managerial continuity of care have been shown more difficult to quantify but are most frequently considered through patient-reported experience measures, such as the Nijmegen Continuity Questionnaire[15].

1.3   The policy landscape

Continuity of care has been traditionally valued highly in General Practice, but over the last 20 years, there has been a trend away from prioritising longitudinal continuity in favour of promoting access, whether that be timely, physical or other aspects of access[16]. Attempts to promote more timely access to General Practice have been supported by the GP Access Fund, (formerly known as the Prime Minister's Challenge Fund from 2013 to 2018). In addition, NHS England had been working with practices to enable patients to get routine consultations during evenings and at weekends.

In November 2019, the Conservative Government committed to delivering 50 million more appointments in General Practice by 2024/25, supported by investment to support the recruitment and retention of doctors in general practice. At the time, there were 307 million appointments per year in GP surgeries; the announcement representing over a 15% uplift in appointment numbers and equates to an increase of almost an extra appointment per person in England per year[17]. This was always going to be extremely challenging, particularly given the ongoing decline in GP numbers; in June 2020 there were 33,515 full-time equivalent GPs in England, 599 less than there were in June 2019. This brings into focus the challenge of delivering additional capacity, seen as necessary to improve access.

Given this context, it is unsurprising that policy focuses on future models of General Practice that draw on the diverse skills of a range of professionals, not just doctors but also

---

[11] Sidaway-Lee K, Gray DP, Evans P. A method for measuring continuity of care in day-to-day general practice: a quantitative analysis of appointment data. The British Journal of General Practice: The Journal of the Royal College of General Practitioners. 2019 May;69(682):e356-e362

[12] Bice, T., & Boxerman, S. (1977). A Quantitative Measure of Continuity of Care. Medical Care, 15(4), 347-349. Retrieved July 14, 2021, from http://www.jstor.org/stable/3763789

[13] Ha, N.T., Harris, M., Preen, D. et al. A time-duration measure of continuity of care to optimise utilisation of primary health care: a threshold effects approach among people with diabetes. BMC Health Serv Res 19, 276 (2019). https://doi.org/10.1186/s12913-019-4099-9

[14] Pollack CE, Hussey PS, Rudin RS, et al. (2016) Measuring care continuity: a comparison of claims-based methods. Med Care 54(5): e30–e34

[15] Uijen AA, Schellevis FG, van den Bosch WJ, Mokkink HG, van Weel C, Schers HJ. Nijmegen Continuity Questionnaire: development and testing of a questionnaire that measures continuity of care. J Clin Epidemiol. 2011 Dec;64(12):1391-9

[16] Julian M Simpson, Kath Checkland, Stephanie Snow, Jennifer Voorhees, Katy Rothwell, Aneez Esmail. Access to general practice in England: time for a policy rethink. British Journal of General Practice 2015; 65 (640): 606-607.

[17] £1.5 billion to deliver Government commitment for 50 million more general practice appointments - GOV.UK (www.gov.uk)

physiotherapists, nurses, mental health professionals, clinical pharmacists, link workers and physician associates to name a few. In January 2019, the NHS Long Term Plan[18] committed to expanding the number of non-GP professionals working in General Practice. However, this has yet to have a quantifiable impact on appointments; whilst the total number of direct patient care staff increased by 9.3%[19], 45.4% of appointment occurred with a non-GP healthcare professional in England in January 2020 which is comparable to January 2019 (44.4%)[20]. The move to more team-based models of care will likely impact how practices consider and support relational continuity of care for patients.

Compounded by the move to team-based models, the current demand and working pattern of the modern GP (including portfolio roles and part-time working) makes it challenging for staff in General Practice to prioritise longitudinal continuity[21]. Policy initiatives to encourage continuity of care, so far, have proven to be limited in impact. For example, a Health Foundation evaluation found that continuity did not improve for patients aged over 75 who were offered a named accountable GP.[22] Recent research published in the British Journal of General Practice also confirmed that longitudinal continuity of care is declining[23].

The recent GP contract sets out a requirement for each patient to have a GP they usually see and is accountable for their care. Moreover, the NHS contract requires GPs to inform each registered patient, of who their accountable GP is and therefore, who has clinical responsibility for their physical and mental health care.

The prevailing policy context, and the wide range of possible ways to increase continuity, mean that this programme is focused on the 'piloting' stage of innovation, rather than being a wider demonstration programme. The programme will therefore attempt to identify whether there are feasible, acceptable and implementable ways to increase continuity, rather than try to find a universal blueprint for all.

1.4   Covid-19 in General Practice

The Covid-19 pandemic has influenced how patients use General Practice and wider health care systems, with the outbreak presenting a new set of workload and challenges but also opportunities in how these are managed, accelerating innovation and digital modes of access in General Practice. As this coincides with the period of this study, it is important to briefly describe the impact of the Covid-19 pandemic on General Practice in England insofar as this may affect continuity of care.

The initial response to the pandemic in March 2020 saw a shift towards the use of remote consultations as a first-line approach to care, and towards hub solutions to improve ways of working throughout a period of infection control and staffing challenges. The need to rapidly change working practices in response to the pandemic, therefore, presented spread and adoption challenges and opportunities that required urgent attention. Diversifying consultation modes has been part of the national strategy for a number of years, with a target set that every patient will have the right to video consultations by April 2021. However, it has been shown that these were offered by only around 11% of practices and only 3% of patients stated that they had used the service[24]. The pandemic in 2020 provided an impetus which drove a rapid move to

---

[18] NHS Long Term Plan » Online version of the NHS Long Term Plan

[19] (from 12,858 to 14,050 between December 2018 and December 2019)

[20] Pressures in general practice (bma.org.uk)

[21] Royal College of General Practitioners. Continuity of care in the modern general practice. 2016.

[22] Barker I, Lloyd T, Steventon A, 'Effect of a national requirement to introduce named accountable general practitioners for patients aged 75 or older in England', BMJ Open, 2016; 6(9).

[23] Paddison C, Abel G, Campbell J, 'GPs: working harder than ever', Br J Gen Pract 2018; 68(670): 218–219.

[24] https://www.england.nhs.uk/wp-content/uploads/2019/09/remote-consultations-reserach-summary-of-findings.pdf

online triage and consultations; with 90% of remote consultations in April 2020, compared to 31% in April 2019[25].

In April 2020, NHS England recommended that practices move immediately to total digital triage followed by remote management, wherever possible, and have offered guidance to teams for the rapid procurement of remote consultation solutions to facilitate the new way of working[26]. The rapid pace of change has been both a challenge and an opportunity. The pandemic may prove to be the catalyst for change, albeit disruptive change, that is required to focus on evaluating and improving current practice.

[25] Implementation of remote consulting in UK primary care following the COVID-19 pandemic: a mixed-methods longitudinal study | British Journal of General Practice (bjgp.org)

[26] Report template - NHSI website (england.nhs.uk)

2   Increasing Continuity of Care in General Practice Programme

The 'Increasing Continuity of Care in General Practice' programme was inspired by The Health Foundation research[27] which demonstrated that patients with ambulatory care sensitive conditions, who see the same GP a greater proportion of the time, have fewer unplanned hospital admissions. The research looked at potential opportunities for improvement that could be used to increase continuity at GP practice level.

The primary aims of this programme were to understand whether approaches can be used to increase continuity of care and explore whether increasing continuity of care can improve patient outcomes. It focused on the process of improving continuity of care in practice and aims to understand how different structural solutions, enabling technologies and cultural conditions may increase continuity of care in the General Practice setting.

The programme also explored the relationship between increased continuity and increasing access to General Practice services. The programme set out to identify the possibilities, benefits and unintended consequences of increasing continuity of care in the current context, where the General Practice workforce as a whole is under strain,[28] there is concerted policy pressure to increase timely access,[29] and patients' needs are becoming more complex[30].

The programme was developed with the advice and support of the Royal College of General Practitioners.

2.1   Introducing the Project Teams

The programme supported five large-scale projects across English GP practices and federations to carry out targeted improvement work to increase continuity in their practices. The five project teams covered over half a million patients and over 45 practices. Three of the projects ran from January 2019 to July 2021, one from January 2019 to June 2020 and one from January 2019 to late 2021. The initial plan was for the 24-month projects to complete in December 2020, however, a six-month 'pause' period was introduced from April to October 2020 to accommodate the impact of the Covid-19 pandemic and the additional pressures that generated.

Grants of up to £250,000 per project were awarded from The Health Foundation to support teams in developing and implementing interventions, and the dissemination of learning.

The five project teams funded as part of the programme are depicted in Figure 1 overleaf.

---

[27] Barker I, Steventon A, Deeny SR, 'Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data', BMJ 2017; 356.

[28] Davies E, Martin S, Gershlick B, 'Under Pressure: What the Commonwealth Fund's 2015 international survey of general practitioners means for the UK', Health Foundation, February 2016.

[29] NHS England. General Practice Forward View. 2016.

[30] Steventon A, Deeny S, Friebel R, Gardner T, Thorlby R, 'Emergency hospital admissions in England: which may be avoidable and how?', Health Foundation briefing, May 2018.

Figure 1: Introducing the Project Teams

Valentine HP

Practice-led project
- covering one practice

Prioritising continuity for patients with new and recurring problems

Continuity Counts

Locally-led project
- covering 5 practices

Promoting evidence of the 'why' continuity and role of personal lists

Morecambe Bay

Federation-led project
- covering 10 practices

Developed tools to match usual GP to patients within clinical systems

Pier Health

PCN-led project
- covering 7 practices

Supporting continuity via AskMyGP and patient education materials

One Care

Federation-led project
- covering 23 practices

Developed tools to match usual GP to patients within clinical systems

2.2 Interventions

Across the five projects, there were areas of commonality and difference in the activities that were implemented. Due to challenges and delays due to the Covid-19 pandemic, some activities were in the process of being implemented or embedded at the time of writing.

There are four key features of these approaches across the project teams:

1. **Staff engagement and communication:** to raise awareness of the evidence base for continuity, secure 'buy in' and explore locally how this could be increased
2. **Patient engagement and communication:** to raise awareness of continuity, provide information on its benefits and setting out what patients can do to request this
3. **Patient allocation and workflow improvement:** to increase continuity of care through appropriate allocation of GPs and patients, personal lists, alongside other changes to streamline practice processes
4. **Measurement of continuity and a mechanism by which to monitor this:** to locally develop and establish tools, dashboards and reporting mechanisms against continuity measures for continuity monitoring.

Examples of different approaches and interventions within the four categories are described in Table 1.

Table 1: Examples of different interventions and approaches for increasing continuity of care

	Examples include:
Staff engagement and communication	• Appointed **clinical and non-clinical champions** to support and drive continuity within the practice • **Seminars and meetings to discuss the 'why'** on continuity of care, describing and discussing the evidence base • **Regular team meetings** to streamline challenges related to continuity processes and the 'how', some using quality improvement methodologies • **Facilitated peer to peer learning** within practices • **Education sessions and materials**, as well as **psychology sessions** to support staff in **managing complex or high-impact patients** • **Presentations** at annual stakeholder events • **Scripts for reception teams and care navigators** to steer continuity patients to their responsible GP • Incorporated a **reminder to the booking system** for the Reception Team to book the patient with the named GP • **Guidance on consultation methods** to explore symptoms and change health behaviours • Involvement in multi-organisational **quality improvement training** • Developed **illustrative, anonymised 'case studies' of different types of tagged patients** to support clinicians in understanding their distinguishing features.
Patient engagement and communication	• **Education materials** on the benefits of continuity: posters, leaflets, waiting room videos and via an automated message when patients are waiting on the telephone line • Sharing the **GP rota and availability with patients**: whether on a physical board for 'walk in' clinics, business cards given to patients or through online platforms • Commitment and engagement with **PPGs and patient champions** • **Patient engagement** through surveys, interviews and focus groups.
Patient allocation and workflow improvements	• Standardised **searches developed within clinical systems to identify patients** within set criteria for enhanced continuity: examples included repeat or frequent attenders, patients with frailty, etc. • **Identification of patients where the 'usual GP' field in EMIS does not reflect what happens in practice.** Subsequent reallocation to who the patient consults with most often using a data-informed approach • Development of **personal lists** • A **GP Buddy or GP micro-team** approach • **Smoothing workflow processes and amending policies** to minimise duplication of work or redirect tasks to appropriate members of the practice team

	● Application of **continuity of care flag** to the patient record
	● **Template to support communication and informational continuity** between micro-team members
	● A review of **digital solutions** available to primary care and the extent to which they **supported continuity.**
Measurement of continuity and a mechanism by which to monitor this	● Formal **data sharing agreements**
	● **Dashboard and tools developed to monitor continuity** measures including UPC, SLICC and to allow practices to interrogate their data
	● **Data visualisation** to enable teams to easily understand patterns of consultation, changes of continuity over time and comparison against local practices
	● Individual practice discussions to understand their data and ensure measurement **reflects local systems or ways of working**
	● **Training with practice staff** on how to input into and use measuring tools
	● **Sharing data back with practice teams** to engage interest and share progress on their continuity progress.

Appendix A provides a case study on each project team, which includes detail about the interventions that have been implemented.

2.3 Who and what were the interventions targeting?

2.3.1 Patient cohorts

While some project teams, and practices within them, chose to target **all registered patients,** others chose to focus on increasing continuity of care for **specific patient cohorts**. For example:

● Some practices with One Care set out to target the following patient cohorts: older patients, frailty, mental health, polypharmacy, frequent attending, or being on an end-of-life pathway

● The team at Valentine Health Partnership chose as the focus of their project those patients with new or changing symptoms.

2.3.2 Mode of interaction

There were differences in how practices, or individuals within projects, initially viewed relational continuity in terms of the **mode of interaction or contact at the start of the programme**. For example:

● The Continuity Counts project initially deemed that **face-to-face contacts form the foundation of relational continuity**. Alongside the practices they were working with, they recognised that other forms of patient interaction, such as telephone consultations and more recently Instant Messages were useful but were potentially most optimally utilised once the doctor-patient relationship has been established

● In contrast, some practices within the Morecambe Bay, Pier Health and One Care teams implemented online consultation systems. This created a fundamental change in how the workflow was managed, with **greater use of digital technology including online messages, video and telephone consultations**. Here, it was felt that these interactions are just as important as face-to-face contacts in building and sustaining relationships.

However, as the Covid-19 pandemic drove the widespread use of remote consultations, the use of online platforms became standard practice. The Continuity Counts project, therefore, adapted their SLICC measurement tool to include remote consultations and not only face-to-face consultations.

2.3.3   Phased implementation

Two projects chose to employ a phased approach, which allowed a more manageable workload for the project manager yet broadened the reach of the project by increasing the number of practices involved.

- The Morecambe Bay team applied **a phased approach to the project and set out to support three waves of practices** throughout the lifetime of the project. The level of 'hands-on' support for later waves would reduce compared to the first cohort; with lessons learnt, guidance and case studies from wave one practices shared with subsequent waves to enable peer-to-peer learning. Due to the pandemic, the team adapted to focus on two waves within the formal period with the latter being supported through the established toolkit
- Similarly, One Care planned to employ a **three-wave approach to develop continuity of care initiatives across 32 practices** in the project by the end of the formal funding period, spanning 400,000 patients. Due to challenges gaining traction or a new workload resulting from the pandemic, 23 practices were eventually supported.

The evaluation has focused on wave one practices where interventions have had the greatest opportunity to become embedded.

3 Evaluation aims and methodology

3.1 Aims and objectives of the mixed-methods evaluation

It is important to note that this mixed-methods evaluation report should be read alongside individual project reports and the quantitative evaluation report.

The evaluation of the programme is focused on developing and sharing learning about the process of improvement at each of the five projects and their teams. Two evaluations have been commissioned to capture this learning: this mixed-methods evaluation and a quantitative evaluation to be undertaken by the Improvement Analytics Unit (IAU). The quantitative evaluation has set out to explore whether increasing continuity of care has increased across the practices in the programme and how this compares to the national trend. Therefore, it is important that the content of this report is contextualised alongside the findings of the quantitative evaluation and project team reports.

The mixed-methods evaluation team were responsible for the design and delivery of an evaluation that captures the experience of patients and staff and seeks to understand the underlying interventions implemented by each of the projects.

In doing so, we set out to understand more about the continuity of care interventions:

- What was done and where?
- How this was done and with what resources?
- What effect this had on continuity, patients, workforce or the system?
- What learning was gleaned in the processes?

At a more granular level, the Health Foundation posed the following **evaluation questions for the mixed-methods evaluation**:

For patients:

- Has continuity of care increased for patients?
- What approaches were used to engage patients?
- What were the advantages and disadvantages of participation for different patient groups?
- What has been the wider learning about patients views on continuity of care and how do these vary across different groups?

For the workforce:

- What approaches have been used to engage staff? What were the advantages and disadvantages of participation for different staff?
- What has been the wider impact on the workforce?
- What has been the wider learning about staff views on continuity of care and how do these vary across different groups?

For others in General Practice and the wider health and care system:

- What approaches worked best for improving continuity of care?
- How has the project contributed to our understanding of what continuity of care means?
- What are the benefits and unintended consequences of attempting to improve continuity of care?
- What factors affect the success and spread of continuity of care improvement interventions?

● What resources are required to improve continuity of care?

The location of findings linked to the evaluation questions are signposted and can be found in Appendix C.

The scope of this evaluation did not include an assessment of cost effectiveness.

3.1.1 Methodology

The evaluation team undertook:

● Surveys (both baseline and summative) with staff and patients across the projects
● Interviews with patients, strategic stakeholders, leaders, and staff in project teams
● Observation of events such as governance groups and project-wide learning workshops
● Analysis of local project focus groups, survey data and staff interviews undertaken by project sites
● Analysis of existing data, through the GP Patient Survey and local data or reports.

3.1.1.1 Survey Responses

For the baseline patient survey, an online link was made available and shared via the Project Manager of each project and paper copies were completed by patients visiting the practice. The approach to collecting the survey data was managed locally over four weeks (June-July 2019); some practices had designated team members to distribute surveys to patients, some practices placed these in the waiting area. All patients were eligible to participate in the surveys. There were 1,557 respondents to the patient survey; 1,418 were paper-based and 139 were online.

For the summative patient survey, given the changes to General Practice, the approach was modified to overcome the use of paper surveys due to infection control and low footfall in practices. Again, an online link was made available and shared via the Project Manager of each project. Practices shared the link via text messages, social media posts and on their website. The greatest success was noted through text messages sent to patients with a link to the survey. There were 1,878 responses to the patient survey and were all from online surveys. Surveys were open over a period of four-week in April-May 2021 and again, all patients were eligible to participate in the surveys.

Those working in General Practice were asked to complete the baseline staff survey. Surveys were shared via email by the Project Manager of each project. The survey was live over a four-week period (in tandem with patient surveys). There were 253 respondents to the baseline survey and 99 respondents to the summative survey.

Summative patient and staff survey data does not include representation from Valentine Health Partnership as they had completed their project during the evaluation 'pause' period triggered by the pandemic. Additionally, the Continuity by Design project led by Pier Health did not contribute to responses as part of the summative surveys.

3.1.1.2 Focus groups and interviews

Focus groups and interviews were undertaken with 72 patients. The mode in which this was undertaken was flexibly adapted to the local context of project teams and the patient involvement mechanisms already established. Examples of these include waiting room interviews, focus groups with PPGs, focus groups and telephone interviews with survey respondents and interviews with local patient champions. Patients interviewed or part of focus groups were volunteers. We are unable to report on demographic data on these participants but do acknowledge that there may be some voices that were not captured during these activities. However, we are limited by the demography and socioeconomic profiles of each project and their practices and cannot claim that these are representative of the population as a whole.

Staff interviews and focus groups included a wide range of staff groups, such as partnered GPs, salaried GPs, advanced nurse practitioners, practice nurses, trainee GPs, healthcare assistants, paramedics, medical directors, receptionists, administrative assistants, patient administration managers, practice managers and business managers. This covered 75 members of staff in General Practice. Interviews and focus groups moved to the virtual setting in the summative phase of the evaluation. Where existing local focus groups and interviews were being conducted, recorded sessions were analysed in a bid to minimise duplication and burden.

Interviews and focus groups were not transcribed but detailed notes were taken in line with the topic guide framework set out in Appendix D. Where conversations took place virtually and consent was granted, conversations were recorded for note-taking and analytical purposes. Thematic analysis of the content was undertaken in line with set coding frames with examples described below.

3.1.1.3   Data analysis

Thematic analyses of the above activities were undertaken in line with the established framework[31]. Coding frames were developed with common themes to collate free-text responses, examples of these include:

- Benefits of continuity: better patient knowledge, shorter/less consultation, patient satisfaction, staff satisfaction, improved patient outcomes, cost savings. Building trust/confidence/rapport, patient safety

- Consequences of continuity: delays or restrictions in booking a consultation, need for different GP, increased workload, issues covering GP absence, heartsink, not necessary, no disadvantage

- Helping or hindering factoring factors for implementation: staff communication and engagement, review of progress, time and resources for embedding change, commitment to change, working as a team, patient communication and engagement, staffing and resource challenges, leadership and lack of availability of appointments.

We had initially hoped to incorporate locally collected data in terms of complaints, patient feedback, staff vacancies and turnover. However, following discussion with several project teams, these data requests were felt to be unnecessarily burdensome given local competing demands and would be difficult to attribute to the projects due to the influence of Covid-19 and ways of working.

Descriptive statistics were used for quantitative survey data to present messages. Data obtained from project teams are also described in this report for observations of change. We did not have access to the raw data to undertake additional analysis. This highlights the importance of considering the messages from the mixed-methods evaluation report alongside the project team reports and the quantitative evaluation outputs.

3.2   Limitations and considerations

3.2.1   In the methodology of this mixed methods evaluation

As with all mixed-methods studies, there were limitations to the evaluation of the Increasing Continuity of Care in General Practice Programme. The project teams which were selected to take part in the programme all have their own features, and often significant variations within the project contexts themselves. This evaluation was undertaken based on a Service Evaluation model for the programme, in line with the following definition, "'A study in which the systematic collection and analysis of data are used to judge the quality or worth of a service or intervention,

---

[31] Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC medical research methodology, 13, 117. https://doi.org/10.1186/1471-2288-13-11

providing evidence that can be used to improve it"[32]. Therefore, the insights described must be taken within the local setting of the projects and caution should be taken when assuming that these findings are transferable and generalisable.

General Practice is in a period of transformation; where priorities have shifted focus towards delivering care at scale, the diversification of workforce and integrating technology into practice, not to mention the Covid-19 pandemic. We are cognisant of the challenge and **limitation of attributing findings from project teams directly to the programme**. We face a similar challenge in disentangling approaches within the projects themselves, given a number of different activities and changes were implemented locally.

The evaluation was reliant on local project managers and project leads to facilitate introductions, support evaluation activities, and disseminate materials. **Where communication was delayed or absent, this had implications for the information gathered for the evaluation, limiting the breadth of learning captured and reported**. At times, locally collected data were collated to minimise burden or duplication and are reported here but it is recognised that this may present some bias. The evaluators do recognise the mix of pressures facing project teams and therefore highlight this limitation as an example of the impact of competing priorities.

The timing in which this evaluation has been commissioned means that some project teams had already begun to make early progress in setting up and implementing their approaches when we had collected baseline data in June-July 2019. This could lead to **an altered baseline position of the attitudes of patients and staff**; it was recognised that there was an inherent limitation in this methodology. Where projects have adopted a phased approach to delivery, the evaluation has focused on wave one practices where interventions have had the greatest opportunity to become embedded.

The foundations on which project teams are starting their journey are remarkably different; these include some of the most respected voices in the continuity of care community whilst others have less experience yet are committed to making changes to drive continuity within their local area. Therefore, limitations exist in being able to detect a change over time for areas that have a well-established system designed to drive continuity of care.

Within our methodology, we use a number of methods to answer our evaluation questions. Before any interview, survey or focus group, **we must introduce the topic of continuity of care and the aims of the programme**. This, of course, **may result in bias** responses from both patients and staff on their views and motivations towards continuity of care. However, this is not a new concept and is a common limitation facing service or programme evaluations and interview based qualitative research.

Survey methods were used to capture the scale in views from staff and patients. We are **unable to attribute a response rate** given the flexibility and pragmatic approach to data collection adopted in local approaches and therefore cannot provide insight to the representativeness of the sample. Differences were measured between the baseline and summative surveys, yet it must be recognised that this is **an unpaired sample** and therefore there are limits in true comparability. The **sample size for staff surveys was limited** and reduced in the summative, reflecting the contextual challenges facing General Practice at this time. Given these constraints on sampling, survey findings have been used to illustrate change, but are not intended to provide statistically significant findings.

As we are undertaking five case studies with programme-level insights, **we caution translating the findings as representative of the national picture but instead, should be regarded as**

---

[32] See Healthcare Quality Improvement Partnership (HQIP), 'A Guide for Clinical Audit, Research and Service Review'
http://www.hqip.org.uk/public/cms/253/625/19/190/HQIP-Guide-for-Clinical-AuditResearch-and-Service-ReviewRevised%202011.pdf?realName=x5

experiences detailed within the local context. However, to be cognisant of the challenges facing sample size calculations and refine the 'saturation' concept, Malterud et al., (2016) developed the model of 'information power'. This concept shifts the focus away from the number of participants involved in qualitative investigations and directs the focus towards the contribution of new knowledge from the analysis.

Similarly, we must consider **the influence that each project has on the programme-level insights**. The number of practices, staff and patients are not equal within each project and therefore we recognise the limitation that views that may be held by a small number of people in one area, may be masked by the wealth of information gathered at a larger site. Our methodology has aimed to mitigate this by undertaking thematic analyses and triangulating across multiple methods.

There are limitations in using a five-point **Likert scale that may limit the depth of information gathered**, however, this was chosen to mirror the national GP Patient Survey and balances the number of questions with the ease of completion. Our assumption that patients understand the concept of continuity of care is also a limitation.

3.2.2 Wider limitations

The disruption to usual care in general practice during the COVID-19 pandemic meant that the IAU were unable to carry out the original planned quantitative evaluation. The initial methodology of the quantitative evaluation involved the creation of a carefully selected set of practices similar to those in the programme, known as a counterfactual. Differences in trends in continuity of care and outcomes between the programme practices and these counterfactual practices providing "usual care" would have provided an estimate of the impact of the programme. However, during the COVID-19 pandemic there was no "usual care" and so a robust counterfactual could not be constructed.

Local measures of change in continuity, reported by project teams, have therefore been described within this mixed methods report. This has been supplemented by a quantitative study undertaken by the IAU which provides descriptive analyses comparing trends in continuity of care in general practice nationally to trends in practices participating in the programme using data from electronic health records for patients registered at English general practices.

4   Impact of the programme

This section of the report describes the degree to which the initiatives influenced continuity of care; covering the perceived importance and priority of continuity of care, impact on continuity measures and change in the ease or difficulty in seeing the preferred GP. This is informed by pulling together different sources of information from the mixed-methods patient and staff surveys, the GP patient survey and locally collected measures from the project teams.

4.1   The perceived importance of continuity of care

Project teams undertook activities to engage with staff and patients to communicate why continuity was important (see Table 1 above). The impact of these efforts was evident in the survey responses in the mixed-methods evaluation, where continuity increased in perceived importance across the three staff groups surveys: GPs, the wider clinical team and practice management and administration.

4.1.1   Opinion from GPs

Whilst the responses from GPs who thought continuity of care was perceived to be important for all patients was relatively unchanged over time, the degree of perceived importance increased; the proportion of GPs who felt that continuity of care was **'very important' increased from 16% to 37%** following work on the continuity of care initiatives. This is highlighted in Figure 2 below.

Figure 2: GP opinion on the importance of continuity of care for all patients
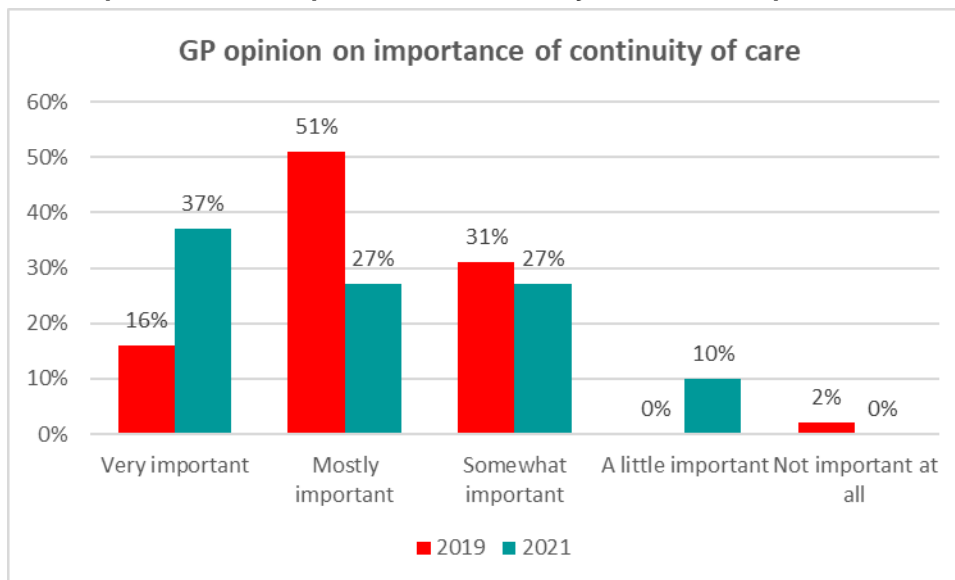
Source: Mixed-methods evaluation survey, 2019 n=51; 2021 n=30

Further analysis suggests that the importance placed on continuity of care differs between the GP Partners and Salaried GPs who took part in the survey. From Figure 3, it appears that Salaried GPs placed higher importance on continuity of care than their GP Partner colleagues although caution should be held when drawing wider conclusions from this small sample (of 20 GP Partners and 10 Salaried GPs).

Figure 3: Partner and Salaried GP opinion on continuity of care
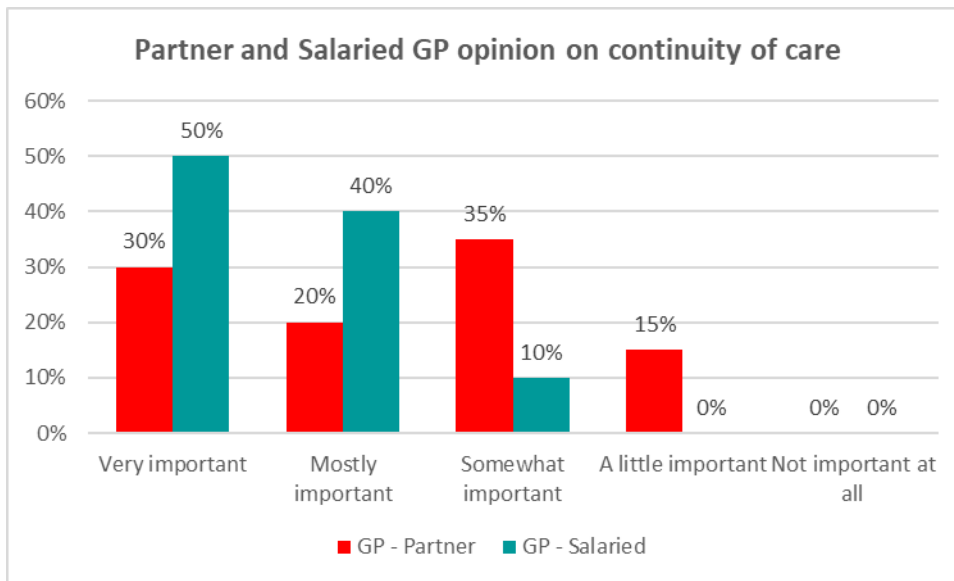
Source: Mixed-methods evaluation survey, n=30

4.1.2   Opinion from the wider clinical team

There is also suggestion of a shift in the perceived importance of continuity of care among the wider clinical team, such as clinical pharmacists and nurses. Depicted in Figure 4, the proportion of those who think that continuity of care is 'important' (combining 'very' and 'mostly' responses) **increased from 78% to 93% over the course of the programme support**.

Figure 4: Wider clinical team opinion on the importance of continuity of care
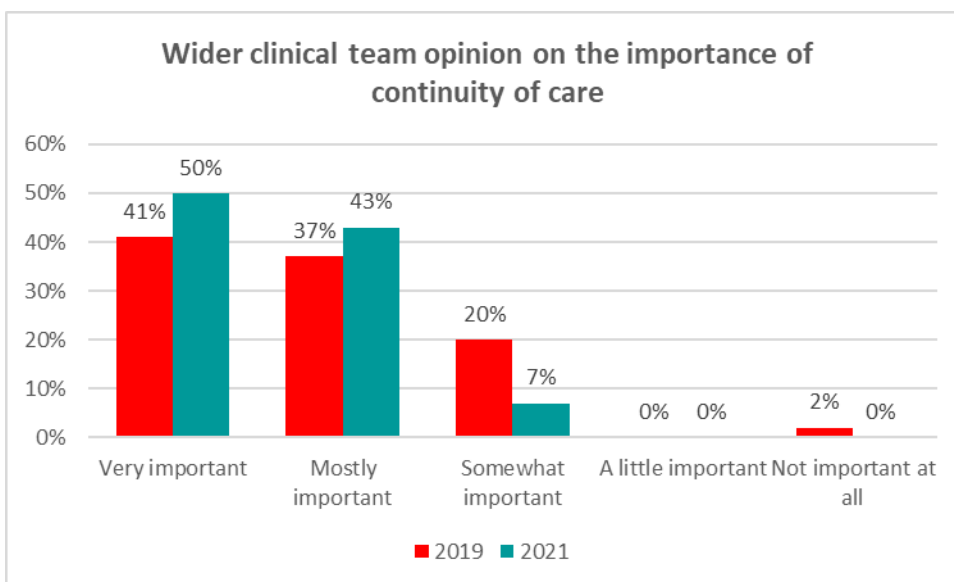
Source: Mixed-methods evaluation survey, 2019 n=51; 2021 n=14

4.1.3   Opinion from the practice management and administration team

In a similar trend to that seen in the GP group, responses from the practice management and administration team highlight an increase in the importance placed on continuity of care; **'very important' responses increased from 37% to 54%** throughout the formal programme period.

A modest increase in the total proportion of those who felt continuity to be important (combining very and mostly) was noted, 74% in 2019 versus 79% in 2021. This could suggest that there was an element of strengthening existing views on the importance of continuity of care. The roles of respondents included administrator, receptionist, care coordinator, operations manager and practice manager. A graphical representation can be found below in Figure 5.

Figure 5: Practice management and administration team opinion on the importance of continuity of care
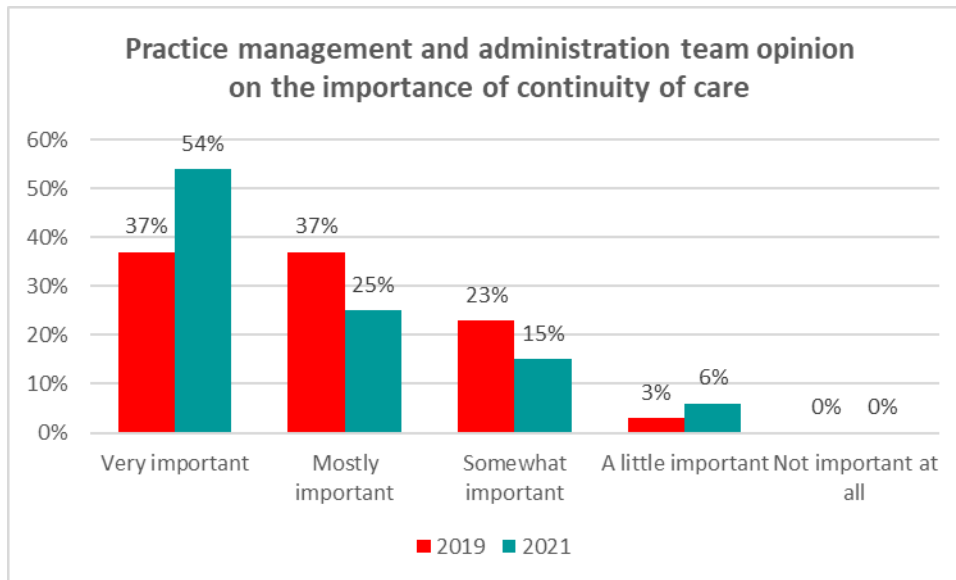
Source: Mixed-methods evaluation survey, 2019 n=147; 2021 n=51

4.1.4   Opinion from the patient perspective

To provide a rounded view of the work undertaken by the project teams, the same question was posed to patients through the mixed-methods evaluation survey. Depicted in Figure 6, there was no real change in how important patients believed continuity to be (79% versus 81%).

Figure 6: Patient opinion on the importance of continuity of care
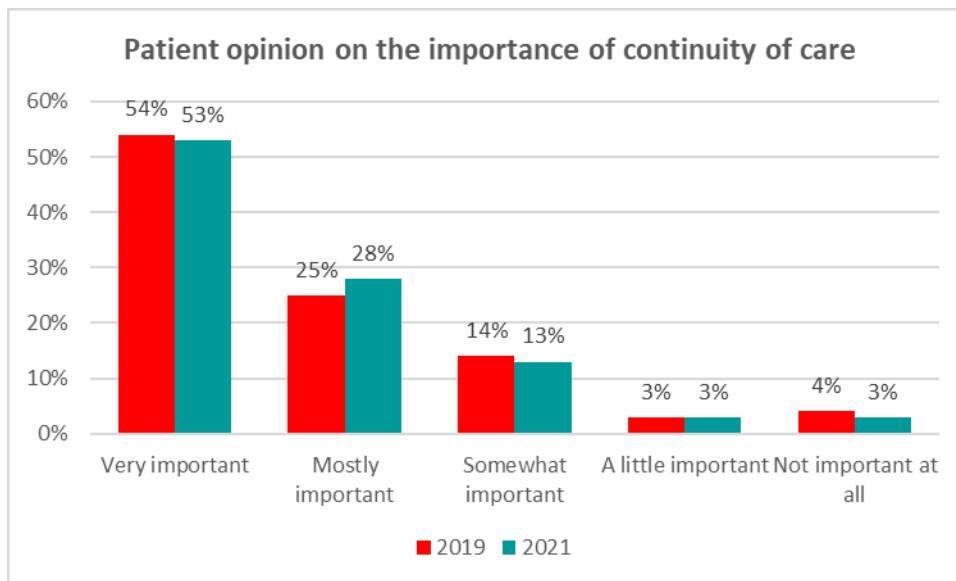
Source: Mixed-methods evaluation survey, 2019 n=1549; 2021 n=1857

However, it is valuable to recognise that when compared to the baseline results, the 2021 results highlight a **greater alignment and agreement of how patients and clinicians view the importance of continuity of care**. These results also indicate that despite the Covid-19 pandemic, the importance placed on continuity of care from patients has not been lost.

4.2   Continuity of care as a strategic priority

Staff surveyed in roles across the practices within the programme, as part of the mixed-methods evaluation, described increasing continuity of care as a key priority in spite of Covid-19. More specifically, 60% of respondents ranked increasing continuity of care in their top 3 strategic areas: 63% of GPs, 46% of the wider clinical team and 62% of practice management and administration teams. This was followed by 43% of respondents who ranked expanding roles within the team and 40% who ranked extending access in their top 3 priority areas. This is outlined below in Table 2.

Table 2: Strategic priorities within project practices

Strategic area	Featuring in the top 3 priorities
Responding to the demands of Covid-19	89%
Increasing continuity of care	60%
Expanding roles within the team	43%
Extending access	40%
Primary care networks	28%
Digital-first care	22%
Expanding services available locally	18%

Source: Mixed-methods evaluation survey, n=90

4.3   Impact on continuity measures

Determining whether the initiatives were able to increase measures of continuity of care sits within the remit of the quantitative evaluation report. The quantitative evaluation aimed to identify differences in trends in continuity of care and outcomes between the programme practices and counterfactual practices to quantify the impact of the programme. However, during the COVID-19 pandemic there was no "usual care" and so a robust counterfactual could not be constructed.

Local measures of change in continuity, reported by project teams, have therefore been described within this mixed methods report, alongside GPPS and evidence from our own mixed-methods survey.

This has been supplemented by a quantitative study undertaken by the IAU which provides descriptive analyses comparing trends in continuity of care in general practice nationally to trends in practices participating in the programme using data from electronic health records for patients registered at English general practices.

4.3.1   Evidence from the locally collected measures from the project teams

Project teams have used a number of metrics to measure continuity, definitions of which are outlined below in Table 3.

Table 3: Description of continuity measures

Metric	Description	Additional information
Usual Provider of Care (UPC)	Calculates the proportion of consultations that are with the most frequent provider (GP), using data from a 12 month period. Requires patients included in the calculate to have a minimum number of consultations (usually two).	One Care has made the following adaptions to this measure for use locally: ● Extended to a minimum number of consultations to nine in the previous 12 months ● Defines two measures: – UPC – aligned to this description – UPC Usual GP – Calculates the proportion of consultations that are with the most frequent provider (GP) who is also the GP named in the patient's record.
St Leonard's Index of Continuity of Care (SLICC)	Calculates how often a patient has a consultation with the GP who is named in their patient record. [33]	One Care has made the following adaptions to this measure for use locally: ● SLICC Frequent attenders - Filtered for patients who are frequent attenders (those who consulted 9 or more times in the previous 12 months). ● SLICC Other patients – Filtered for patients who were not frequent attender patients (those who consulted less than 9 times in the previous 12 months). The Continuity Counts team disaggregated this measure into face-to-face and telephone consultations, whereas other projects have combined these and also included video consultations.
Own Patient Ratio (OPR)	Calculates the proportion of list-holding GP's consultations that are with their own patients.	The Continuity Counts team disaggregated this measure into face-to-face and telephone consultations.
Continuity of Care Index (CoC Index), also known as the Bice-Boxerman	Calculates the dispersion of consultations, using the frequency of consultations to each GP and data from a 12 month period.	The Morecambe Bay team utilised this measure. 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 the same UPC (0.50).

4.3.1.1 Change in measures of continuity

Each project has undertaken its own local analysis of measures of continuity, each prioritising and tailoring measures that they believe to be most appropriate to the context of their work and their local priorities. Further information can be found in their own reports.[34] It is therefore **not possible to compare results** between projects, but instead, each should be considered in turn.

It is also important to recognise the implications of the pandemic between the baseline and final positions.

---

[33] Sidaway-Lee K, Pereira Gray D, Evans P (2019) A method for measuring continuity of care in day-to-day general practice: a quantitative analysis of appointment data, British Journal of General Practice 2019; 69 (682): e356-e362. DOI: https://doi.org/10.3399/bjgp19X701813

[34] As this is a summary description of local team reports, we can only report the total number of patients and/or respondents if this was outlined within the report. In the absence of this, we describe the percentages extracted from the report verbatim.

One Care

Across the 23 participating practices, One Care focused their measurement on frequent attender patients, defined locally as patients who consulted more than 9 times in the previous 12 months over the period 2019/20 and 2020/21.

For One Care, *UPC* ranged from 10-66% in 2019/20 to 25%-77% in 2020/21. There was a reported average improvement by all practices of 4%, with an increase of up to 15% where the greatest improvement was seen.

The project report that the highest continuity scores were achieved in Practices with Personal Lists. It also reports a project view that "practices should aim to achieve 50% UPC as a starting point".

The other three measures used locally in the tool require the correct GP to be named on the electronic patient record system and as a result, absolute values were slightly lower than for the *UPC.* For these measures:

- For *UPC Usual GP (a local adaption of the UPC which calculates the proportion of consultations that are with the most frequent provider (GP) who is also the GP named in the patient's record as their usual GP)*, for frequent attender patients, an average improvement of 3% was seen across practices
- For *SLICC Frequent attenders*, an average improvement of 1% was seen across practices
- For *SLICC Other Patients*, an average improvement of 3% was seen across practices.

As might be anticipated, there was variation across these measures by individual practice and given the wider context in which practices were working. Focused on wave one practices (nine practices):

- The *UPC* increased in all nine practices
- The *UPC usual GP* was improved or maintained in five of the nine practices
- The *SLICC* was improved or maintained in seven of the nine practices.

Morecambe Bay

For the period 01/01/19 to 01/06/21, the *UPC* increased for three out of the five "wave one" practices[35] (in contrast to the CCG as a whole, and two of the practices which experienced a decrease). The baseline position of *UPC* for these five practices was between 51% and 63.5%, changing to between 55% and 64% as at 01/06/21. Over the project period, this measure of continuity varied due to project interventions (such as changes the introduction of an online consultation system) and practice changes (such as staff changes or the implementation of a triage list during the pandemic). UPC reached 68% at points during the lifetime of the project in two of the five wave one practices.

It was reported that in the two practices where UPC decreased between the 01/01/19 and 01/06/21, the first experienced a merger during this period which had a negative impact on the measurement of continuity, and the other were not able to implement the actions they had identified.

The *CoC Index* increased for four of the five practices, with the greatest increases in those practices with an increased UPC.

---

[35] Evaluation activities were focused on wave one practices due to the timing of the programme and delays caused by the pandemic.

Continuity Counts

For the period 01/01/19 to 31/03/21, across the five participating practices, the *SLICC* for face-to-face consultations improved in one practice, was maintained in three practices and declined in one practice. For Continuity Counts, the baseline position of the *face-to-face SLICC* ranged from 25% to 64% across the five practices, with the range increasing to between 15% and 70% by the end of the project. A *face-to-face SLICC* of over 60% was achieved by three of the five practices at points over the lifetime of the project with some examples where this exceeded 70%.

Across the same period, for four of the five practices, the *OPR* for face-to-face consultations increased. For three of these practices which used personal lists, this increased over the period from over 50% to 70-80%. For the fourth practice, this increased from 40% to 56%.

For one practice, there have been decreases in the *SLICC and OPR*, where the latest *SLICC* score was less than 20% by the end of the project. The project team reflect that this is a practice which does not use personal lists, has been influenced by differences in attitudes to continuity between the GP partners and a practice consensus to prioritise access over continuity.

Valentine Health Partnership

The project reports that between July 2019 and March 2020, 584 patients were identified in five waves of data analysis as potentially benefiting from continuity and, after their named GP reviewed their notes, 416 (75%) were tagged for continuity. These were patients identified as having changes to the frequency of attendance suggesting a new or emerging condition.

For patients tagged in waves one and two of this project (213 patients), continuity with individual GPs and with micro-teams (measured as the percentage of consultations with the named GP or micro-team) increased during the four months afterwards (compared to the four months before). Three of the four micro-teams in the practice achieved continuity levels of 50% and up to 63% in the other.

Interestingly, the increase of continuity was evidenced beyond the tagged target continuity patients, to those who have more than six consultations in the previous three months. In the first quarter of 2020, 37% of patients were reported to have continuity with their named GP for over 50% of their consultations, compared to 33% in 2019. This increased to 71% of patients having continuity with their micro-team for 50% or more of their consultations, compared to 62% in 2019.

Continuity by Design (Pier Health)

Due to the agreed extension of the Pier Health project, measurement of continuity is ongoing. However, interim findings indicate that for the practice with sustained involvement during the programme to date, a small increase in the *UPC* from 41% in 2019 to 45% in 2021 (up to 01/06/21) can be observed.

Summary

At an individual practice level, there has been variation in the changes demonstrated in continuity measures and depending on the measures prioritised locally. This is highlighted further in the individual project reports where, for example, Morecambe Bay provides annotated data stories for each wave one practice indicating where events such as a GP leaving, or a triage system being implemented have disrupted observed patterns in measures of continuity.

At a project level, all five projects have reported that continuity measures have experienced small improvements or have been maintained in various measures of continuity.

4.3.2 Evidence collected from the GP Patient Survey

The GP patient survey provides an insight into how patients' perceptions of continuity of care may have changed. Data collected from January to March 2018 was used as the baseline and compared to data collected from January to March 2020. This approach allows us to begin to paint a picture of patient experience linked to the initiatives before the Covid-19 pandemic and the wider influence of new ways of working and demands. Nevertheless, given the complex landscape of General Practice and reliance on two timepoints, we must interpret these findings with a degree of caution.

4.3.2.1 Seeing or speaking to the preferred GP

In 2018, 49% of patients in the practices involved in the programme saw their preferred GP 'Always or almost always/A lot of the time' *(n=1399).* This was comparable with the national picture, as depicted in Figure 7. Over time the national figure declined, while for the programme practices, this figure remained at 49% *(n=1354).*

Figure 7: Programme-level
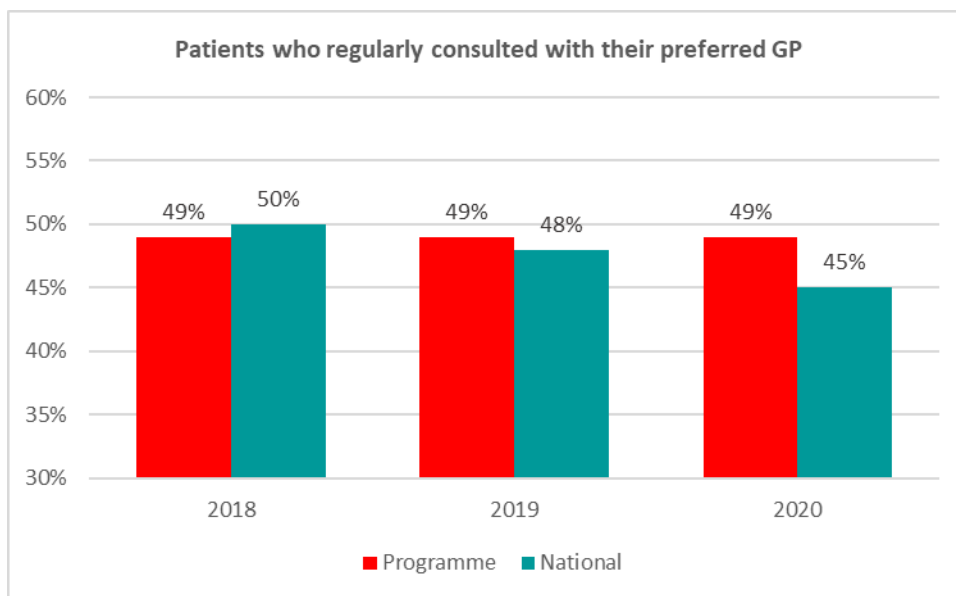
Source: GPPS, 2018, n=1399; 2020, n=1354

When looking at the individual project teams within the programme, a more varied picture is seen. Patients in Morecambe Bay and Valentine Health Partnership described the greatest increase in seeing their preferred GP from baseline. Experience from patients in the GPPS within the Continuity Counts project did not indicate an improvement in the ability to see their preferred GP. It is clear from Figure 8, that most project teams had shown an improvement, not only against the national picture but when against their CCG comparator.

Figure 8: Project-level
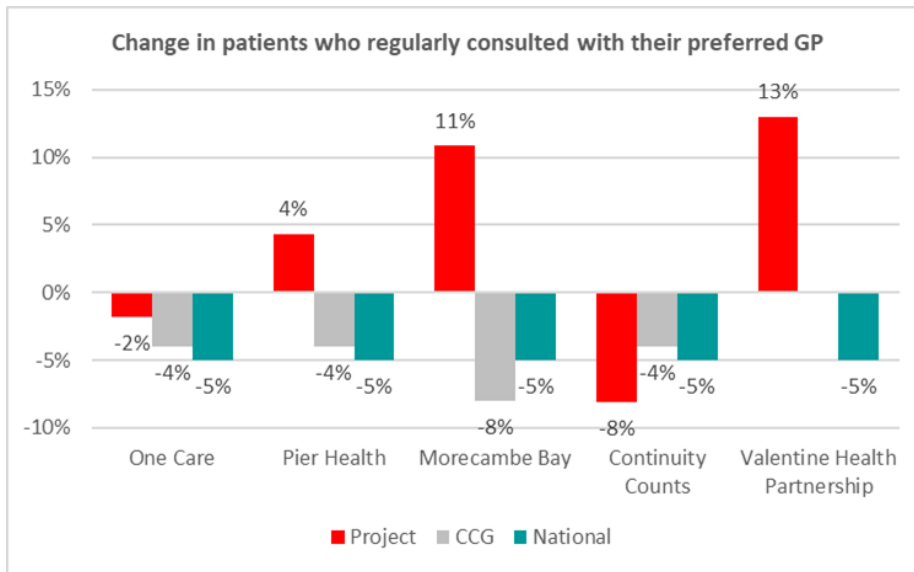
Source: GPPS, 2018, n=1399; 2020, n=1354

Note: Valentine Health Partnership is part of South East London CCG which is newly formed and does not have comparable data at the CCG level.

It is important to proceed with caution when comparing the project teams as each had taken had different approaches across different timelines. For example, at the time of data collection, the Continuity Counts project was in the process of seminars with local practice teams to describe 'why continuity' predominantly with practice teams, therefore it is unlikely that patient perception would be altered in this sample. Also, the scale and variability of practices within each project should be considered. For example, Valentine Health Partnership represents one, albeit large, practice and therefore may be expected to represent a greater impact at the project-level against the multi-practice project teams. Through the project-level lens, we must recognise that challenges from large practices may mask the successes of smaller practices and therefore must triangulate with project team reports for practice-level insights.

Figure 9: Practice-level example from Morecambe Bay
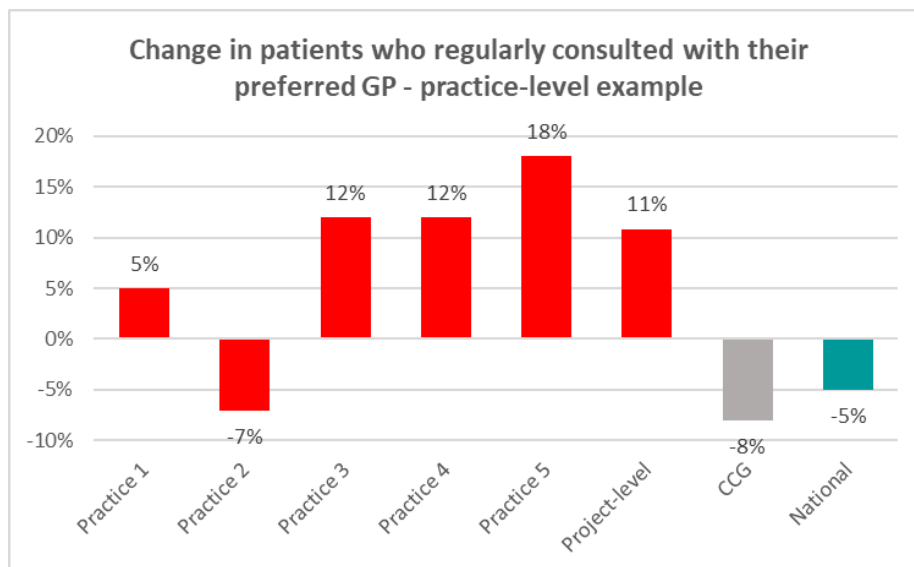
Source: GPPS 2018, n=297; 2020, n=270

However, four out of five of the practices in the first wave of the Morecambe Bay project noted patient-reported improvements in seeing their preferred GP. Practice 2 which did not follow this trend openly discussed their hesitancy to change initially; however, in this practice, progress was made later but too late to be captured in the GPPS timepoints. This is depicted in Figure 9 above.

4.3.2.2   The impact of increasing continuity of care on timely access

There has long been a debate about the role and interdependencies of access and continuity in General Practice. As described above, patient-reported continuity of care has increased at the programme level and using publicly available data from the GP patient survey, we can explo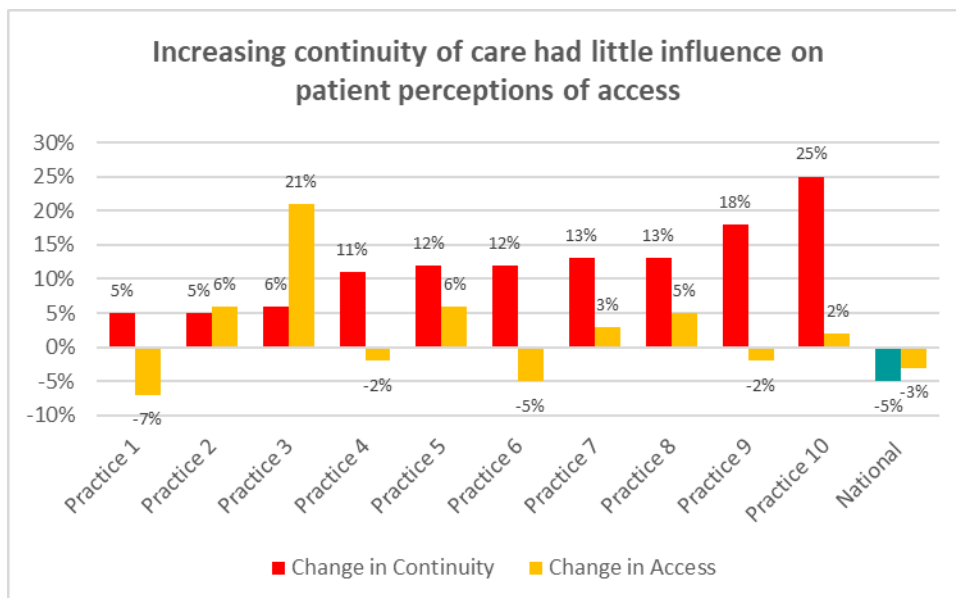re the balance with timely access. In this instance, access was indicated by the question "*How satisfied are you with the General Practice appointment times that are available to you?*" and collating positive responses *'Very satisfied '*and *'Fairly satisfied'.*

Figure 10: Increasing continuity of care had little influence on patient perceptions of timely access

Source: GPPS 2018, n=1034; 2020, n=1031

On balance, Figure 10 depicts little difference in patients' perception of timely access in these practices when compared with the national trend. This indicates that continuity of care may be increased but without detriment to patient perception of timely access.

4.3.3   Evidence from the mixed-methods evaluation survey

4.3.3.1   Increase in patient-reported continuity of care

Patient-reported continuity of care **increased from 0.58 in the baseline survey to 0.64 in the summative survey**. Whilst this is not a matched sample over time, it does indicate increased continuity of care through programme initiatives.

Using existing criteria[36], this continuity of care index was stratified into those with low, medium and high continuity. We can see from Figure 11, that there was no change in the proportion of patients who had high continuity over time, however, **there is an 11% shift in the proportion of patients with a low continuity index into the moderate category**. This suggests that

---

[36] Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data (bmj.com)

those with existing high and medium levels of continuity were able to retain this but those with low continuity had increased over the formal programme period.

Figure 11: Increased patient-reported continuity of care
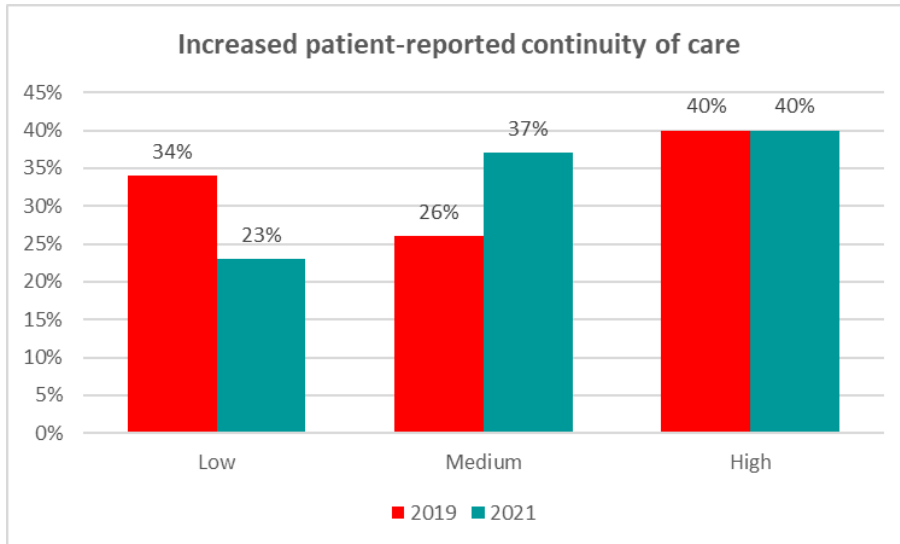
Source: Mixed-methods evaluation survey, 2019, n=713; 2021, n=982

4.4   Ability to see or speak to the preferred GP

Given the difficulties and pressures, it is perhaps unsurprising that half of those surveyed said it was now more difficult to speak to their preferred GP. Data collected from the mixed-methods evaluation and shown in Figure 12 below, highlights that one in five patients found it easier to see or speak to their preferred GP in the past two years (n=306), 30% of patients described that there was no change (n=437), whilst 49% of patients described it to be more difficult (n=715). Locally collected evidence from one of the project teams, the Valentine Health Partnership, described how 70% of their patients, who responded to their local survey, found it easier to see their preferred GP.

Figure 12: Ability to see or speak to their preferred GP in the past two years
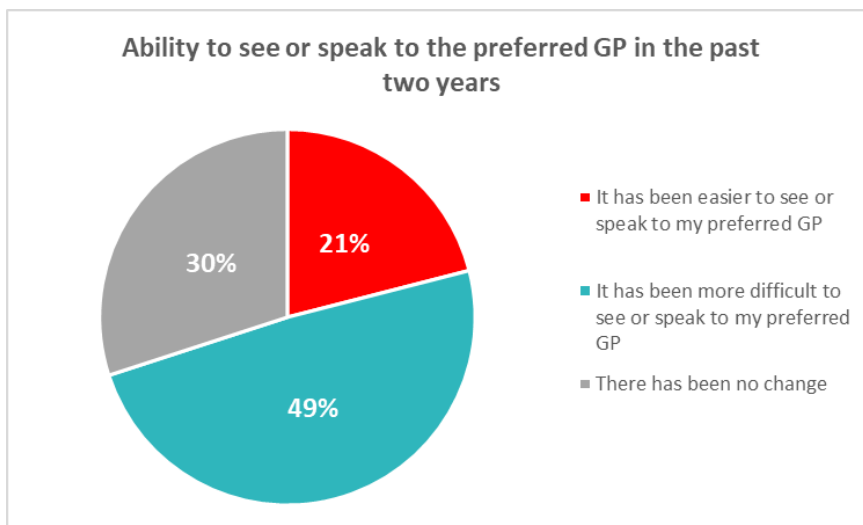
Source: Mixed-methods evaluation survey, n=1458

When probing the characteristics of those who found it easier, we can see a modest difference in that 23% of females (n=212/905) found it easier to see or speak their preferred GP, compared to 18% of males (n=98/530). When we look towards age, from this sample, it seems that younger patients found it easier to see or speak their preferred GP when compared to older cohorts. This is depicted in Figure 13. There was not sufficient ethnic diversity within the sample to draw any conclusions about a link between experience and ethnicity

Figure 13: Association of age groups being able to see or speak to preferred GP

In the past two years, younger patients found it easier to see or speak their preferred GP

Legend:
- There has been no change
- It has been more difficult to see or speak to my preferred GP
- It has been easier to see or speak to my preferred GP
- Number of responses

Source: Mixed-methods evaluation survey, n=1441

Through a broader lens, we explored association in the responses linked to individual practices and their contexts. Analysis from the survey did suggest that there may be an association towards patients in larger practices finding it more difficult to see their preferred GP; however, this is only one aspect and there are other interdependencies to consider such as patient population, local contextual changes through systems and workforce. There was 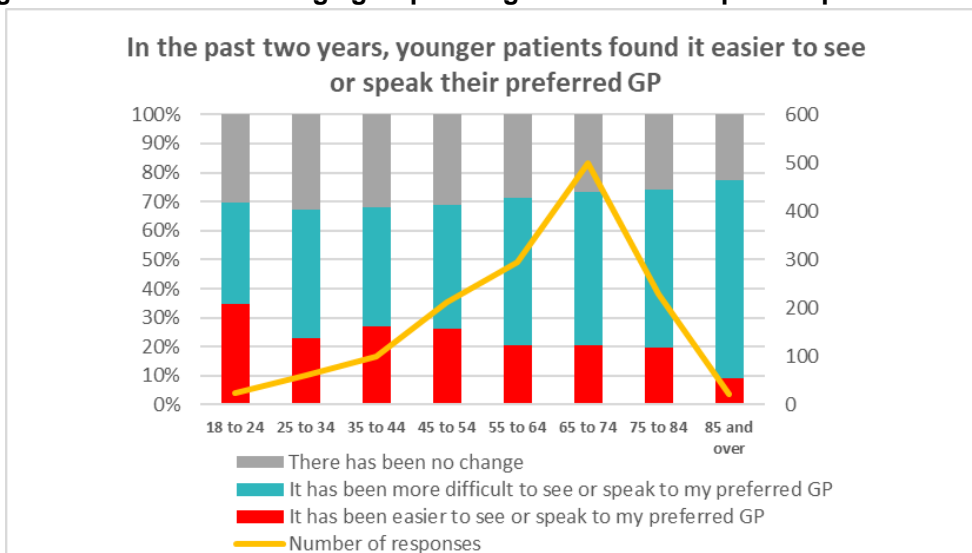no discernible difference linked to rurality; responses were received from 'Largely Rural', 'Urban with Significant Rural' and 'Urban with City and Town' populations and were comparable. We cannot draw conclusions linked to deprivation as respondents had similar levels of deprivation.

4.4.1   Why some patients found it easier to see or speak their preferred GP

Patients described a number of different reasons as to why this was easier for them to see or speak to their preferred GP. These are outlined below in Table 4 and included:

Table 4: Why patients found it easier to see or speak to their preferred GP

Theme	Reasons to why patients had found it easier to see or speak to their preferred GP in the past two years
Practice systems and ways of working	Using online consultation platforms– *"Using the eConsult meant my assigned GP answered my email and from there I have put in his name as preferred GP and he has always been the one to contact me."*
	Increased capacity through remote consultations – *"The increased online/phone appointments available through Covid."*
	Being informed of when the preferred GP was working – *"Having their rota online for you to see"*
	The practice allocating each patient a GP – *"Our surgery has assigned each patient and GP and so it is generally likely you can see your preferred GP unless it is urgent*

Theme	Reasons to why patients had found it easier to see or speak to their preferred GP in the past two years
	and they are not in on that day". "my understanding when talking to the reception is that we have been allocated a specific GP, which in my opinion is wonderful"
	Reception teams prioritising consultations with the preferred GP – *"Receptionists always book me with designated GP unless an urgent appointment"*.
	More stability in the GP workforce – *"Locum GP spent more time at practice."*
	New ways of working more generally – *"The practice seems to be working differently and in a very positive direction"*
Patient factors	Taking ownership to ask for the preferred GP – *"I specifically request to speak to preferred GP"*
	Planning consultations for when the preferred GP is working – *"… she works 2 days a week I plan contact when she is around."*
	Continuity prioritised due to the patient's condition – *"The support of my doc recently when suffering severe anxiety. Told me if I couldn't get an appointment, to ask the receptionist to email her. Awesome care is given"*
	Willingness to wait for an appointment – *"I have sometimes had to wait a day or so, but basically the practice is well run"*

Source: Mixed-methods evaluation survey

4.4.2   Why some patients found it more difficult to see or speak their preferred GP

Similarly, we probed reasons why patients found it more difficult to see their preferred GP in the past two years. Some examples are shown in Table 5 and include:

Table 5: Why some patients found it more difficult to see or speak to their preferred GP

Theme	Reasons to why patients had found it more difficult to see or speak to their preferred GP in the past two years
Practice systems and ways of working	Using online platforms– *"The system is very impersonal and gives the (false) impression that one's GP is unapproachable. It seems to have been designed to prevent patients 'bothering' the doctors rather than ensuring that anyone with a medical problem can get timely and helpful advice."*
	Communications with GP at inconvenient times – *"eConsult replies are at a time we can't talk/ at work/ etc. If we make an appointment to see a GP, it is for when we are available. With eConsult, replies are not often convenient for us."*
	The use of the total triage model – *"The telephone system seems to preclude face to face contact with the Doctor or having any choice as to which Doctor one sees. The downside of this is that there is little patient continuity and it also means that Doctors in the practice do not know who they are speaking to. Patients are 'faceless' creatures".*
	Signposting and care coordination – *"The Care Navigator usually directs me to anyone but a doctor- let alone my preferred GP"*
	Not having sight of when preferred GP is available – *"As I don't know how often or when the GPs in the practice work it's impossible to say."*
	When there is a rota visible, this is not always up to date – *"The daily diary shows preferred GP is working or not working … this is often not accurate as when I send a message, I'm unable to send to preferred GP although shown as working for example."*
	Too long to wait for an appointment – *"Usually have to wait 2-3 weeks if not more for appointments, even a phone call"*
Staffing factors	Practice is under-resourced – *"Not enough staff, too many patients"*

Theme	Reasons to why patients had found it more difficult to see or speak to their preferred GP in the past two years
	GP shift patterns – *"...they seem to work odd hrs. Afternoon one day, morning the next so don't think they think about patients"*
	GP turnover – *"They keep leaving and I am just assigned to someone new or who I've never met before and therefore has no idea of my medical history"*
	GP workload – *"Increased pressure of workload for the GPs"*
External factors	Covid-19 and public messaging – *"The Covid messaging has been over the top and presents a barrier to getting through to the surgery and is unnecessary and should be at least updated to stay relevant."*

Source: Mixed-methods evaluation survey

4.4.3 Those who experienced no change in seeing their preferred GP over the past two years

Interestingly, many of those who described that there was no change in their ability to see their preferred GP explained that this was because they were already able to see or speak to their preferred GP.

Further analysis shows that within this 'no change' group, more than three-quarters of respondents said they had high or medium continuity of care. Therefore, we must not make assumptions that 'no change' equals 'no continuity' as it seems fair to consider that a proportion in this group may have high baseline continuity.

4.5 Impact of specific interventions

One of the questions for the mixed-methods evaluation was to describe which approaches worked best to increase continuity of care. However, given the complexity in the maturity and context both across and between different project teams, this will be difficult to attribute to a specific intervention. However, there was learning gleaned which noted that the fundamental system changes (i.e. patient allocations or patient "flags" on electronic patient record systems, and implementation of online consultation platforms) were the most resilient in the pandemic. Comparisons were drawn to highlight how these were believed to have withstood the challenge when compared to staff engagement sessions, scripts for reception teams and patient engagement materials.

4.6 Summary

This analysis has shown that:

- There are indications that staff and patient engagement resulted in greater importance placed on continuity of care, and was maintained as a strategic priority despite Covid-19 pressure
- Some locally captured quantitative measures suggest improvements to CoC, with variation by practice in each team
- Some corroboration from GPPS that programme teams have at least managed to maintain continuity compared to national and local (CCG-level) declining continuity
- Qualitative survey data suggests that patient allocation and workflow changes are perceived by patients to have improved continuity, although with some patients less approving of changes. Awareness also by patients that staffing and external pressures may impede progress on continuity
- Finally, no consistent suggestion that patients perceive improved continuity coming at expense of timely access.

5 Benefits and consequences realised from increasing continuity of care

This section describes the benefits and consequences which were realised in practice during the increasing continuity of care programme period. This is structured in three sections:

● Project stakeholders described benefits and consequences for patients
● Project stakeholders described benefits and consequences for the workforce
● Project stakeholders described benefits and consequences for the system

5.1 Project stakeholders described benefits and consequences for patients

Patients were perceived to be more informed about continuity of care and how to achieve it. This was evidenced through surveys, interviews, focus groups and observation at programme events:

● Patients who found it easier to see their preferred GP in the past two years described how they took ownership of the process, requesting to see or speak to them and planning non-urgent consultations around when the preferred GP would be working
● Reception teams noted that adding continuity considerations on the telephone messaging meant that: *"patients are aware of importance [of continuity] and often comment on it".*

Interestingly, the importance that patients placed on continuity did not change over the formal programme period. This suggests that the programme has not changed patients' views of continuity so much as it has empowered those who value continuity with the knowledge, means and processes to demand and achieve greater continuity.

The doctor-patient relationship enabled coproduction and shared decision-making. Patients who reported higher levels of continuity felt that they are more involved in decisions about their care. One patient described that *"It's a case of building a relationship with someone so that we're BOTH making decisions that are based on shared understanding".* This was observed across different situations in the study, where:

● There was a 9% increase of all patients surveyed who agreed that they felt more involved in decisions about their care (63% in 2019 vs 72% in 2021) *2019, n=1516; 2021, n=1458*.
● Patients who found it easier to see or speak to their preferred GP in the past two years felt more involved in decisions about their care than those who found it more difficult, depicted in Figure 14 overleaf (94% who found it easier agreed that they felt more involved in decisions about their care versus 65% who found it more difficult to see or speak with their preferred GP) *n=1458*

Figure 14: Perception of involvement in care
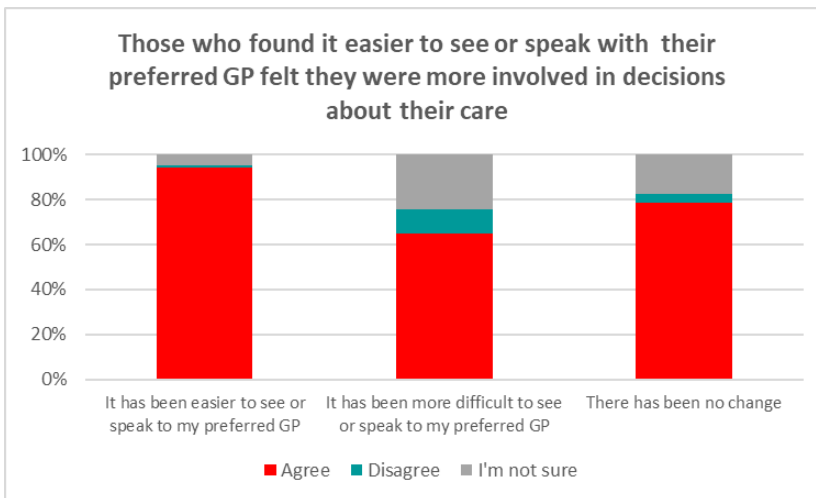
Source: Mixed-methods evaluation survey, n=1458

In a very similar proportion, **those who found it easier to see or speak to their preferred GP felt that the GP was more responsive to their needs and concerns** (93% for easier versus 64% who found it more difficult) *n=1458.* Those who found it easier regularly described how the consultations were "easier" and they felt more "comfortable". A recurring theme was not having to start the story at the beginning, *"Not having to explain the story from the start every time. I have mental health problems and explaining everything is time-consuming and difficult to do".*

There was also a suggestion that these patients were more inclined to be proactive in self-care, as the patients who found it easier to see or speak to their preferred GP were **more confident to take an active role in their health and wellbeing** (95% for easier versus 78% who found it more difficult) *n=1458.*

When comparing a number of different factors against one another to show change over time, we can see that the impact described by patients was **less about 'knowing each other' but more about working together effectively**. Patients feeling that they knew their GP and vice versa reduced modestly over time, yet to no detriment of responsiveness and shared decision-making. This is depicted in Figure 15.

Figure 15: Increase in factors which convey working together effectively
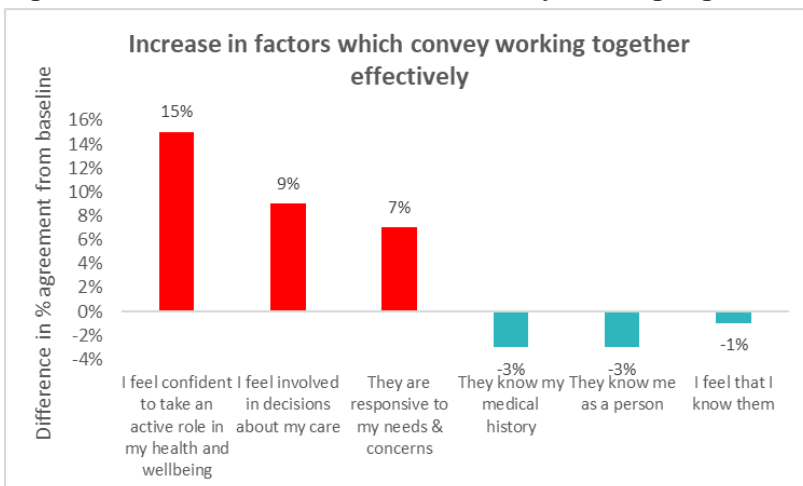
"Continuity of care is about having confidence in one person…how your doctor goes about dealing with your problems; being thorough, being understood, having them reflect it back to you so that you are on the same page, being open and clear about the next steps".

Patient interview

Source: Mixed-methods evaluation survey, n=661

More widely, **patients who found it easier to see or speak to their preferred GP in the past two years reported having greater overall satisfaction with their practice**. Of those patients who found it easier, 98% stated that they had a good experience with their practice, compared to 71% of those who found it more difficult *(n=1458)*. Interestingly, for those patients who found no change in being able to see or speak to their preferred GP, 93% of patients reported an overall good experience with their practice*(n=1458)*. This suggests that **being unable to see or speak to the preferred GP results in a detrimental effect on overall experience** with a practice.

When asked, **61% of patients would be willing to wait longer to see or speak to their preferred GP**, with 15% disagreeing and the remaining were unsure *(n=1458).* However, from our data, we can't specify how long they would be willing to wait. A balance must be struck to ensure clinical safety whilst promoting continuity, as some patients described that they "*have been willing to wait, up to a month, for an appointment"* to see their preferred GP. However, we have little context as to whether this was a non-urgent consultation or chosen for convenience to their own needs.

The culture shift towards continuity has resulted in some patients becoming *"disgruntled"* when they prioritise rapid access over continuity. For some patients, the prioritisation of continuity within practice principles made them feel that they had **lost their ability to choose between access and continuity of care**. A number of patients described to us that they would rather have greater visibility for the special interests of GPs, for example in dermatology or mental health, and this would grant them the ability to decide who may be best for them to see given their request or condition.

5.2   Project stakeholders described benefits and consequences for the workforce

Increased staff satisfaction was reported across the programme. This was linked to a number of reasons:

- Through **managing their own patients**, their results and care pathway, without the stress of trying to piece together the decisions or thought process of a colleague
- Finding it **easier to manage clinical uncertainty** without referring to another service
- **Increased sense of professional responsibility**, one GP described the impact of the continuity of care initiatives describing *"[a] greater sense of responsibility for a small number and helpful to streamline their care (avoiding multiple opinions)"*
- **Improved quality of consultations** which enable GPs to find it "*easier to spot nuanced change in conditions"*
- **Improved collaborative** working across colleagues both within and across practices within the project
- Specifically, in the Valentine Health Partnership project, 73% of staff surveyed said the increased continuity achieved through the project had **made their working life easier** or not affected it *(n=30)*
- Whilst we were unable to evidence it quantitatively, there was a belief that there were **fewer patient complaints** received from patients. However, a member of the administration did describe that "*patients are happier which makes my role more pleasant".*

Whilst other work has mentioned how continuity of care might lead to a more rewarding experience for GPs, **to our knowledge, this is the first study of its kind to describe increased job satisfaction due to continuity of care beyond GPs**. Staff occupying several different roles in General Practice reported a positive impact on their role and satisfaction due to increasing, or attempting to increase, continuity of care. A common theme was noted from administration teams who described that *"it is easier to know which GP to send documents/*

enquires to". It is an interesting point to consider that whilst the programme set out to improve relational continuity of care with GPs, the backroom processes and changes improved informational and managerial continuity for wider teams.

However, we must also recognise that there have been numerous cases described where adhering to and implementing continuity-focused processes has **caused challenging conversations and additional stress for reception teams and care coordinators**. To mitigate some of this additional burden, a practice in One Care described how they undertook a practice-wide poll to understand how long it would be acceptable for a patient to wait for a appointment in a number of different scenarios. This revealed that GPs felt that patients could tolerate longer waits than were felt to be acceptable by front-line staff. This exercise highlighted the variety of views across the practice and following this, 'ground rules' were set in the practice to ensure that everyone made decisions on the same parameters. Beyond this, those working within the practice recognised that they must have a united message and approach with patients to truly embed the continuity culture and ways of working.

Considering the process changes made to ways of working, a common finding from across the programme was that through patient allocations or personal lists, a **more evenly distributed workload was noted across the clinicians in a practice**. By the very nature of reducing variation in workload will result in some, particularly GPs, noting a reduced workload, some increasing workload and others having no effect. At times, this surfaced tensions within practices and this is something that has been highlighted in the final reports of projects such as Valentine Health Partnership. As part of our interviews, one GP expressed, *"I think, overall, I continuity for my patients remains good though extra pressures have meant that I am frequently only managing that through working outside core hours e.g., into the evening and on days off".* However, this was not exclusive to GPs in the practice; we heard from wider clinical roles who described *"other members of the team taking some of the workload"*, felt to be a benefit of the project.

Some GPs have perceived that this increase in workload is due to the **management of complex patients for who they are now responsible**. For example, Pier Health highlight that "*an unintended consequence of implementing continuity is that these [high impact] users place a lot of strain on a single GP*". There is a recognition that these complex patients have become more visible through the allocation of a responsible GP. As the Continuity Counts project highlights in their final report, complex patients "*are just as common in pooled list practices but are less obvious as they rotate around different GPs often receiving multiple investigations and becoming frequent attenders*". Some project teams have worked with practice teams to support them in managing these patients; for example, using seminars or regular clinical meetings to discuss examples of complex patients and providing education sessions and materials with advice on setting boundaries and managing risk.

5.3   Project stakeholders described benefits and consequences for the system

Considering the benefits and consequences for the system, we look towards the influence of interventions on the practices and wider healthcare services. Theoretical perceived benefits of increasing continuity of care and captured through early conversations in the evaluation included reduced consultation rates, reduced volume of tests and prescriptions and reduced hospital attendances and admissions. This area of interest was more difficult to extract learning as this was less evident, or more difficult for local teams to measure, when compared to the benefits and consequences for patients and the workforce. It may be that system benefits and consequences would be more evident over the longer-term. Through our engagement with local teams, we can describe that there have been some indications of:

- **Strengthened links with local PPGs**
- **Better understanding from teams of their practices and their data**

- **More efficient and streamlined practice processes**
- More efficient use of remote consultations, *"the massive increase in remote consulting that has occurred caused by the Covid-19 pandemic has only emphasised further to me the importance of continuity of care for patient safety and practice efficiency".* This was supported by local survey data which showed that 76% agreed that it made it **easier to provide follow up by telephone or video consultation** (n=30)
- Shorter consultations for patients which were targeted for enhanced continuity of care
- Local data from the Valentine Health Partnership suggested that patient who had achieved continuity with their usual GP more than 50% of the time had fewer attendances at A&E and urgent care.

6 Implementation of interventions

6.1 Our approach to understanding implementation

The programme is an intervention, with a core focus and set of aims but delivered in different contexts. How the programme was implemented in each project varied, and we must learn from how this implementation was conducted and what factors enable or impede implementation. To do so in a structured way, we draw on a framework that allows us to examine and systematically define the different elements which affect implementation.

The integrated-PARIHS (Promoting Action on Research Implementation in Health Services) framework has been considered in assessing implementation[37]. i-PARIHS views implementation through assessing and aligning the initiative to be implemented with the intended recipients in their local, organisational, and wider system context. To this end, implementation has been considered in five layers, as illustrated in Figure 16.

Figure 16: The five layers used to consider implementation

The i-PARIHS framework also considers the characteristics of recipients, context, innovation, and facilitation and these can be cross-referenced to different layers within the programme structure:

- Innovation through the **project** interventions
- Recipients as **patients** and **workforce**
- Context through the lens of the **practice**, **project,** and **programme**
- Facilitation by the **project team leads** and the **programme team**.

In this section, the contributing factors for increasing continuity of care are described in greater detail under these five layers and concerning the characteristics of this framework.

First, however, we must consider the baseline context of the projects within the programme. It is important to highlight that "setting the context" itself is a challenge within implementation science, as it is dynamic and the 'moving parts' continue to interact with what is being implemented. We have been cognisant of this in our approach and findings, recognising the emerging and adaptive mechanism within setting the context. [38]

---

[37] Harvey, G., Kitson, A. PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. Implementation Sci 11, 33 (2015). https://doi.org/10.1186/s13012-016-0398-2

[38] May, C.R., Johnson, M. & Finch, T. Implementation, context and complexity. Implementation Sci 11, 141 (2016). https://doi.org/10.1186/s13012-016-0506-3

6.2   Baseline context

It is important to recognise that project teams and the practices within these projects started from different positions in their continuity journey. This section describes some of the features in how this baseline context differed.

6.2.1   Established voices in the continuity of care community

Increasing continuity of care was, of course, the common aim across the programme however the foundations on which project teams (and the practices within them) were starting their journey are remarkably different. We considered that the projects, and perhaps individuals within the projects, had long-established roots and motivations of continuity of care in practice. The programme involved well-established leaders and voices of the continuity of care community, whilst also supporting those where increasing continuity of care was a new challenge within their local area.

In practices where continuity of care had been a long-standing priority, one would anticipate that the baseline awareness of continuity of care across patients and staff groups, and the degree of continuity of care experienced at baseline, would be higher than in other practices and projects. Therefore, it is important to be realistic about the potential for further improvement through continuity of care initiatives with staff and patients who are already familiar and committed to the concept, compared to those practices where this was less embedded or prioritised historically. Nevertheless, the quantitative data did not necessarily support this; at the programme-level, participating practices had, on average, a lower proportion of patients with a preferred GP when compared to the national picture, as well as a lower proportion of patients seeing or speaking to their preferred GP.[39]

6.2.2   Practice topography

Similarly, we also considered where continuity may be high at baseline due to practice size, ways of working, patient demand and involvement. Using Morecambe Bay as an example, a number of small practices noted that they had 'intrinsic continuity'; patients were generally older and believed in the traditional ethos of the "family doctor" and therefore would request their responsible GP when booking and were more likely to wait to see them.

---

[39] GPPS, 2018 data set

Figure 17 provides an overview of the contributing factors for increasing continuity of care with each layer then discussed in further detail below.

Figure 17: Contributing factors for increasing continuity of care
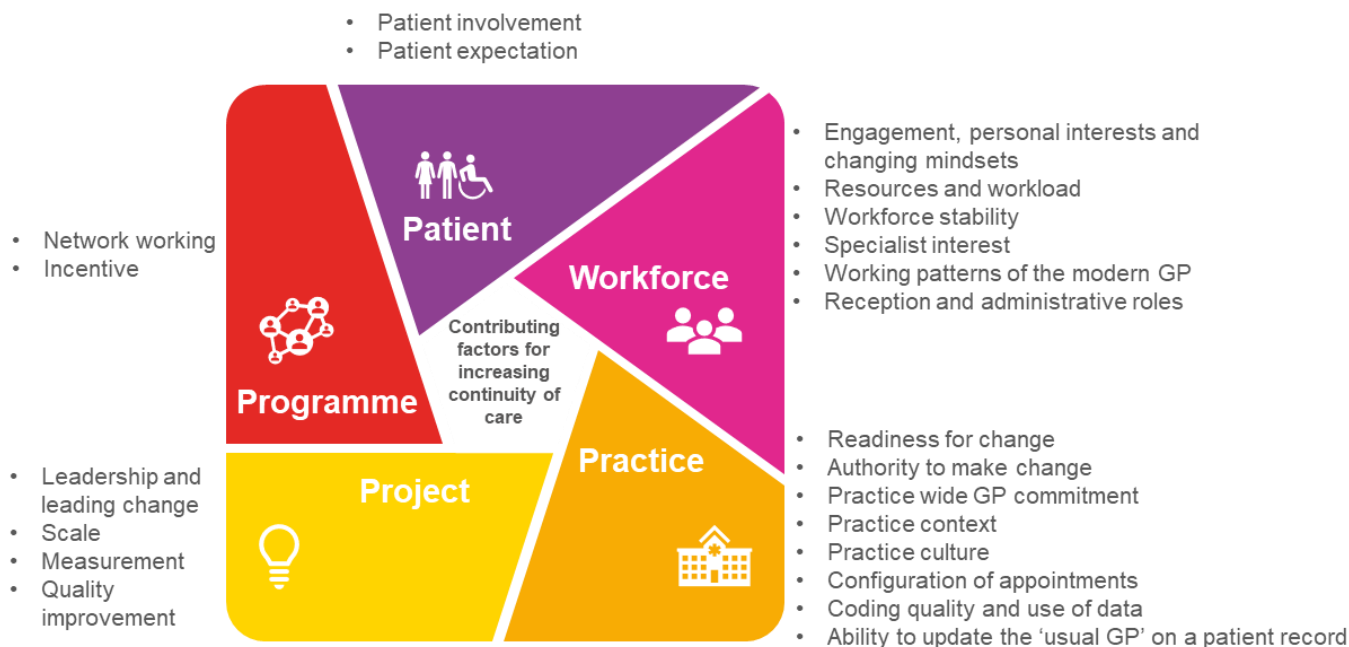
6.3   Patient factors

6.3.1   Patient involvement

All project teams involved patients in their initiatives and approached this in a number of different ways. The Continuity Counts project embedded patient involvement through their governance structures by identifying patient continuity champions within practices, alongside GP and administrative champions. However, they had experienced some challenges in identifying and retaining patient champions, as these individuals are volunteering their time and may have other commitments which limit their involvement.

Projects teams also involved patients through focus groups, semi-structured interviews and through their practice Patient Participation Groups (PPGs). Involvement via PPGs has included discussions on the concept of continuity of care, capturing personal anecdotes and experiences, and co-design of education materials. It has become evident that there is substantial variation in the stage of development of individual PPGs; some working well, some in their infancy and, in some practices, there is no active PPG. This was the focus of discussions at early Learning Workshops, recognising this as a common challenge across the programme.

6.3.2   Patient expectations

As has been demonstrated in section 4.1.4, whilst many patients believe continuity of care to be of importance, this is not a view shared by all patients. Qualitative comments within our surveys revealed some patients describing a desire for continuity for certain episodes of care, or certain conditions, but in being happy to access alternative GPs for other urgent or unrelated medical problems. In the consequences of implementing this programme, it has been highlighted that some patients have perceived there to be delays in access to a GP in waiting for their responsible GP and this may be a particular issue for a patient who does not value continuity. Communication with patients through promotional materials, waiting room videos and

engagement with the staff has therefore been important in implementation, increasing patient awareness of the potential benefits of continuity and in gaining their understanding of the rationale for changes in their practices' ways of working.

6.4   Workforce factors

6.4.1   Engagement, personal interests and changing mindsets

Whilst the project and practice leaders committed to the ambitions of the initiatives, inevitably not every practice or staff member valued continuity of care equally.

Project leads therefore needed to present new information in an engaging way to generate broader ownership of continuity initiatives, and potentially to change entrenched views. For example, within the Continuity Counts project, the team reflected that there was a challenge in presenting the research evidence base for continuity in an engaging way after the initial seminars. This was further compounded by the restrictions associated with the pandemic, where these were moved to the virtual environment. For the Morecambe Bay project, supporting staff to understand the experiences of patients (and staff) was important in enabling change and in overcoming some of the process barriers to achieving continuity.

Likewise, in Valentine Health Partnership, at the start of the project, only 50% of clinicians were very positive about continuity of care. Other members of staff expressed concern that increasing continuity for selected patients would also increase their workload. It was from these concerns that, with staff, their toolkit was created, which simplified the allocation process for patients, provided evidence on the benefits from the literature on continuity of care and emphasised that the aim of the project was to "work smarter, not harder". Discussion at clinical meetings and staff development sessions were valuable to build on this and agree clinical workflows and responsibilities; GPs described greater confidence in navigating patients to their colleagues without feeling as though they are "fobbing them off" or unfairly sharing the workload.

Some resistance was noted in practices who were satisfied with their baseline level of continuity and with how the practice operated. Observationally, this was most prevalent in smaller practices, with smaller networks of GPs who effectively already acted as an informal micro-team.

Within that, some practice members had different views on what continuity of care in General Practice should look like. Three key points which were regularly discussed in the pre-Covid-19 segment of the programme included:

- Some considered continuity is best delivered through face-to-face interactions, whilst others believed continuity can be delivered through all interactions
- Some considered that continuity of care should be delivered equally for all patients, whilst others believed that it should be targeted to those who would benefit most
- Some considered that continuity should be measured across all contacts, whilst others believed it may be more prudent to focus on increasing this for routine consultations initially.

6.4.2   Resources and workload

Predictably, constraints to General Practice resources have, at times, limited active involvement in the project, and ultimately the ability to provide continuity of care. When challenged by lack of resources, staff described that despite continuity being important to them, their focus was managing the current workload and struggled to find the time, or the "headspace", to consider

what change was needed. It should be noted that these findings were not limited to continuity of care but are routinely described as key challenges to quality improvement in General Practice.[40]

One practice, for example, described that there was limited development time to make changes "on top of the day job". Most projects incorporated funding to backfill time spent on the project and away from daily duties, however, some GPs believed that even if they had additional funding support, they would have struggled to find the time to use it.

6.4.3 Workforce stability

Stability, or lack of stability, within the workforce was shown to be an important factor in project implementation and in delivering continuity for patients. Whilst it is recognised that staff turnover or periods of absence are relatively common workforce issues that are hard to mitigate against, there have been a few instances where this has caused a delay to progress in the short term. This also caused some disruption to projects such as Continuity Counts with a programme of seminars, noting that a GP missing one seminar meant that that individual was disadvantaged in subsequent meetings and recaps were needed on the technical details on the metrics being used ore example. More positively, projects described that a stable workforce was considered an influential factor for successful implementation of continuity of care initiatives; being able to work more closely and more "in tune" with one another.

Whilst acknowledging the demanding landscape of General Practice, deprived communities face a markedly disproportionate challenge. This is evidenced across the workforce, patient experience, access and continuity of care. Collectively, this creates a barrier for practices in deprived communities and their capacity to deliver change faced with competing challenges. For instance, one practice in Pier Health, which served a relatively more deprived population, reported their difficulty in recruiting GPs and reflected that delivering continuity of care with one permanent GP has been *"highly stressful"*.

6.4.4 Specialist interest

There have been some examples of where continuity of care may transfer to a colleague with a specialist interest for a specific episode of care. For example, GPs may often refer patients between themselves for conditions in which their colleague has a specialist interest who will maintain continuity during consultations for this condition. This was regarded as an informal, micro-team approach to episodic or conditional continuity of care but it is recognised that it is a barrier to delivering relational continuity of care according to some metrics of continuity.

6.4.5 Working patterns of the modern GP

The range of roles now available to GPs beyond routine clinical practice, such as undergraduate and postgraduate education, research, special interests, drug rehabilitation work, occupational health, and so on, has increased markedly over the past decade. The diversification of these roles has been largely welcomed as they provide varied opportunities for GPs to learn, flourish and ultimately, provide enhanced quality of care. However, this comes together with the rise of the modern GP working patterns which consist of salaried, sessional, portfolio, and part-time GPs. Collectively, therefore, we must consider what impact reduced clinical time has on implementing continuity of care initiatives.

Most GPs who were engaged as part of the evaluation worked part-time in their practice. It was acknowledged that, of course, part-time schedules reduce the opportunity for patients to see their responsible GP, however, it was noted in places, that patients were aware of responsible GP working patterns and will self-manage to the days that they are in the practice.

---

[40] https://www.health.org.uk/sites/default/files/upload/publications/2019/2019-THF-QI_GeneralPractice.pdf

However, this is not without challenge. It was argued that it was not part-time working that hindered an ability to deliver continuity of care but the shift patterns of the part-time GPs. Some described how sequential non-working days can provide a barrier to continuity as patients are less willing to wait until their responsible GP's next day in the practice.

The Continuity Counts team highlight this misconception that good levels of continuity cannot be provided by part-time GPs in their final report, noting that this can be addressed through GP education.

6.4.6   Reception and administrative roles

Across all projects, the reception and administrative teams have played an important role in implementing operational changes in ways of working to deliver increased continuity and in encouraging the patient to undertake their consultation with their responsible GP where appropriate, supported by agreed scripts.

In their final report, the One Care project reflect that they have *"found the support of the reception team is vital to improving continuity of care".* They highlight that this is in contrast to existing evidence[41] which found that the link between receptionists, consultation systems and continuity of care, the receptionist influence was small compared to other factors ultimately decided by the GPs.

6.5   Practice factors

6.5.1   Readiness for change

In line with other quality improvement projects in General Practice, lack of preparedness for change has been a barrier to implementing continuity of care initiatives. One practice had implemented an online consultation system with little prior work to prepare and inform the patients, the staff and the systems. As a result, they struggled to manage the change to working practices. Staff felt ill-equipped to implement the system and changes were being made daily to cope with short-term challenges but lacked the wider viewpoint to consider the impact across all staff groups. The system had the potential to manage demand and continuity, but all efforts were simply devoted to "getting through the day". To remedy the situation and drive the practice to a state of readiness to begin to focus on continuity of care, the project's improvement lead undertook an After Action Review. During this time, staff felt that they had their voices heard and fostered a shared vision for future ways of working.

Interestingly, there was an occasion when a practice within the Morecambe Bay project considered withdrawing from the project due to the pace and impact of change, however, the project team spent time with their staff and listened to challenge and concerns. They were trained to undertake sequential PDSA cycles and "test out" change and ironed out any problems before being fully adopted.[42]

6.5.2   Authority to make change

Having the authority to make changes within the practice has been an emerging enabler. This has been highlighted by the One Care project in their final report who reflect that, whilst practice staff needs to support continuity, *"it needs the GPs to decide that [continuity of care] is the priority for their practice"*. This can then be implemented across the practice by having a clear policy to support continuity of care and explaining the benefits and rationale to colleagues and patients.

---

[41] Freeman G (1989), Receptionists, appointment systems and continuity of care Journal of the Royal College of General Practitioners, April 1989

[42] https://www.health.org.uk/sites/default/files/upload/publications/2019/2019-THF-QI_GeneralPractice.pdf

6.5.3   Practice wide GP commitment

Similar to the project level, having a clinical champion to lead practice involvement has been an important factor in successful implementation. This was highlighted by the Morecambe Bay project in their final report; *"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 (McKinsey & Company, 2003) which support the changes of mind-sets".*

However, in reflecting on the lessons of why some practices may have made greater progress in their continuity journey than others, it has become apparent that a critical mass of GPs within that practice must be committed to undertaking improvements to increase continuity and must have similar views on its importance concerning other strategic priorities such as access. As the Continuity Counts project reflected in their final report, with regards to personal lists, "*this only works if the practice is fully committed. One doctor alone is likely to struggle to provide continuity*".

6.5.4   Practice context

The context of each practice is important in implementing interventions. Context can be wide-reaching incorporating size, patient population, location and features of the practice (a training or research practice for example).

Evidence has shown that practice size is negatively correlated with continuity [43] [44]. There is no clear relationship between practice list size and the likelihood of having a responsible GP. However, there is a strong negative association between list size and the likelihood of a respondent seeing their responsible GP, even after adjusting for the characteristics of the practices' respondents.[45]

As revealed by Morecambe Bay staff, this may be because it is more likely in smaller practices to build a 'tight-knit' way of working, especially in rural areas. They describe this as an enabler for informal continuity and we have observed this within conversations during coffee breaks to discuss "who knew this patient best?" and would be best placed to treat them. Furthermore, in One Care, it is believed that frontline staff are in a better position to have a good understanding of their patients as well as how to tailor the interaction with their patients.

It could be argued, however, that although practices with a smaller size list are at an advantage when delivering continuity of care, they are perhaps less resilient should unexpected change happen i.e. the impact of losing a long-term GP in a smaller practice may result in a greater detrimental shift on how the practice operates and the continuity they can deliver, compared to a larger practice.

Projects have highlighted that training practices are at a disadvantage in achieving the highest levels of continuity as it is not usual practice to name trainees as the responsible GP given their status and the time-limited period within the practice. Recent changes will mean that training doctors will spend longer periods in practices and in recognising that they have an important role to play in delivering the workload; projects have therefore had to consider how best to involve them within continuity.

[43] Baker R, Freeman G, Boulton M, Windridge K, Tarrant C, Low J, Turner D, Hutton E and Bryan S (2001) Continuity of Care: Patients' and carers' views and choices in their use of primary care services. National Co-ordinating Centre for Service Delivery and Organisation

[44] Kristjansson E, Hogg W, Dahrouge S, Tuna M, Mayo-Bruinsma L and Gebremichael G (2013) 'Predictors of relational continuity in primary care: patient, provider and practice factors' BMC Family Practice 14, 72.

[45] Barker I, Steventon A and Deeny S (2017) 'Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data', BMJ 356, j8

Over the last decade, we have seen a surge in policies that promote General Practice at scale, most recently in Primary Care Networks (PCNs). Whilst we recognise that there are benefits to working at scale, which include better integration of teams, wider scope of services and financial sustainability[46], the impact of PCNs on continuity of care is as yet unclear.

This context and the individual way practices operate, as the Morecambe Bay project highlight means that *"change concepts cannot simply be adopted en masse; GP practices must go on their own continuity improvement journey"*.

6.5.5   Practice culture

Building on the context described above, in their final report, the Morecambe Bay project also highlight that *"human dimensions of change are not to be underestimated".* It describes practice examples where it has been important to understand the mindsets of practice staff and their position in the phases of transition[47] which can create barriers to change. Through the engagement of staff in the project, a continuity mindset has been developed which the project consider has enabled GP practices to be mindful of continuity in the changes they have made in response to the pandemic and the planning for recovery and restoration.

The Continuity Counts project also explored this in their report, reflecting that a continuity culture was evident in their participating practices with personal list practices; where the responsibility for individual patients was assigned to the named doctor who was the list holding doctor. They described this continuity culture as *"persistent despite changes in the practice doctors"*. In contrast, in practices without a clear personal list, there was much less evidence of a continuity culture.

6.5.6   Configuration of appointments

The configuration of appointments, use of same-day clinics and pooled lists, are some of the most heavily discussed challenges amongst projects, reducing a GPs ability to deliver continuity through pre-bookable consultations. This is exemplified by one of the practices within the Continuity Counts project which reported that GPs were 'deluged' by coping with same-day appointments and in Valentine Health Partnership where a significant daily walk-in clinic is delivered. The pandemic has since impacted some of these models of care.

Whilst acknowledging the challenge, in this instance, the walk-in clinic presented as an opportunity for GPs to promote continuity. For example, in clinics, the benefits of continuity were promoted should the patient require follow-up, and some materials were developed displaying the clinicians working on that day to encourage patients to attend the clinic when they knew their responsible GP is working.

Nevertheless, the shift of focus from access to continuity can unexpectedly confuse staff whose mindset has been shaped by an access-prioritised system. For example, some GPs at One Care felt that they 'needed permission' to challenge patients and direct them towards waiting to see their responsible GP.

6.5.7   Coding quality and use of data

The Valentine Health project team initially planned to identify patients for continuity through a combination of frequency of attendance and analysis of clinical problem codes. However, the coding quality of clinical problems varied significantly between GPs, with some coding clinical problems in free text. Furthermore, longstanding practice processes for booking on the day appointments meant that patients sometimes booked with 'Dr Walk-in Clinic' so work-arounds

---

[46] Rosen R, Kumpunen S, Curry N, Davies A, Pettigrew L and Kossorova L (2016) Is Bigger Better? Lessons for large-scale general practice. The Nuffield Trust

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

were developed to allocate patients to the GP who consulted with them. As a result, patients were identified for continuity by frequency of attendance and their usual GP reviewed the notes to assess, on clinical grounds whether they would benefit from continuity.

6.5.8   Ability to update the responsible GP on a patient record

The reallocation of patients to a reflective 'usual GP' in clinical systems such as EMIS has been an important enabler in improving continuity of care in projects including Morecambe Bay, One Care and Pier Health. Once the required changes to each patient record were identified, practices involved found that this had to be undertaken through a manual process of changing individual records. This was a repetitive and time-consuming task. As the programme progressed, projects sought to find innovative ways to increase the efficiency of this process. In Morecambe Bay, a Robotic Process Automation programme was developed to enact usual GP changes en masse for practices. The refined programme enables one robot to complete 1,500 changes within 24 hours.

6.6   Project factors

6.6.1   Leadership and leading change

Having a strong and engaged leadership covering all practices and staff groups was recognised as an effective enabler for change in General Practice, and in this case, implementing the continuity of care initiatives. The optimal leadership arrangement appears to be project leadership team comprising of a clinical and non-clinical project manager, supported by a clinical and non-clinical lead within each practice.

By contrast, the absence of clinical and operational leadership presented a potential challenge to implementation. For example, One Care, a Federation that supports the management of many practices, encountered initial difficulty in recruiting a project manager, which later placed increased pressure on the individual upon onboarding. The initial project proposal omitted the role of a clinical project lead, but over time, the project opted to include the Medical Director in a more prominent role including supporting the delivery of the project and in the dissemination of findings with wider audiences.

6.6.2   Scale

Across the projects, there was variation in scale, covering single practices projects to multi-practice projects such as the One Care project which spanned 23 practices. The scale was a challenge for those who were leading and managing the projects as, for example, the project manager had to build relationships, sustain engagement, and provide support to many practices, with overlapping timescales, throughout the project. This engagement was important in helping practices to tailor interventions to their local context.

In Morecambe Bay and One Care, the phasing of involvement was considered to be important in addressing the issue of scale, with the learning from each used to inform the next.

6.6.3   Measurement

Measuring continuity has been important in all projects, with three of the five projects developing tools to measure continuity to enable them to share this information with practices. This was reinforced in the final report from the Continuity Counts project where they state that *"we initially suspected that measuring continuity was necessary if it is to be understood and implemented in practices and we found that this was true, supporting the maxim that: "You can't manage it if*

you don't measure it.". The Morecambe Bay project developed a dashboard with an automated feed and a user-interface, allowing practices to interrogate the data further.

Whilst the pandemic and the rapid change in the mode of consultation disrupted measurement, the projects have identified several other factors which may need to be considered in interpreting these measures of continuity:

- Practice mergers
- Period of absence of GPs (such as maternity leave)
- Turnover of GPs
- Patient turnover.

In considering measurement, whilst metrics such as the UPC and SLICC can provide an insight into the proportion of consultations that provide continuity with a responsible GP, this does not necessarily reflect the strength of the relationship between the GP and patient.

6.6.4   Quality improvement

The underpinning approach of one of the projects, Morecambe Bay, was routed in quality improvement. They reflect that this knowledge and experience of applying quality improvement (QI) tools, techniques and approaches have been invaluable to the project, and their final report provides examples as to how different tools have been used in particular circumstances. The project manager was able to bring this expertise and delivered facilitated sessions to share this knowledge and coach primary care staff. The project team reflect, however, that GP practices wishing to undertake their own continuity improvement journey can utilise the Continuity of Care toolkit which imparts this QI knowledge, experience and application to continuity of care.

6.7   Programme factors

6.7.1   Network working

Having access to wider networks and being able to access specialist, often external, expertise (in data analytics or communications) appears to be a crucial enabler for the continuity of care initiatives.

Learning workshops have been organised by the programme team to facilitate shared learning and this has been regarded by all project teams as being valuable. One participant described, "*For me, being able to meet continuity colleagues was lovely and make it easier for ongoing discussions by email and phone. But more than that was the opportunity to have conversations and discussions about what we are all doing which was incredibly useful to check what we're doing and get ideas. It was also a comfort to know we share the same challenges. I came away feeling part of an extended continuity of care family".* As a result of the pandemic, these learning events transitioned to a virtual setting without disruption; the relationships between the project teams had already been formed which supported this transition.

Going further, projects utilised the programme-wide networks to refine their approaches and troubleshooting emerging challenges. For example, inviting guest educational lectures from the Continuity Counts project and undertaking cross-project practice site visits. Given this, there has been some convergence of interventions, particularly with regards to methods of identifying the reflective responsible GP and being able to update this with practice systems and project dashboards or measurement tools. Whilst sharing of concepts and approaches was encouraged, clearer collaboration ground rules could have supported communications between teams and the acknowledgment about where ideas have come from.'

6.7.2   Incentive

At a programme level, the funding awarded to projects has been an incentive for their involvement. It is unlikely that projects would have been able to achieve the progress they have without this funding.

6.8   Factors relating to the process of change or the delivery of continuity

The evaluation has elucidated a number of factors which have enabled or constrained the projects in their local context. These have been described in this chapter. However, we have also found it useful to consider these factors in two categories 'factors relating to the process of change in General Practice' and 'factors relating to the delivery of continuity'. These are depicted in Table 6 below.

Table 6: Factors relating to the process of change in General Practice or the delivery of continuity of care

	Factors relating to the process of change in General Practice	Factors relating to the delivery of continuity of care
Patient factors	• Patient involvement	• Patient expectations
Workforce factors	• Engagement, personal interests and changing mindsets • Resources and workload • Workforce stability	• Specialist interest • Working patterns of the modern GP • Reception and administration roles
Practice factors	• Readiness for change • Authority to make change • Practice-wide GP commitment • Practice context • Practice culture	• Configuration of appointments • Coding quality and use of data • Ability to update the responsible field on a patient record
Project factors	• Leadership and leading change • Scale • Quality improvement	• Measurement
Programme factors	• Network working • Incentive	

6.9   The Covid-19 pandemic as an influencing factor for implementation

The Covid-19 crisis served as a stark reminder of the fragility of our health and our healthcare systems. Yet, at times, the disruptive change triggered through the pandemic could be acknowledged as an enabler for practices to make change locally. A commonly described positive in the first few months of the pandemic was **improved collaboration and strengthened relationships**, particularly with PCNs and also improved integration of locum staff. New and emerging leaders came to the fore as much of the bureaucracy and hierarchy was sidelined.

Perhaps surprising to some, during the pandemic there was a clear "burning platform" that overrode many of the cultural barriers and sources of resistance to change that had previously existed in some practices. In a number of cases, practices which were initially more reluctant to partake in the programme and project activities were more open to conversations about increasing continuity of care.

It was clear that the more formal, planned activities relating to the project's ambitions became less of a priority. **In the early stages of the pandemic, patients adhered to the national directive to only see a healthcare professional if there was an urgent need and this allowed those who worked within the practices time and headspace to assess their own situations.** One practice refocused their project 'priority group' to their shielding patients and set out to provide increased continuity for them. The traditional schedules and diary demand which often hindered the ability to deliver continuity were eased, allowing some practices to 'start from zero' and consider continuity within their scheduling system without the challenge of managing the backlog. An example of this was shown through the implementation of total triage systems, where practices described the initial rush to get the new way of working up and running. However, after a short time, they went back to unpick the initial approach and instead, incorporated continuity into their total triage solution whereby GPs would select 'their' patients from the unified list. This demonstrated the informal and often subtle ways in which continuity was considered and woven into new ways of working triggered by the pandemic.

Nevertheless, we noted a cyclical relationship of continuity in the experiences of project teams; when consulting with patients with high continuity, the transition to remote consultations was believed to be easier, yet it felt more difficult to build relationships in that format and compounded with the competing demands. One GP described, *"Already having a trusting relationship and knowledge of one's patients makes remote working easier, more satisfying and more effective. Remote working has made it much harder to develop therapeutic relationships".*

Beyond the impact on General Practice more fundamentally, the **Covid-19 pandemic and the demands of the mass vaccination programme influenced the progression and pace at which project teams were implementing their initiatives**. One project manager described how it felt that they had "*started a journey that they couldn't quite finish*". Each project team set out with clear ambitions and through the pandemic, it was often challenged, and progress was slower than had been anticipated.

6.10   Summary of the resources required to implement

Bringing together the contextual factors and key ingredients for success, we use this section to outline the resources that have been required in project teams. This incorporates:

- A balance of people with the right skills and influence to facilitate change at both a project and practice level. Table 7 outlines these key roles.

Table 7: Resources required for implementation

Role	Description	Even better if
Project Level		
Clinical Lead	A clinical leader who leads engagement with practice stakeholders and is passionate about increasing continuity of care for their patients	Has influence at a strategic level; organisationally or in field of interest
Project Manager	A project manager to build engagement, maintain momentum and facilitate shared learning	Spends time in each practice to build engagement Has Primary Care experience Has Quality Improvement expertise and experience Has experience of successfully working with Clinical Lead to deliver change
Specialist expertise, including: • Analytics • Marketing and communications	Short term specialist expertise may be sought for specific activities, including for example: - Identifying specific patient cohorts to target - Developing measuring tools, dashboards, and automation programmes - Developing patient and educational materials. This expertise may be sought from partner organisations such as the local CCG and Acute Trust, or external organisations.	Pre-existing connections to organisations that have this expertise have been beneficial in facilitating exploratory conversations.
Practice Level		
Clinical Champion	A clinical champion in each practice who can "get traction" with other clinical colleagues	Backfill can be funded to release champions from clinical duties to focus on project activities such as attendance at steering groups
Non-Clinical Champion	A non-clinical champion knowledgeable about the practices own ways of working and systems to embed and sustain changes	Has the seniority and/ or influence to "push forward" the project internally
Patient Champions	Some projects had representation from a patient champion. Their role involved participation in steering groups, bringing a patient perspective to the conversation, testing materials and providing a gateway to wider PPGs.	Established PPG

- Building on a solid understanding of the evidence relating to continuity of care. Sharing evidence with practices about what is known about continuity and the benefits associated with this helped to generate buy-in from teams within the local practices and created local discussion.
- Creating shared expectations. Whilst the programme can be described as GP-led, many of the day-to-day process changes were the responsibility of non-clinical teams. It has therefore been important to involve the workforce from across the practice.
- An ability to share continuity measures and enable practices to track their progress over time.
- A structured approach to working with practices to enable change. This has varied across projects but the resulting toolkit (developed by the One Care and Morecambe Bay projects,

and supported by RCGP) for use by others, outlines a six-step process that is underpinned by a quality improvement methodology.

7 Spread of continuity initiatives

This section of the report describes how learning from continuity of care initiatives and work of the programme has spread. As part of this, we describe the activities and successes both within the project teams and beyond them. Within this section, we outline the lasting legacy of the programme and include descriptions of outputs that will last beyond the formal programme period.

7.1 Theory of spread and diffusion

To understand how learning and awareness of continuity initiatives have spread, we looked to the theory of diffusion[48]. This theory originated to explain how, over time, an idea or product gains momentum and diffuses or spreads through a specific population or social system. The result of this diffusion is that people, as part of a wider system, adopt a new idea, behaviour, or product. This simple theory has stood the test of time and has helped form the basis for many other areas of study[49], such as dissemination and implementation science in health.[50]

Whilst the first to adopt tend to do so because of excitement with the novelty and feeling unconstrained by social norms, the next to adopt (often opinion leaders) do so because of a measured appraisal that an innovation's advantages outweigh its disadvantages whereas often the subsequent early and late majorities adopt because they feel social pressure to do so.

Whilst some project team members within the Increasing Continuity of Care programme can be regarded as the innovators or early adopters in the primary care sphere, it should not be overlooked that there were varying degrees of adoption across the projects and in the practices within the projects themselves.

7.2 Activities and success

Based on the theory of diffusion, we describe in this section successes of how the implementation or awareness of continuity of care initiatives spread over time. We focus on two arms of spread:

- Spread within the project teams
- Spread beyond the project teams.

7.2.1 Within the project teams

Evidence of successful sharing of learning was evident within multi-practice teams. A simple representation of this is in the projects who took a **'wave' approach**; Morecambe Bay and One Care used the learning from wave one practices shaping their approach in the wave two practices.

Another good example originates from Pier Health. At the initiation stage of the project, a number of practices felt particularly under pressure (due to workforce limitations and upcoming practice mergers) and were unable to take part in the implementation of continuity-related activities. However, through sharing learning and successes, those **previously absent practices expressed an interest** in becoming involved with activities to promote and increase continuity of care. Interestingly, this coincided with the changes to the ways of working brought

---

[48] Rogers, Everett. Diffusion of Innovations, 5th Edition. Simon and Schuster.

[49] Estabrooks CA, Derksen L, Winther C, Lavis JN, Scott SD, Wallin L, et al. The intellectual structure and substance of the knowledge utilization field: a longitudinal author co-citation analysis, 1945 to 2004. Implement Sci. 2008;3:49.

[50] Norton WE, Lungeanu A, Chambers DA, Contractor N. Mapping the growing discipline of dissemination and implementation science in health. Scientometrics. 2017;112(3): 1367–90.

on by the Covid-19 pandemic. The hypothesis is that whilst the face and delivery of General Practice were in a period of change, the values of continuity of care came to the fore and the associated initiatives seemed less fundamental in terms of change than those triggered by Covid-19.

Similarly, towards the end of the formal programme period, there was a greater interest from practices to **share learning and initiatives with their PCN**. Comments from senior GPs in the project teams described how it would be important to ensure that the principles and ways of working were shared across the PCN.

Through the evaluation, we have observed spread beyond the PCN but to Federation levels in Morecambe Bay. For example, the project team will have hosted two **federation-wide sessions on continuity of care**. This has opened up the conversation and showcase of initiatives with the wider patch and, importantly, with the support of the CEO.

7.2.1.1 Programme-related activities

As part of the programme structure, **learning workshops** run by RCGP provided the project teams with an opportunity to come together to learn from one another. These were well-received and allowed for engaging peer-challenge and support. Moving to the virtual setting, small breakout groups allowed more interaction and diverse voices heard.

To support more ad-hoc discussions and sharing, a **forum was set up within the Basecamp** platform. Initially, the focus was on facilitating communication between the project teams without the sight of evaluation or wider teams. Over the course of the programme, this forum became less actively utilised. However, this evolved, and a second channel was developed to incorporate the 'community of practice' where non-project members could join to discuss continuity-related topics. At the time of writing, there were 118 participants within the community of practice. This appeared to supersede the initial discussion forum; however, the content became more clinician-led with little discursive content from non-GP roles within the community.

The networks developed across the project teams resulted in **visits between teams**, for example, Sir Denis Pereira-Grey delivered a talks Pier Health and One Care. More widely, the SLICC measurement, which originated from St Leonard's Research Practice (Continuity Counts project) was incorporated into the Morecambe Bay dashboard and the measurement tools used by both One Care and Pier Health.

Through interactions between project teams, it was clear that there was **cross-pollination and spread of ideas**. Over time the 'menu' of approaches to increase continuity became similar across teams, yet still nuanced in each context. For example, each team undertook a task relating to the allocation (or reallocation) of patients to GPs – whether that be in the form of personal lists or ensuring that the 'usual GP' field on electronic patient record systems reflected true practice. Another example links back to the grounding of interventions. Whilst in all but one, the original proposals from award holders had little reference to specific improvement science approaches, this was championed explicitly by one team in particular. We noted a **more structured quality improvement approach** gradually became apparent across different teams.

7.2.2 Beyond the project teams

Sharing values of the programme and lessons on continuity of care have disseminated into the wider primary and academic communities. As part of the learning support, RCGP hosted and delivered two waves of **webinars on lessons from the programme**[51]. The first session covered:

---

[51] Continuity of care resources (rcgp.org.uk)

- The continuity landscape
- Practical tips on implementation
- Evaluation and measurement.

These were accessible on YouTube and through the RCGP and The Health Foundation web teams. At the time of writing, they had 410 views across three parts. These resources have been shared more widely, including within the Primary Care Improvement Community and the NHS General Practice Network.[52] Supporting this, The Health Foundation produced a **blog** describing 'four lessons from the frontline'.[53]

Conferences have been an avenue where work of the programme has been showcased, through the RCGP conferences, WONCA, Health Services Research UK and Evaluation Society conferences. Representation has included award holders within the project teams, programme team, evaluators, RCGP and expert panel members in the field of continuity. Similarly, **continuity-related academic publications** were part of the project plan for the Continuity Counts project team. Five articles were published on some aspect of GP continuity published in the *BMJ* and the *British Journal of General Practice*[54 55 56 57 58]. One paper, in particular, has received much traction and describes the 'fork in the road' for continuity in the new ways of working, co-authored by Sir Denis Pereira-Gray and RCGP President, Martin Marshall[59]. The projects sites were also highly commended in a **nomination for a Health Service Journal Award** focused on changing culture.

Members of the Morecambe Bay team became involved with linking continuity of care with the wider General Practice core digital offer and 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 team went on to inform the procurement strategies for primary care and discussed the pros and cons of how continuity is considered in each online and video consultation system.

7.3   Programme legacy

One of the key outputs from the programme funding has been the **development of the Improving Continuity Toolkit for GP practices**, supported by colleagues at RCGP. From the outset, One Care had planned to develop a toolkit to share knowledge of the interventions and the steps taken in implementation. Through the programme's network, traction was built in the shared learning specifically between the One Care and Morecambe Bay projects. This was accelerated by the 'pause period' of the programme, where the two project managers continued to develop the local projects – whilst also supporting wider Covid-19-related activities in their respective Federation, CCG, or Trust. Together, they brought experiences of continuity initiatives in over twenty practices: spanning across different geographies and each with their own contextual challenges, such as rurality, deprivation, and experience of making improvements locally. Insights and tools from the mixed-methods evaluation were incorporated into the toolkit output.

The Continuity Toolkit provides:

---

[52] Active signposting can improve continuity of care — NHS Networks

[53] Improving continuity of care in general practice: four lessons from the frontline | The Health Foundation

[54] Pereira Gray D, Sidaway-Lee K, White E, Thorne A, Evans PH (2018) Continuity of care with doctors - A matter of life and death? A systematic review of continuity of care and mortality. BMJ Open;8(6):e021161.

[55] Pereira Gray D, Sidaway-Lee K, Kingdon H, Dineen M, Evans P, Harding A. (2019) Core management data in general practice. Br J Gen Pract;70(690):36-37.

[56] Pereira Gray D, Freeman G, Johns C, Roland M (2020) Covid 19: a fork in the road for general practice. BMJ; 370:m3875

[57] Sidaway-Lee K, Pereira Gray D, Evans P (2019) A method for measuring continuity of care in day-to-day general practice: a quantitative analysis of appointment data. *Br J Gen Pract;* 69 (682): e356-e362

[58] Sidaway-Lee K, Pereira Gray D, Harding A, Evans P (2021) What mechanisms could link GP relational continuity to patient outcomes? Br J Gen Pract; 71(707):278-281

[59] Gray DP, Freeman G, Johns C, Roland M. Covid 19: a fork in the road for general practice. BMJ. 2020 Sep 28;370:m3709.

- The guided approach to improving continuity in line with the NHSI six stages to project management[60]
  - Start out
  - Define and scope
  - Measure and understand
  - Design and plan
  - Implement
  - Handover and sustain
- Helpful tools and templates to support the steps, which include
  - A tracker for the six-stage process
  - An overview of the benefits of continuity of care and links to relevant literature
  - Quality improvement tool guidance and templates
  - Survey content and analysis templates to measure patient and staff response
- Examples and stories from GP practices of what others have done.

In line with their own principles, the toolkit was tested back to understand the usability and applicability across the remaining project teams. This was also shared more widely through continuity community of practice Basecamp site, the RCGP network, webinars with the Q community and conference presentations. The ambition is that the toolkit will serve as a legacy piece for the programme which can help support GP practices to implement continuity initiatives beyond the formal funding period, and without the hands-on support and direction from project teams. The resources are currently held on the RCGP website and can be accessed here.

Another target for the legacy of the programme is the developing conversation with stakeholders from the electronic patient record providers. It is clear from the work of the programme that measurement is key; however, this often becomes a manual or "offline" task for members of the practice team. Given that the data inputs originate from within systems, such as EMIS and SystmOne, those associated with the programme are exploring the feasibility of building in a one-stop, simple measurement tool within the system itself.

7.4   Considerations for the future

The project teams have made several suggestions to continue to build the evidence base for continuity of care within the General Practice policy context. Their suggestions include:

- That software suppliers are mandated to provide GP continuity measurements, making these easily accessible in NHS General Practices. Another suggestion is that this software should incorporate modules to identify patients who could benefit from continuity and booking systems that make it easier to offer continuity where it is needed
- That the Health Foundation and RCGP should actively disseminate evidence gathered through this programme
- That funded research be considered on a randomised trial of improving continuity and its benefits
- That Health Education England prioritises the teaching of GP trainees about research on continuity of GP care and the mechanisms which can enable this
- That measurement of continuity is included in the quality and outcome framework or an enhanced service payment for continuity is created. This would allow continuity to compete for the time and 'headspace' needed to deliver it.

---

[60] NHSI Project Management Stages

8 What new learning has been gleaned through this process

Throughout the evaluation, much learning has been gathered from local teams about continuity of care and lessons from implementing initiatives to increase it. This section goes on to describe new areas of learning which evolved from the Increasing Continuity of Care in General Practice Programme.

The learning was informed by evaluation activities, content in learning workshops and key messages emerging from the project teams.

8.1 An emerging role for episodic continuity in General Practice

Moving beyond the traditional longitudinal continuity approach, evidence emerged for the effectiveness of relational continuity in an episodic manner – whereby patients would consult with the same GP for a particular episode of care or condition.

Through our engagement, a picture started to build where some patients described the principles for episodic continuity, through statements such as *"I like to see the same GP if possible while following through a particular health issue. Otherwise, I see whoever is available, although I do get on better with some GPs than others"* and "[I like to see the same GP] *for an ongoing problem so one doesn't have to explain it each time. I am quite happy to see someone else for odds and sods"* .

Local analysis in the Valentine Health Partnership Final Report showed that on average, around 60-65% of patients targeted for enhanced continuity in any 3 months reverted to lower levels of GP attendance; supporting their hypothesis that some usually healthy patients experienced a period of symptoms or illness associated with higher GP attendance and then revert to being low users. During that episode, there was a belief that these patients would benefit from continuity of care.

When generating buy-in from practices across the programme, there was often some pushback where some found the move to longitudinal continuity a 'step too far' or too fundamental in terms of changes to ways of working. However, episodic continuity was seen to act as an entry or gateway to providing increased continuity. One project team coined the phrase "start small, go for all" concerning gaining buy-in from members of staff on implementing continuity of care initiatives.

8.2 Continuity of care remained a priority through the Covid-19 pandemic

The Covid-19 pandemic General Practice hard and for many across the programme, happened amid the implementation of their continuity of care initiatives. Whilst local teams were reconfiguring ways of working and responding to new demands, for many, continuity of care remained at the heart of the practice. This evaluation has shown that continuity of care was the second-highest priority for practices within the programme, behind responding to the demands of Covid-19.

Through our engagement, we heard many anecdotes from practices about the move to a pooled list or total triage model, which was part of the national directive in the early pandemic response. However, **many of those working within the programme adapted to weave continuity into new ways of working triggered by the pandemic**. We heard of reception teams or care coordinators adding initials of the usual or responsible GP to the start of the

patients' name to allow the GP to select 'their' patients from the pooled list. In some areas where continuity initiatives were less mature, the same principle of GPs selecting 'their' patients from the pooled list did occur but perhaps in a more informal way.

8.3 The importance of continuity of care in remote consultations

Another fundamental change to General Practice through the pandemic was the uptake of remote consultations, where practices rapidly implemented new online consultation platforms. Interestingly, for a number of practices across the programme, the use of the online consultation platforms was a pre-Covid-19 approach targeted to increase continuity of care (by offering the patient the option to see a specific GP) whilst managing access. Therefore, in these practices, there was less of a fundamental shift to ways of working through the pandemic.

The very nature of moving to remote consultations raised concerns, for some, about continuity of care and what impact reduced face-to-face consultations would have on the doctor-patient relationship. A number of viewpoints emerged through our engagement, which described how **having an existing relationship with a patient made remote consultations easier but there were some concerns that building a new relationship in a remote setting might be ineffective**. Interesting discussions often centred on the hybrid required between face-to-face and remote consultations, whereby **a face-to-face consultation would be required at times to 'top-up' the relationship**. Given that much of clinical insight is informed by non-verbal cues or how the patient presents, having a face-to-face consultation would allow the GP to establish a 'new baseline' between remote engagements.

8.4 Continuity of care and timely access are not necessarily opposing principles

In this evaluation, we highlight that increasing continuity of care can be achieved without detriment to timely access. There has been a long-standing debate that places access and continuity as two opposing principles. However, findings from this programme suggest that this does not need to be the case. **Learning from the programme has shown the synergies that can be achieved when reframing the relationship between continuity and access**. Through our engagement, a member of the administration teams described that they were now providing *"more positive access"* for patients. Through this lens, some positives can be achieved when considering access beyond the realms of 'timely' or 'rapid' but instead pivots to reflect the quality of that access. One of the projects, Pier Health, also refers to this as a model of care designed to *"promote access to continuity"*.

8.5 Increasing continuity of care can be beneficial to others in the practice beyond GPs

Whilst the evidence base describes the benefits of continuity of care for patients and GPs, there is a paucity of literature that described benefits to the wider teams in General Practice. **This evaluation describes benefits for non-GP roles across the practice**.

Job satisfaction increased, with a member of the administration team describing how "*patients are happier which makes my role more pleasant*". A prominent theme through the evaluation was having a responsible GP on the electronic patient record system or a personal list, which made directing queries and requests easier for administration teams. It is interesting to consider here the different types of continuity of care; the benefits of process changes increased informational and managerial continuity which improved satisfaction of the support teams and enabled relational continuity which benefited patients and the GP.

8.6   MDT micro-team working hadn't gained the traction that was expected

A number of the **initial proposals from the project teams expressed an ambition to develop micro-teams**. The composition of the team-based models initially hoped to include multidisciplinary roles and was, in one proposal, described as "the most effective way of maximising relational continuity across all consultation types (face-to-face, telephone and home visits) by what is increasingly a part-time workforce across General Practice". For some, the micro-team approach was not considered to be an attractive option as there were concerns that this may dilute the personal responsibility of the GP.

When implementing micro-teams, **many found that this was a difficult task** and often "too fundamental" a shift compared to their current ways of working. There was some discussion that micro-teams may be more effective in larger practices, which ultimately go on to mimic the experience of smaller practices which generally have an intrinsic high level of continuity. This does pose some interesting questions when the broader policy directive in General Practice is to encourage working at scale. There was also some discussion that the capacity of some of the additional roles which form part of the multi-disciplinary team may constrain their ability to work across multiple micro-teams.

It should not be overlooked, however, that some practices across the programme did implement a micro-team approach but this **focused on a small number of GPs working together for a group of patients and was often labelled as a "buddy group"**. For example, Valentine Health Partnership was shown to be successful in reducing the number of GPs that the patient consulted with and as a result, increased continuity of care.

8.7   Measurement of continuity of care is key

The importance of measuring continuity of care was central to this programme and the famous quote of "what gets measured get managed" surfaced in many different arenas. Local project teams developed their own measurement tools or dashboard to track impact over time. Using individual practice data to understand continuity measures (often against other practices across the region or wider) was **shown to be one of the greatest hooks in generating and maintaining buy-in across the programme**.

Whilst there are complexities in measuring continuity of care, there is currently no accessible, national tool to allow practices with an interest in continuity to measure it. However, through the programme, there have been ongoing discussions with electronic patient record systems to explore an option to embed continuity measurement and allow for easy access to track continuity of care locally and at scale.

8.8   Nuances in measuring continuity for practices at different stages of their continuity journey

All projects have highlighted the importance of being able to measure continuity, both as a mechanism by which to engage practices, but also to allow progress to be tracked.

For those embarking on a continuity journey, the UPC (most seen) measure (section 4.3.1.1) is considered to be the most accessible. Other measures rely on the responsible GP name being correct on the electronic patient record system which may not always be correct in practices. This may be because the practice does not employ a personal list, has not to be able to maintain this field over time or due to a lack of understanding about the purpose of having a named responsible GP. As One Care highlights, "*the UPC 'Most Seen' is a good indicator to focus on because it shows the informal level of continuity of care within the practice, and they can build on it*".

For those practices where the patient record appropriately reflects their responsible GP, the OPR[61] is also considered to be helpful for GPs as it allows them to quickly understand how many of their own patients they are seeing and how this has changed over time.

As well as measuring the continuity of care data, teams across the programme set out to find the best way to visualise the data. The team at Morecambe Bay struggled to find a dynamic measure of continuity of care that would support the use of Statistical Process Control [62](SPC) charts. For example, the UPC takes account of each monthly measure and the previous eleven months and therefore, is not sensitive or applicable for use in traditional improvement tools such as SPC charts.

As reflected in the Morecambe Bay Project Report, *"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 do not quantify the strength or effectiveness of the doctor-patient relationship.

---

[61] Own Patient Ratio (section 4.3.1.1)
[62] NHS England » Statistical process control tool

9   Conclusion

The 'Continuity of Care in General Practice Programme' aimed to explore the potential for general practice to increase continuity of care for its patients and improve their care. This mixed methods evaluation set out to capture the experience of patients and staff and sought to understand the interventions implemented by five project teams awarded funding by The Health Foundation to increase continuity of care in General Practice. This evaluation report outlines these findings and considers what learning was gleaned in the process.

Over the period in which this programme has been undertaken, General Practice has been through a period of rapid change and faced deep challenges. Nonetheless, the evidence presented within this report highlights that **benefits can be achieved through increasing continuity of care for both patients and the primary care workforce** within the practices involved in this programme:

- Continuity of care can enable patients to take a more active role in their health and wellbeing and be more inclined to be proactive in self-care
- Implementing continuity of care interventions can lead to quality and efficiency gains, such as streamlined processes, better distribution of workload and more effective consultations.

It must be noted that **there were some challenges encountered through the implementation of changes**. At times, patients were disgruntled about new ways of working and this led to challenging conversations and additional stress for reception teams and care coordinators.

In comparison to the patients and the workforce, there was a paucity of evidence that had shown benefits or consequences to the wider system through the mixed-method evaluation. It may be that these will come to fruition beyond the formal programme period.

Locally reported measures of continuity, at a project level, suggest that **levels of continuity have been maintained or have experienced some improvements**. Our patient-reported continuity of care index also suggested that those practices with existing high and medium levels of continuity were able to maintain this, and, for those with low continuity, this had increased over the formal programme period.

Given the context in which practices had been working, it can be observed that **this is in contrast to the national trend**, in which patient reported continuity across England has decreased, although it is not possible to attribute this to the impact of the programme.

In individual practices where locally reported levels of continuity have decreased, this is thought to have been influenced by a lack of consensus in the prioritisation of continuity between the GP partners, an inability to implement project interventions, as well as practice changes which have impacted measurement, such as a merger.

A range of improvement interventions were implemented and sat across a number of core themes: staff engagement and communication, patient communication and engagement, patient allocation and workflow improvements and the measurement of continuity of care. Of the interventions implemented by practices, those which best withstood this period **combined embedded changes in ways of working and processes, as well as bringing about a cultural shift towards a continuity culture**. Measuring continuity can be complex but it can be an important first step in enabling improvement.

The evidence base for continuity of care is widely established; however, this programme has been valuable in enabling practices to implement different approaches to increase continuity of care. This mixed-methods evaluation has contributed to the continuity of care evidence base;

showing that both **longitudinal and episodic continuity of care can be beneficial,** and that continuity of care **does not need to come at the expense of timely access**.

The programme has also brought new insights which are valuable in advocating for continuity and its relationship with national priorities such as access and relationship-based care. The Continuity of Care Toolkit highlights options of 'what can be done' and holds practical tools to facilitate the implementation of continuity of care improvements.

This programme moves forward the conversation about continuity of care in General Practice from 'why continuity' to 'how continuity'. The work of the mixed-methods evaluation indicates that implementing interventions to increase continuity of care is achievable and that it *can* be done in the challenging landscape of General Practice.

A. Case studies

A.1 Continuity Counts

A.1.1 The Project Team

- Led by the Continuity Counts team, based in St Leonard's Practice in Exeter
- Supported five practices in Devon with a combined population of 41,129 patients.

A.1.1.1 Context

- The lead practice is a formally certified research practice and its project management team have a background in academic research
- The project team and lead practice are passionate about continuity of care in General Practice, studying this for over 40 years. The practice has contributed to the evidence base around continuity, publishing a range of articles including the first systematic review of continuity of doctor care and mortality (Pereira Gray et al 2018)
- The practices involved range in size from 6,000 patients to 11,000 patients. Three of the practices were located in Exeter, one in the coastal town of Exmouth and one in a rural location in mid-Devon
- The collaborating practices volunteered to be part of the project and signed a memorandum of understanding with the project management team
- The underpinning use of a personal list system is well established within the St Leonards Practice, with more varied application across three other collaborating practices. This is not in place for one of the five practices. Personal lists are based on the principle that each patient has a named doctor who takes responsibility for their list, and the practice actively encourages patients to book consultations with their own doctor where possible.[63]

A.1.2 The interventions

The project aimed to improve relational continuity between registered patients and their personal doctors using educational methods. The initial focus of the project was on face-to-face contacts, but this has been expanded given the rapid shifts in modes of consultation arising from the pandemic.[64] The project has been focused on increasing continuity of care in General Practice for **all patients**, although in one practice did choose to also consider patients who were 'frequent attenders'.

Examples of these interventions are outlined below.

Interventions and approaches for increasing continuity of care

	Examples include:
Staff engagement and communication	- Appointed **clinical and administrative continuity champions** to support and drive continuity within the practice **Quarterly practice interactive seminars with GPs to:** – Increase awareness of the evidence base for continuity of care and its implications – Encourage participants to consider local opportunities and ways of working to increase continuity of care

---

[63] Pereira Gray DJ. The key to personal care. J R Coll Gen Pract 1979; 29(208): 666–678

[64] Pereira Gray D, Sidaway-Lee K, Harding A, Evans P (2020) Reduction in face-to-face GP consultations. Br J Gen Pract;70(696):328 Letter

|	
	– Share and discuss data on local measures of continuity
	– Face to face initially but transitioned to online in response to the pandemic
	● **Seminars were also held with administrative and reception teams** from each practice
	● **Scripts for reception teams** to direct patients to their personal GP.
Patient engagement and communication	● Ongoing engagement with a **patient champion from each practice,** utilising their support to organise and deliver a seminar with their **PPG.** These presented research-based evidence on the benefits of continuity to support patients to better secure the benefits of the GP patient relationship, as well as consider ways to communicate this message more widely with patients through the PPG network
	● **Education materials** on the benefits of continuity including leaflets
	● Undertook its own **patient survey** to capture the patients' views of the quality of their most recent GP consultation using a validated questionnaire and offered to patients immediately after their consultation. As continuity of care is about improving the doctor-patient relationship, it can be tested by evaluating how patients themselves perceive the quality of the consultations.
Patient allocation and workflow improvements	● Discussion about **personal lists** and their implementation, for example, how GP buddy groups were used in some practices in the patients personal GP was not available or having own informal lists where formal personal lists were not in place
	● **Amended policies** to redirect tasks to appropriate members of the practice team.
Measurement of continuity and a mechanism by which to monitor this	● Formal **data-sharing agreements** with each participating practice
	● **Development of a measuring toolkit** to monitor continuity measures including SLICC and OPR
	● Individual practice discussions to understand their data and ensure measurement **reflects local systems or ways of working**, e.g. incorporating telephone consultations or excluding same-day sessions
	● **Training with practice staff** on how to complete the templates to provide monthly analyses (which evolved into the measuring toolkit)
	● **Sharing data back with practice teams** to engage interest and share progress on their continuity progress.

A.1.3   Enabling implementation

The following resources were considered to be important in the implementation of the project:

● Clear clinical leadership with a passion for personal lists and continuity of care, to lead engagement with project stakeholders, including the GP and patient seminars. This has been provided through two individuals within the project team including the project lead

● A research fellow who has provided research and project management support as well as leading seminars with administrative teams and providing analytical expertise to the development of the measuring toolkit

● Within each participating practice, a clinical, administrative and patient continuity champion was valuable. Within each practice, however, there is a recognition that "one doctor alone is likely to struggle to provide continuity" and successful implementation can be better enabled where a critical mass of GPs view continuity as a priority for the practice

● An Advisory Committee Steering Group comprising all champions which met twice a year

● A short-term specific input from:
    – A research assistant who has undertaken the completion of their local patient survey
    – Graphic design expertise in the development of the project's logo and communication materials.

A.1.4   Locally measured impact

The project reports that for the period 01/01/19 to 31/03/21, for four of the five practices, the *OPR* for face-to-face consultations increased. For three of these practices, which used personal lists, this increased over the period from over 50% to 70-80%. For the fourth practice, this increased from 40% to 56%. This is depicted in Figure 18.

**Figure 18: Continuity Counts Face to Face OPR**
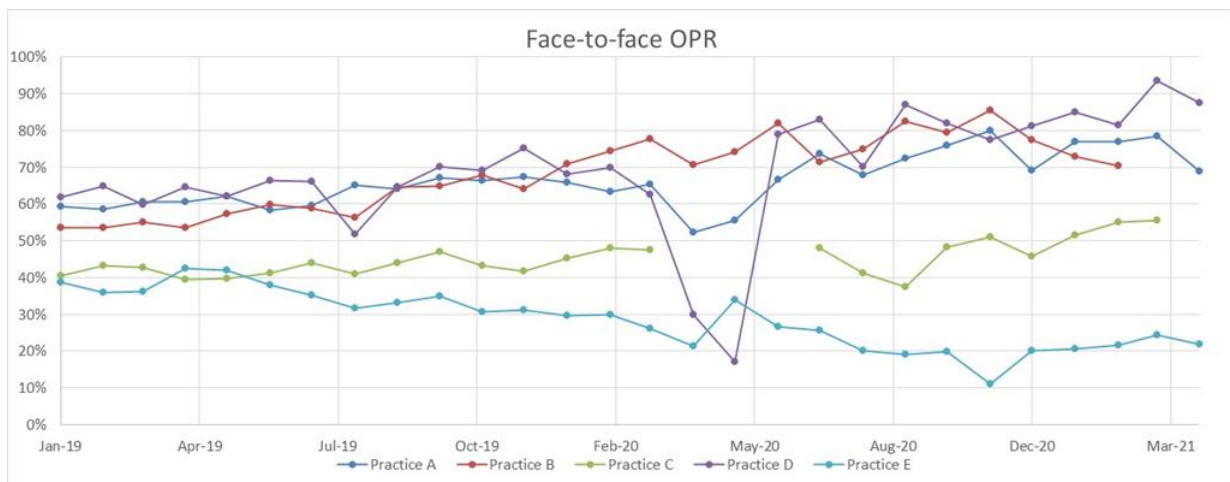
Source: Continuity Counts Final Report

The OPR is a doctor-centric measure and the increase suggests that doctors are seeing their own patients for a greater proportion of their time and experiencing the doctor benefits of continuity.

For the period 01/01/19 to 31/03/21, across the five participating practices, the *SLICC* for face-to-face consultations improved in one practice and was maintained in three others (This is against a falling trend nationally and the pressures of the pandemic). The exception is in one practice that did not use personal lists. A telephone SLICC was also measured with variable results across each practice given local changes to ways of working. This is depicted in Figure 19.

Figure 19: Continuity Counts Face to Face SLICC
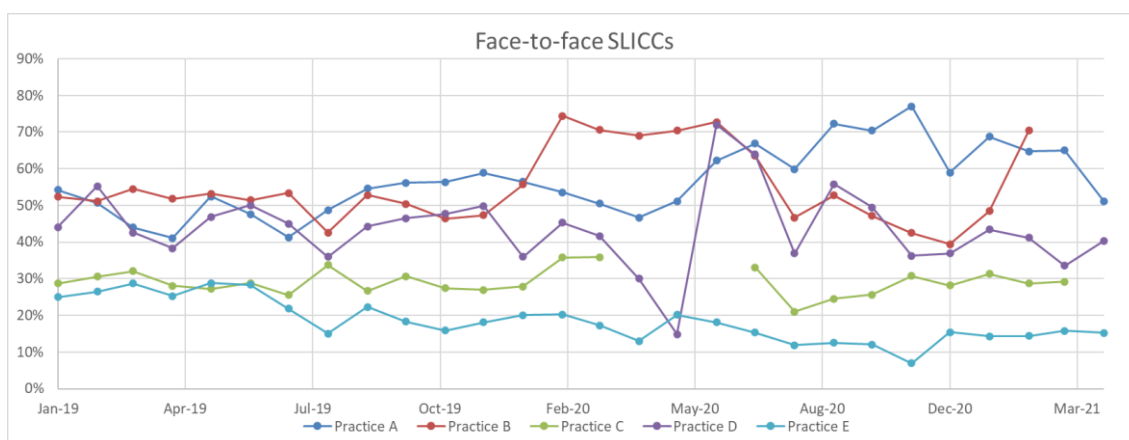
Source: Continuity Counts Final Report

The SLICC is influenced by the number of non-list holding GPs in the practice and the number of consultations they provide. The project highlight that it is possible that in the practices where

the OPR is rising but the SLICC remains steady, that demand has increased to the point that it is necessary to have more GPs to manage this.

For one practice, there have been decreases in these measures of continuity, where the latest SLICC score is reported to be less than 20%. It is reported that this has been influenced by differences in attitudes to continuity between the GP partners and a practice consensus to prioritise access over continuity.

The project team reflected that they found personal lists to be the single most important factor determining whether GP continuity of care, as measured by the SLICC, occurred. High GP continuity was defined as all patients having a 50% or greater chance of consultation with their accountable GP whenever they attend. This was observed only in personal list practices within their project. GPs using personal lists described them as being *"efficient"* within the practice by clarifying clinical responsibility, simplifying the flow of information, and building better relationships between patients and their doctors. They protected GPs from excess consultations by patients on other GPs' lists and provisionally, personal list practices seemed to cope better with workload pressures,

Through their own patient survey[65], in response to a question on whether patients had a regular doctor, a range of between 79% to 91% of patients replied positively, in contrast to national evidence nationally that only 47% of patients report having a preferred GP[66]. Practices with personal lists were at the highest end of this range. Patients rated GP consultations highly with one GP having patients awarding a mean of 4.9 out of 5 on several questions.

A.1.5 Spread

A.1.5.1 Spread within the projects and project teams

Valuable relationships have been built with other teams in the programme, for example, members of the Continuity Counts team have delivered lectures on GP continuity and the measurement of this across practices from One Care and Pier Health and have also benefited from introductions to a Practice in this area who delivers exceptionally good GP continuity. The team also supported a panel session at the Morecambe Bay virtual conference, supported the use of SLICC as a measure in the Morecambe Bay dashboard and clarified the glossary of measurement terms used in the toolkit.

A.1.5.2 Spread beyond the project teams

Spread more widely has taken the form of:

● Leading presentations for the Health Foundation/ RCGP webinar on continuity

● Joining a poster presentation for WONCA on 20-minute consultations

● Collaborating with other project teams to present an hour-long webinar at the RCGP Annual Conference health virtually in 2020

● Using the experiences and insights gained during the programme to inform research, publishing five relevant articles in the *BMJ* and the *British Journal of General Practice*. This includes:

Focus	Brief description	Reference
Measuring continuity	This describes a method of measuring continuity in day-to-day General Practice. This paper was	Sidaway-Lee K, Pereira Gray D, Evans P (2019) A method for measuring continuity of

---

[65] This survey was derived from two validated questionnaires from Reis *et al.,* (2008) and Barr *et al* (2014; CollaboRATE) seeking 50 patients responding for each GP, achieving 1122 in total. This was undertaken in four of the five practices.

[66] Tammes P, Morris RW, Murphy M, Salisbury C (2021) Is continuity of primary care declining in England? Practice-level longitudinal study from 2012 to 2017. Br J Gen Pract; 71(707):e432-e440.

Focus	Brief description	Reference
	presented at the national conference of the Society for Academic Primary Care in 2019.	care in day-to-day General Practice: a quantitative analysis of appointment data. Br J Gen Pract; 69 (682): e356-e362
Encouraging professionalism in General Practice management	This identified eight key pieces of information all of which can be obtained from General Practice computers which assist in the logical management of modern General Practices.	Pereira Gray D, Sidaway-Lee K, Kingdon H, Dineen M, Evans P, Harding A. (2019) Core management data in General Practice. *Br J Gen Pract*;70(690):36-37
Continuity and personal care	An editorial on personal care in General Practice emphasised the importance of GP continuity and the provision of empathy by GPs.	Pereira Gray D, Freeman G, Johns C, Roland M (2020) Covid 19: a fork in the road for General Practice. *BMJ*; 370:m3875
GP empathy	A co-authored article emphasising the important development emerging from other research studies that when patients perceived that the GP had provided empathy that good outcomes were experienced.	Tzortziou Brown V, Gregory S, Pereira Gray D (2020) The power of personal care: the value of the patient-GP consultation. *Br J Gen Pract*;70(701):596-597
The mechanisms by which continuity effects occur	An article on the mechanisms as to how the effects of continuity occur are the first of its kind and was published in June 2021.	Sidaway-Lee K, Pereira Gray D, Harding A, Evans P (2021) What mechanisms could link GP relational continuity to patient outcomes? *Br J Gen Pract;* 71(707):278-281

- Collaborating with other GPs who work in General Practices using the EMIS system to enable continuity to be measured using the SLICC and OPR
- Working with RCGP and One Care to build a group of GPs providing good continuity of care who can act together as continuity champions.

A.1.6   Other unique reflections

In their Final Report, the project teams have highlighted a number of learning reflections. Many of these have been discussed within the main body of the report, but it is interesting to also highlight the following:

- The team encountered **myths** (strong beliefs in a minority of General Practices which are not based on or which are contradicted by research) which have been important to address:
  1. It is not possible to provide continuity of general practitioner care with part-time GPs
  2. All General Practices are like my General Practice
  3. That many, or even most, patients do not benefit from continuity of GP care
  4. That organising a General Practice through personal lists is old-fashioned
  5. Informational continuity and management continuity can compensate for relationship continuity
  6. Continuity of GP care means more work
- Whilst the team were able to transition seminars from face to face to online, there is a reflection that those held via Zoom were **less intimate and effective**, for example making it more difficult to observe changes in behaviour
- Through the seminars, it became evident that the information that continuity of doctor care was associated with reduced mortality was **not widely known**. The team reflect that this has made a substantial impact on some GPs, alongside the process of feeding back to managing partners information about current continuity performance in their practice. GPs vary greatly in the systems of internal practice organisation and often do not know about important developments in other local practices. The team reflect that **some GPs**

undervalue themselves by not fully appreciating the added value they can bring to their patients through good patient-GP relationships, built by continuity of care

● The topic of GPs following up episodes of illness in other partners' patients recurred through the seminars. **Referring patients quickly back to their personal (responsible) GP** can greatly increase continuity. One GP found this a revelation and described it as *"a liberation"*. However, in pooled list practices, providing episodic care may be a way of starting to improve continuity

● In personal list practices, the responsibility for individual patients was assigned to the personal (responsible) doctor who was the list holding doctor. Correspondingly the relevant correspondence and results for those patients came to their personal doctor. The continuity culture within these personal list practices was persistent despite changes in the practice doctors. In other practices without a clear personal list, there was much less evidence of a **continuity culture**.

A.2   Morecambe Bay Primary Care Collaborative (MBPCC)

A.2.1   The Project Team

- Led by South Cumbria Primary Care Collaborative and then Morecambe Bay Primary Care following a merger of the two GP Federations in October 2020
- Supported 10 practices, across two waves, with a catchment population of 97,275 patients
  - This mixed-method evaluation has focused on wave one practices, maximising the time for initiatives to be embedded and assess impact. The five wave one practices cover a population of 50,021 patients.

A.2.1.1   Context

- Interested practices responded to an expression of interest and five of the eight responding practices were selected to be included in 'wave one' of the project
- Of the wave one practices, registered patient populations ranged between 2,876 and 24,938 and four practices were multi-site
- Each practice joined the project for different motivations but with the same goal to improve continuity of care for their patients.

A.2.2   The interventions

Quality improvement underpinned the project approach, following the improvement journey of the six stages of project management as advocated by the NHSE Quality, Service, Improvement and Redesign (QSIR) programme. This improvement journey framework was adapted for each practice and the measures of continuity, process mapping, and feedback from patients and staff informed the identification of changes to increase continuity of care.

Examples of the interventions which have been developed and tested are outlined below.

MBPCC interventions and approaches for increasing continuity of care

	Examples include:
Staff engagement and communication	- Appointed **clinical and non-clinical champions** to support and drive continuity within the practice **Face to face meetings** with staff led by the project manager to utilise QI techniques to understand and streamline challenges related to continuity processes and identify and test changes to improve these - Three practice staff from two wave one practices attended five-day multi-organisational **quality improvement training** via locally run QSIR programme. Additional planned training was cancelled due to capacity constraints in practices during the pandemic.
Patient engagement and communication	**Focus groups** with patients to understand their experiences and views of continuity of care.
Patient allocation and workflow improvements	**Usual GP allocation**: – **Identification of patients who do not have a reflective GP in the 'usual GP' field in EMIS** (i.e. the 'Usual GP' field is not the GP the patient usually consults with) – 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 – During the programme pause, the modelling spreadsheet was developed further although still required a manual process of changing individual records (which proved to be repetitive and time-consuming) – A **Robotic Process Automation programme** was therefore developed to enact usual GP changes on mass for practices. This was undertaken in one wave two practice. The refined programme enables one robot to complete 1,500 changes within 24 hours; the

	Morecambe Bay health community has access to four robots, potentially allowing 6,000 changes in 24 hours
	● **Smoothing workflow processes** to minimise duplication of work or redirect tasks to appropriate members of the practice team. This included redirecting admin workload from GPs to other members of the team, the ambition was that this would free up more clinical teams and reduce the additional burden
	● A review of 22 **digital solutions available to primary care and the extent to which they supported continuity**. This was shared in a reference document for GP practices.
Measurement of continuity and a mechanism by which to monitor this	● To ensure safe and legal data sharing, **information governance** in the form of data sharing agreements were put in place to ensure support to project practices and across Morecambe Bay
	● The **Continuity of Care Dashboard** support practices to measure their current levels of continuity and allow comparison to other practices in Morecambe Bay.
	– This plots a measurement of continuity of care over 12 months, at monthly intervals, using data from the previous 36 months. This data can also be disaggregated by particular patient cohorts
	– Incorporates **a number of measures of continuity including** UPC and SLICC
	– **Data visualisation** within the dashboard, such as run charts, enable teams to easily understand patterns of consultation, changes of continuity over time and comparison against local practices
	– Used as a tool to **engage practices and shape changes.**

A.2.3   Enabling implementation

The following resources were considered to be important in the implementation of the project:

- A full-time project manager with quality improvement expertise who was able to spend time in each practice to build engagement
  - There is a reflection that a project manager with quality improvement expertise and experience in primary care would have been valuable, but such individuals are scarce
  - The project managers pre-existing links with the acute trust and clinical commissioning group has been beneficial to the project in accessing additional specialist expertise
- A GP clinical lead and member for the Federation Board whose practice was involved in wave one
- Within each participating practice, the following roles were valuable:
  - A clinical lead. The project team have reflected that 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 four levers of the influence model introduced by McKinsey & Company in 2003 which support the changes of mindsets
  - From wave two, an administration lead was incorporated into the project governance arrangements, recognising the importance of non-clinical staff in embedding and sustain changes to practice processes
- A Steering Group with membership drawn from clinical and operational leads
- A short-term specific input from:
  - The Business Intelligence (BI) Team in the acute hospital trust to enable the development of the dashboard and Robotic Process Automation programme for usual GP allocation
  - Locally run QSIR training programme (which was delivered in part by the project manager as a qualified QSIR Teaching Associate).

A.2.4   Locally measured impact

The project reports that data across the combined member practices show little movement from the median line until Covid-19; where a decrease is seen across all cohorts and measures except for 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.

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 are provided in the project final report (which is depicted in Figure 20 below). This is supplemented by a data story that has been provided of each wave one practice, adding narrative and context to these measures.

Figure 20: Morecambe Bay: Percentage change in UPC and COC Index between baseline and end of the project
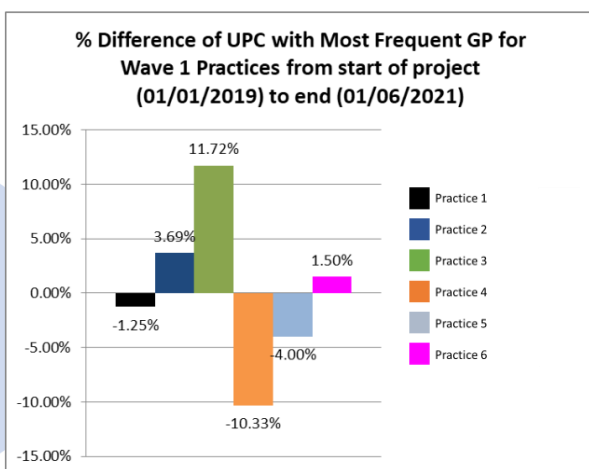
Figure 5: Graphical representation to demonstrate the percentage difference of between UPC at the start of the project to the end.
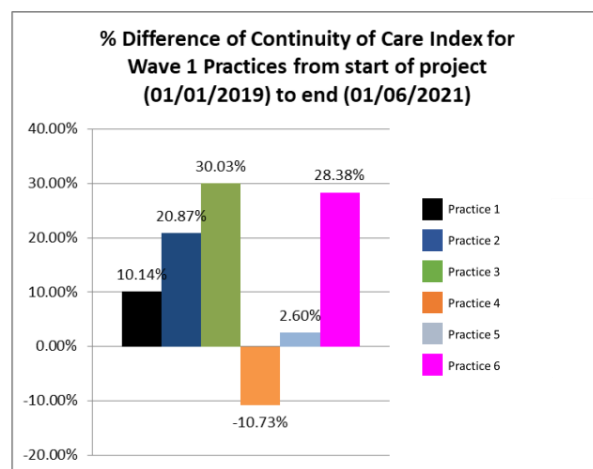
Figure 6: Graphical representation to demonstrate the percentage difference of between COC Index at the start of the project to the end.

The UPC shows an increase for three of the five wave one practices, in contrast to the CCG which decreased. Of the two practices that experienced a decrease, that with the largest percentage difference underwent a practice merger within the period (impacting their measurement of continuity) and the other was not able 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.

The CoC Index increased for four of the five practices, with the greatest increases in those practices with an increased UPC.

A.2.5   Spread

A.2.5.1   Spread within the projects and project teams

The project has been undertaken in three phases, with the learning from each used to inform the next.

Due to the impact of Covid-19, a legacy plan has been agreed, which will see support broaden 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.

Through their established steering groups, networking between practices was established, which was also beneficial in sharing lessons from wave one to wave two practices. The project has also engaged in programme wide learning events, peer to peer learning and information sharing sessions and has been an active part in collaboratively developing materials and outputs for shared use.

There is a reflection that collaboration with other continuity project teams increased during the second year of the project, being conscious of each other's strengths. Benefits of this virtual partnership team working included idea generation, shared workload, gained new perspectives, increased creativity and learning and boosted productivity.

A.2.5.2   Spread beyond the project teams

Across Morecambe Bay (beyond the scope of the project), emerging learning has been shared as part of updates to the MBPCC Board and Morecambe Bay CCG Primary Care Committee, and on the MBPCC website.

Working collaboratively with One Care, the Continuity of Care Toolkit has been developed. 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 teams. Originally developed to support project wave three practices, it is now shared nationally on the Royal College of General Practitioners website as well as forming a pivotal role in the localities legacy plans.

At a programme level, the MBPCC project has shared learning with the other project teams 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 features 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.

Across Morecambe Bay, an event 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. This was the first local virtual event for primary care, outputs of the event were widely shared, and a local Digital Design Authority was 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, including the development of an online and video consultation engagement and procurement process. This involvement will hopefully reduce the barriers that digital products can cause and promote continuity of care during the procurement and implementation processes.

A.2.6   Other unique reflections

In their Final Report, the project has highlighted several learning reflections. Many of these have been discussed within the main body of the report, but it is interesting to highlight the following:

- 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. The learning from wave one did allow the scoping process to be accelerated for

wave two practices and 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 cannot simply be adopted en masse; GP practices must go on **their own continuity improvement journey**

● Knowledge and experience in applying quality improvement (QI) tools, techniques and approaches have been invaluable to the project, and the projects final report examples are provided as to how different tools have been used in particular circumstances. As an example, this includes the use of the William Bridges[67] three phases of transition adapted by QSIR, to target conversations with particular practices depending on their own local context. The project manager was able to bring this expertise and delivered facilitated sessions to share this knowledge and coach primary care staff. The project team reflect however that GP practices wishing to undertake their own continuity improvement journey can utilise the Continuity of Care toolkit which imparts this QI knowledge, experience and application to continuity of care

● 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. For example, Covid-19 changed the way practices operate with 'total triage' and offering remote consultations. Practices responded very differently when setting up new ways of working, with some harnessing the opportunity to focus on continuity and others created new processes in haste that had a detrimental impact on it

● The pandemic provided an opportunity to expand the 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 has led to an **unexpected but important outcome for the project**, with the application of learning from project practices transferring to the **implementation of online digital tools**. This is supported by increased engagement mechanisms/processes and strengthened governance and leadership across primary care digital in the ICS.

---

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

A.3   One Care

A.3.1   The Project Team

- Led by One Care, a GP-led organisation that represents and supports practices in Bristol, North Somerset and South Gloucester (BNSSG)
- Supported 23 practices, across three waves, with a catchment population of around 400,000 patients
  - This mixed-method evaluation has focused on nine wave one practices, maximising the time for initiatives to be embedded and assess impact.

A.3.1.1   Context

- Continuity of care was an emerging topic of interest for a number of practices involved before their involvement in the Programme, for example with:
  - A number of practices submitting independent bids to The Health Foundation for the programme
  - Positive responses to a questionnaire completed by practices gauging their level of interest to become involved in the programme
- Given the large geographical area that One Care covers, the demographics vary widely across BNSSG with areas of both deprivation and prosperity, and rural and urban environments. The practices themselves also varied significantly, from the number of GPs per head of population, sessions worked, single or multi-site practices and the length of consultations offered
- The initial ambition was to support 32 practices on their continuity of care journey but due to challenges surrounding the pandemic, this was reduced to 23 practices.

A.3.2   The interventions

One Care's approach has been to support practices, at their own pace, to identify their own local priorities to increase continuity of care.

Some practices have targeted specific patient cohorts, for example, patients with learning disabilities or those undergoing palliative care. Others embedded interventions to promote continuity across the whole practice population.

Examples of these interventions are outlined below.

One Care interventions and approaches for increasing continuity of care

	Examples include:
Staff engagement and communication	- Appointed **clinical and non-clinical leads** support and drive continuity within the practice - Education materials in the form of **leaflets for frontline and clinical staff** working within surgeries, to help facilitate staff training and expand their knowledge of the benefits of the new model of continuity - Presentation at the One Care's **annual stakeholder event** - Incorporated a **reminder to the booking system for the Reception Team** to book the patient with the named GP - Some practices trialled a **GP Buddy approach**. Where a patients' usual GP was unavailable, the patient consulted with the GP Buddy - Facilitated **peer to peer learning** within practices – An example of where one particular GP was achieving much higher continuity of care and the team looked at what this GP was doing to encourage continuity (in this instance, reminding patients to book their next consultation with this GP and checking they were the named GP on the electronic patient record system to improve the flow of information and correspondence)

	● **Scripts and training for reception teams and care navigators** to steer continuity patients to their usual GP (either all of the time, or in one practice, for a patient during a particular episode of care).
Patient engagement and communication	● Engagement with **patient groups raising awareness of why continuity of care is important.** Engagement with the **Patient Reference Group (PRG),** including: – co-development of communication materials – using **interactive games** to educate on service demand; whether an issue is urgent a requires a same-day consultation or whether waiting a little longer to see your usual GP is preferable ● **Created patient information materials** to promote continuity and its evidence base; in the form of posters, leaflets, waiting room videos and animations ● Delivery of patient information via an **automated message when patients are waiting on the telephone line** ● Utilised their strong **social media presence** where they share articles and update on the continuity of care project and concept. A number of practices have also shared educational messages via their practice-led social media accounts.
Patient allocation and workflow improvements	● **Identification of patients who do not have a reflective GP in the 'usual GP' field in EMIS.** Subsequent reallocation of specific patient cohorts to who the patient consults with most often via a locally developed matching tool. This knowledge has since been combined into The **Usual GP Measuring Tool Guide** ● Application of a **continuity of care flag** to the patient record (for those who prioritised continuity for a particular patient cohort) ● Implementation of **personal lists** ● **Smoothing workflow processes** to minimise duplication of work or redirect tasks to appropriate members of the practice team.
Measurement of continuity and a mechanism by which to monitor this	● Developed the **One Care Usual GP Measuring Tool:** – Provides a user-friendly tool for practices using the EMIS electronic patient record system to measure and interpret measurements of continuity of care, utilising UPC and SLICC metrics – Enables practices to review their own activity and prioritise/ tailor improvement actions.

A.3.3   Enabling implementation

The following resources were considered to be important in the implementation of the project and particularly given the scale of the One Care project:

● A full-time project manager to motivate and maintain momentum, as well as facilitate the sharing learning and networking

● A GP clinical lead at Federation level

● Within each participating practice, the following roles were needed to drive the improvement and to be the conduit between practice and project. There was a reflection that these roles required people with passion and commitment to continuity of care:

– A clinical lead able to *"get traction"* with other clinical colleagues

– An operational lead working at such a level to have seniority to drive the project, whilst also being knowledgeable about ways of working and clinical systems to support embedding actions such as adding flags to patient records

● A Steering Group with membership drawn from member practices

● A short-term specific input from:

– The One Care **marketing and communication** team to develop patient education tools

– The One Care **analytics team** to develop the Usual GP Tool for measuring and allocating the 'usual GP'.

A.3.4   Locally measured impact

The project reports that impact arising from their project include:

● Enabled practices regardless of their different constituent make up to improve continuity for their patients
● Delivered a continuity of care project at scale across a large group of practices
● Raised the profile of continuity of care with both patients and staff.

The Usual GP Tool was used to derive a dataset for 2019/20 and 2020/21. One Care has also chosen to use narrow the focus of their metrics to frequent attender patients, defined as those patients who have consulted with a GP nine or more times in the past 12 months.

Across the 23 participating practices, continuity of care for frequent attender patients[68], as measured by *UPC*, improved for all the practices:

● From a range of 10-66% in 2019/20 to 25%-77% in 2020/21[69]
● With an average increase by all practices of 4%
● With an increase of up to 15% where the greatest improvement was seen.

The project view was that practices should aim to achieve 50% UPC as a starting point.

The other three measures used locally in the tool require the usual GP to be named on the electronic patient record system and as a result, absolute values are slightly lower than for the UPC. For these measures:

● For *UPC Usual GP (a local adaption of the UPC which calculates the proportion of consultations that are with the most frequent provider (GP) who is also the GP named in the patient's record as their usual GP)*, for frequent attender patients, an average improvement of 3% was seen across practices
● For *SLICC Frequent attenders*, an average increase of 1% was seen across practices
● For *SLICC Other Patients,* an average increase of 3% was seen across practices.

In their own commentary, the project highlight that the highest continuity scores were achieved by Practices with 'Personal Lists'.

Taking a more in-depth look at the wave one practices, the charts below (Figure 21), compare measures of continuity, for frequent attender patients, between January 2020 and January 2021.

---

[68] Defined locally as patients who consulted more than 9 times in the previous 12 months

[69] Data extracted from project report which did not disclose total number of patients included in the calculation

Figure 21: One Care; Comparative Continuity of Care Scores in wave one Practices (Jan 2020 to Jan 2021)
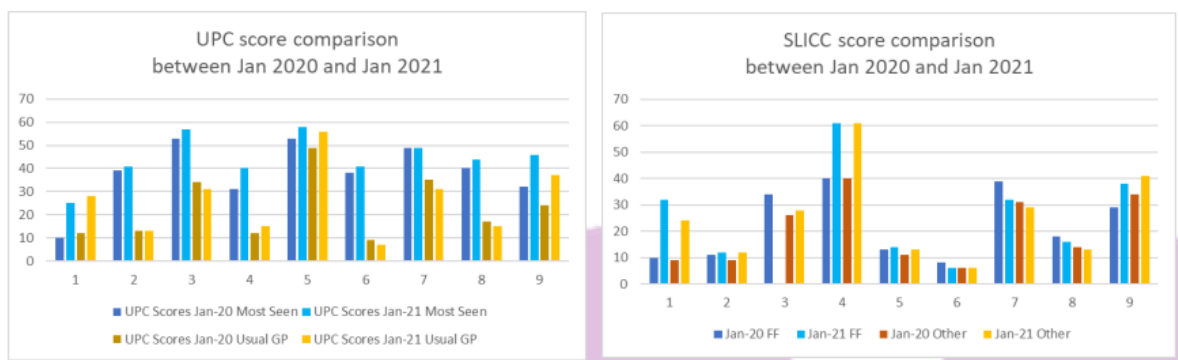
Source: One Care Project Final Report, n undisclosed

● These charts reveal that the UPC most seen GP metric is the only measure showing improvement across the nine practices

● Five of the nine wave one practices show that the *UPC usual GP* metric has either been improved or maintained. This is in the context of the challenges facing General Practice in January 2021 as a result of the pandemic and the mass vaccination effort

● For *SLICC* metrics, seven of the nine practices have either maintained or improved these measures of continuity.

A.3.5   Spread

A.3.5.1   Spread within the projects and project teams

The project has been undertaken in three phases, with the learning from each used to inform the next.

Due to the impact of Covid-19, it has been agreed that remaining funding is to be offered to Practices that have not yet begun their continuity of care improvement journey. Practices are being invited to apply for a £500 bursary to support them in improving continuity of care. Of the practices selected for involvement, some are focused on utilising the toolkit, two 2 practices are going to explore micro-teams and one is focused on practice culture to promote continuity.

The project team have actively worked on networking between practices and between the 5 projects involved in the programme. This has included engaging in programme wide learning events, as well as more peer-to-peer learning and information sharing sessions.

A.3.5.2   Spread beyond the project teams

Spread more widely has taken the form of:

● A co-authored a 6-Step **Continuity of Care Toolkit** which shares the learning and ideas from participating practices. It is a 6-step approach with 42 practical resources and 39 editable downloads. This is shared on the RCGP website

● As part of networking arising from the project, the project team have linked in with **academic colleagues** with an interest in continuity of care including Bristol and Amsterdam Universities

● Shared learning **nationally and internationally** through participation at The Health Foundation webinars and Q Community, the RCGP conference and a presentation to WONCA (World Organisation of Family Doctors) 2021 Europe conference.

A.3.6   Other unique reflections

In their Final Report, the project team have highlighted a number of learning reflections. Many of these have been discussed within the main body of the report, but it is interesting to highlight the following:

- Although the focus is usually on routine consultations, there is a growing recognition that continuity across **urgent consultations** is also important
- One practice chose to focus on **episodic continuity**, rather than longitudinal, enabling the practice to continue to improve continuity of care, despite the pressures of the pandemic
- There is not an **optimum number of sessions a GP** must work to achieve good measures of continuity. This can be achieved by GPs working a low number of sessions, suggesting it is the processes practices put in place to support continuity that is important
- The results from the One Care Project appear to support the existing evidence base by Barker with **smaller Practices achieving greater continuity** although this may also be linked to being single site practices. Practices in the project range from 7,000 to 44,000 patients. Informally it seems higher levels of continuity can be achieved by larger Practices, including those that are multi-site, but they need the supporting systems in place
- Practices in **high areas of deprivation** involved within the project have achieved good levels of continuity. This was achieved by being clear on their policy and processes for maintaining continuity of care coupled with an ongoing training programme and regular audits.

A.4 Continuity by Design (Pier Health)

A.4.1 The Project Team

- Led by Pier Health, a GP Super Partnership for the Weston & Worle locality in the South West of England, which serve a population of 94,000 patients
- Originally started with nine member practices of Pier Health. During the programme, two of these practices merged and two opted out of the programme due to competing pressures in their practices
- Under the additional pressure of Covid-19, all but one practice had to pause their engagement with the programme and as a result, an extension has been agreed beyond the timing of this report (to late 2021). Given this, the mixed-method evaluation has predominantly focused on Tudor Lodge Surgery as this has made the greatest progress to date.

A.4.1.1 Context

- Pier Health practices are set in the surroundings of the coastal town of Weston-Super-Mare. In 2018 NHS England identified Weston super Mare as being exceptionally challenged regarding GP shortages, high list sizes, high patient demand, high workload and chronic difficulties with GP recruitment
- The project's clinical lead has championed continuity in their own practice and across the wider community for over 28 years. Across local practices, there are reported to be low levels of continuity and inequitable variation across the area and particularly in those areas with the highest levels of deprivation
- Pier Health has previously been involved in different programmes to drive improvements across their practices. For example, to address the workload and workforce challenges, they became one of seven NHS England GP Retention Intensive Support Site (GRISS) programme; the learning from which, in part, informed the focus and scope of this programme for Pier Health.

A.4.2 The interventions

The project team defines continuity of care as being the development of personal therapeutic relationships that are built up over accumulating clinical encounters. The project has therefore focussed on enabling and enhancing these therapeutic relationships by increasing continuity of care with the patients identified preferred clinician.

The project has involved a redesign of **front door processes** and a **change in Practice culture** to move from a failing access focussed model of care with low continuity rates to one designed to promote "**access to continuity**".

The project has set out to redesign their model of care to make it easier for **all patients** to experience a higher level of continuity, rather than focusing on particular groups of patients.

The programme involved two phases:

- **Opening Up Access:** Implementing an online consultation and workflow tool (AskMyGP) to better manage demand and capacity. This meant preventing practices from separating patient need into urgent and non-urgent and instead focus on doing today's work today. This had begun in one practice before the start of this programme but was rolled out to all eight practices by May 2020
- **Designing in Continuity:** Increasing continuity of care across Practices through a range of activities and processes. There was engagement with staff from each practice to

understand their current challenges, operating procedures and to explore the culture and openness to implementing a significant change.

Examples of these interventions are outlined below.

Interventions and approaches for increasing continuity of care

	Examples include:

Staff engagement and communication	• Development of **educational and promotional materials** including:
	  – A staff leaflet, similar to the patient leaflet but including more detail about why continuity is important to the surgery, and how they can help to achieve continuity for patients
	  – A business card for screens to remind staff to ask the patient who their usual GP is
	• **Meetings and educational events** were held with staff including:
	  – An evening session on how digital tools can enable GP Practices to open up access
	  – A well-attended half-day clinical educational event on the evidence base of the benefits of continuity of care
	• Working with staff to embed a new **culture of designing continuity into the operational model**, for example working with front door staff to implement **processes that encourage and enable patients to see their named usual GP** and to direct all clinical workstreams to the usual clinician rather than a generic pool
	• Engaging with practices to **encourage setting up weekly clinical meetings** to support GPs in managing complex patients
	• Delivering **psychology sessions** to support staff with high-impact patients and developing managing/coping strategies for GPs.

Patient engagement and communication	• **Meetings with the public, patient participation groups** to "sell" the benefits of continuity and explore the barriers
	• Development of **educational and promotional materials** including:
	  – A patient leaflet to explain what continuity is and why it's important
	  – A basic poster promoting continuity and the building of a therapeutic relationship with your Usual GP
	  – A more detailed poster explaining the process the surgery has gone through and why and asks patients to help 'sense check' the reallocations of usual GP.
	• **Patients were advised of their Usual GP when they contacted the surgery**. For patients whose Usual GP had changed, the rationale for the change to the GP they were seeing the most was explained and patients were advised to work with the practice by contacting for care on routine matters when their usual GP was in the practice. Following this step, the reception team also engaged verbally or via email with patient requests for care to reinforce this message of providing continuity, whilst also ensuring requests for urgent care were dealt with appropriately
	• In the remaining stage of the project, publicity materials are to be reviewed and updated in light of the additional channels of communication which have become more important during and since the pandemic.

Patient allocation and workflow improvements	• The Usual GP Tool (developed by One Care) was used to interrogate EMIS and suggest changes to Usual GPs to match patients to their most-seen GP. This apportions high, medium and low demand patients to GP clinical sessions. Surgeries can then use this information to make decisions about which patients need to be **reallocated to a new 'Usual GP'** and which need to remain with their current GP to ensure existing continuity is protected • Initially, an administrative resource was utilised to **manually change the EMIS 'Usual GP' name**. However, building on discussion with the Morecambe Bay project team, a **switching tool** has been developed and will continue to be tested over the remainder of the project • This analysis enables them to identify the need for a **High Impact Users Patient service**. This has been secured from the Red Cross to reduce the pressure on individual GPs from high demand patients.

Measurement of continuity and a mechanism by which to monitor this	This has not been a focus of work to date but progress will be evaluated as part of their final report.

A.4.3   Enabling implementation

The following resources were considered to be important in the implementation of the project:

● A clinical lead who is a GP who is passionate about continuity

● A project manager. This role was initially contracted for one year, with the intention that all approaches would be implemented by Year 1. However, given the changes to the programme, to maintain communication with practices, Pier Health's Operations Director, took over project management duties from January 2020 and will lead this to the close of the project.

More widely, the project has benefited from being part of the One Care Federation and access to their **marketing and communication** team to develop patient education tools and the **analytics team** to develop the matching tool for assigning patients to their "usual GP". Additional expertise from a Programmer has been utilised to develop the 'switching tool'.

Alternative funding sources, from the ISS project, have allowed for resources to be made available to provide practices with the AskmyGP system, as a tool to facilitate continuity of care.

A.4.4   Locally measured impact

Due to the agreed extension of the Continuity by Design project, measurement of continuity is ongoing. However, interim findings indicate that for the practice with sustained involvement in the programme, a small increase in the UPC from 41% in 2019 to 45% in 2021 (up to 01/06/21) can be observed. This is depicted in Figure 22.

Figure 22: Continuity by Design: Change in Continuity of Care, on average, across all GPs at Tudor Lodge Surgery 2017 to 2021 Usual Provider of Care
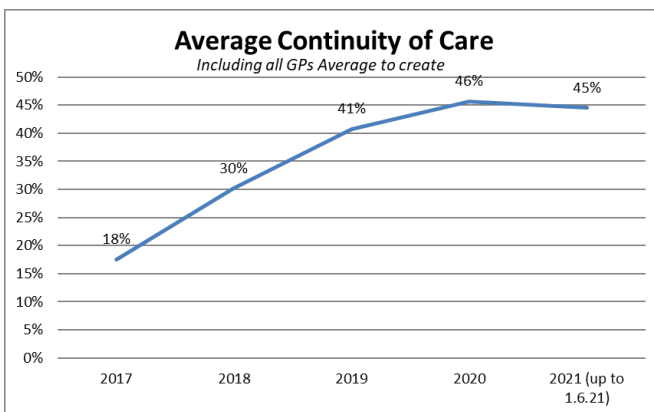
Source: Project team report, n undisclosed

It is recognised however that it is difficult to separate the effects of implementing a digital access tool (phase 1 with overlap with other programmes) and the phase 2 activities to increase continuity.

A.4.5   Spread

A.4.5.1   Spread within the projects and project teams

This team are part of the wider One Care Federation and this allowed for collaboration across the two project teams. For example, they shared the matching tool with the One Care project who worked with them to further refine it.

Similar partnership working was valuable to developing the switching tool and 'unblocking' this resource-intensive barrier of reallocating the usual GP on patient records in EMIS. They valued discussion with other teams including the Valentine Health Partnership team and were connected to a programmer via the One Care project.

As well as participating in programme wide learning events, the team also welcomed the input of the Continuity Counts team in delivering a half-day educational session on the importance of continuity of care for staff.

A.4.5.2   Spread beyond the project teams

Pier Health's continuity clinical lead is also a member of the CCG Governing Body and Clinical Executive Committee of the BNSSG CCG which has provided a platform to effectively champion continuity.

The project team has been able to influence Bristol, North Somerset & South Gloucestershire (BNSSG) CCG policy for continuity of care to become part of the Primary Care Strategy. This differed significantly from the previous version through strongly emphasising the importance of continuity of care, with this stated as one of six objectives to be delivered.

The team have also participated in programme webinars, facilitated by RCGP, designed to share learning with others in this continuity community of interest.

A.4.6   Other unique reflections

In their Final Report, the project team have highlighted a number of learning reflections. Many of these have been discussed within the main body of the report, but it is interesting to highlight the following:

- The team have reflected that in order to implement such a radical change in working practice, it must be underpinned by a cultural shift in attitude towards continuity and requires a depth of understanding and willingness that takes time and effort to develop
- The team encountered an unintended consequence of implementing continuity in which high-intensity users place a lot of strain on a single GP. A range of actions was therefore taken to address this, including encouraging the introduction of weekly clinical meetings to support clinicians with the management of the workload and patients, which is reported to have been effective in helping to reduce stress and in building teams
- Whilst the project has set out to redesign their model of care to make it easier for all patients to experience a higher level of continuity, as part of the learning workshops it has been fed back that in order to build involvement and momentum, it has also been useful to encourage staff to *"start small and then go for all"*. This has meant targeting small groups of patients for improvements in continuity of care and then building on this more widely.

A.5   Valentine Health Partnership

This project took place between January 2019 and June 2020.

A.5.1 The Project Team

- Led by Valentine Health Partnership which provides GP services for over 26,000 patients in and around Woolwich, South East London.

A.5.1.1 Context

- The practice conducted a previous Health Foundation funded project to understand more about personalising care for frequently attending patients. Building on learning from that project, the practice identified a cluster of patients who had consulted with several different doctors, and with other services, during the 6 months before a diagnosis being made. This raised questions about whether a diagnosis could have been reached faster if they had experienced relational continuity and this provided the focus of their project

- Overall, the practice population is younger and more ethnically diverse than the London average and has a transient population. With extensive new river-side housing, the practice population is changing, and registered patients are increasingly socio-economically diverse.

A.5.2 The interventions

The Practice sought to increase continuity of care for those patients who develop new or changing symptoms. The project established systems for identifying these patients, reviewing their clinical problems and targeting continuity towards those who seem most likely to benefit.

Examples of these interventions are outlined below.

Interventions and approaches for increasing continuity of care

	Examples include:
Staff engagement and communication	- Staff participated in four **development workshops to co-design systems and processes to promote continuity** - **Ad-hoc discussions during clinical meetings** if issues or problems were identified with arrangements to provide continuity - Two meetings were held between the clinicians in one of the four practice micro-teams to explore ways to **support effective micro-team working** and identify the processes and resources needed to support this - Developed **resources for clinicians** on working with continuity patients covering aspects such as educating patients, taking professional responsibility, collaborating with your buddy group, sample scripts, evidence base, subgroups who may benefit from continuity and guidance on consultation methods to explore symptoms and change health behaviour - **Receptionist scripts and protocols** to steer continuity patients to their named GP.
Patient engagement and communication	- **Patient interviews and an early patient survey** to explore views and preferences about continuity and to help shape communications and other arrangements about continuity - **Business cards for patients** were developed stating their names GP and their **working days** - **Information on the benefits of continuity** via slides for the waiting room.
Patient allocation and workflow improvements	- **Criteria developed for tagging a patient as needing continuity**. This was set at 6 or more attendances over three months. This criterion was set so as to identify a manageable cohort of continuity patients for each GP. - **Standardised searches** to identify patients suitable for being tagged for continuity. This was undertaken using data on the frequency of attendance and then reviewed by a GP for a decision on whether they needed continuity (then referred to as a tagged continuity patient) - Use of **data visualisation to help GPs to interpret consultation patterns**, including the intensity of appointment use. Data visualisation was also used to create a visual impression of the extent of continuity for patients in each micro team

	● Changes to **operational processes and clinical criteria** for improved continuity arising from staff development workshops. This included developing a flow chart that showed the process for identifying and reviewing patients flagged in the data search who might benefit from continuity. Those who meet the criteria for continuity (have been tagged) then have a **major alert added to their notes**. This appears when receptionists load the medical record to book an appointment
	● Development of an **EMIS Continuity template** to promote informational and managerial continuity, sharing physical, social and functional information between micro-team members. This includes free text boxes relating to medication changes, main symptoms, goals and social circumstances which are defined in the micro-team meeting as helping to provide buddy group cover for a continuity patient
	● Developed **illustrative, anonymised 'case studies' of different types of flagged patients**. Although there was overlap between the socio-demographic and clinical characteristics of the three identified groups (first-time flaggers, repeat flaggers and long-term frequent users), they each had some distinguishing features.
Measurement of continuity and a mechanism by which to monitor this	● Undertaken as part of the local evaluation.

A.5.3   Enabling implementation

The following resources were considered to be important in the implementation of the project:

● A **clinical champion** to lead the clinical behaviour changes needed to improve continuity and to build an organisational culture committed to continuity

● A **managerial/ reception champion** to implement, embed and maintain operational processes for continuity

● An analyst with skills in **data extraction/analysis** to identify patients who may benefit from continuity

● To enable staff to engage with discussions about continuity and how best to achieve it in a local context, it is important to have their **time backfilled**.

The project team also identified the following activities as being important:

● Develop **patient-facing communications** to encourage patients to request continuity with their named or preferred clinician

● Issue **regular reminders to reception staff and clinicians** on the value of continuity and flagging patients to achieve this

● Adapt the **practice induction process** to include alerting all new clinicians about the practice's approach to continuity and the expectation that they will contribute to this

● Continue to **monitor the level of continuity** achieved and the experience of clinicians providing continuity and continue to adapt processes for continuity as new issues arise.

A.5.4   Locally measured impact

The project reports that between July 2019 and March 2020, 584 patients were identified in five waves of data analysis as potentially benefiting from continuity and, after their named GP reviewed their notes, 416 (75%) were tagged for continuity. These were patients identified as having changes to the frequency of attendance suggesting a new or emerging condition.

For patients tagged in waves one and two of this project (213 patients), continuity with individual GPs and with micro-teams (measured as the percentage of consultations with the named GP or micro-team) increased during the four months afterwards (compared to the four months before).

Interestingly, the increase of continuity was evidenced beyond the tagged target continuity patients, to those who have more than six appointments in the previous three months. In the first quarter of 2020, 37% of patients were reported to have continuity with their named GP for over 50% of their consultations (n=73), compared to 33% in 2019 (n=2865). This increased to 71% of patients having continuity with their micro-team for 50% or more of their consultations (n=73), compared to 62% in 2019 (n=2865).

The project team intended to compare the time to diagnosis for flagged patients who were and were not allocated for continuity. However, this was not possible due to data challenges including the absence of symptom codes, challenges in identifying the start of an episode of care in the data and that many flagged patients did not have a definitive diagnosis, their symptoms resolved but were unexplained.

Although the team were not able to test their hypothesis that better continuity for this group enables faster diagnosis and fewer missed or delayed diagnoses, they report that across all patients with six or more consultations in the previous 3 months, patients who received 50% or more of their consultations with their named GP (between Jan 2015 and Dec 2019), made less use of A&E and urgent care services. In examining other analyses, they also identified that this same cohort of patients, who received 50% or more of their consultations with their named GP, had a higher number of referrals to outpatient clinics, compared to patients with lower levels of continuity.

The pause in the mixed-methods evaluation due to the pandemic resulted in Valentine Health Partnership undertaking their own end of project surveys:

- Their staff survey (n=30) showed that:
  - 93% of respondents from across all professional groups said the project made them more likely to inform patients of the benefits of continuity and help them to achieve this with their named GP
  - 73% of respondents said the increased continuity achieved through the project had made their working life easier or not affected it. 17% said it made their working life harder due to a small group of very complex patients booking frequent appointments
  - 80% of respondents agreed that it increased trust between patient and GP while 5% disagreed
  - 62% of respondents agreed that it allowed shorter consultations while 24% disagreed
  - 62% of respondents agreed that it made it easier to manage clinical uncertainty without referring to another service while 14% disagreed.
- A texted question to tagged patients about their experience of continuity received 37 responses of whom 70% said they found it easier to see their preferred GP, while 30% did not.

A.5.5 Spread

A.5.5.1 Spread within the projects and project teams

The project team have been involved in the basecamp community and participated in learning events, reflecting that they provided an opportunity to share learning, hear about other projects, update on progress and describe challenges. The RCGP provided the infrastructure to share learning and resources quickly between teams, which was very welcome.

Spread beyond the project teams

The team have participated in programme webinars and award applications, facilitated by
RCGP, designed to share learning with others in this continuity community of interest. In their
final report, they also share their resources so that others can adapt these to their own local
context.

A.5.6   Other unique reflections

In their Final Report, the project has highlighted a number of learning reflections. Many of these
have been discussed within the main body of the report, but it is interesting to highlight the
following:

- The project team planned to explore the process for 'stepping patients down' from tagging
  during an all-staff development session; however organisational priorities in responding to
  the pandemic meant that this was not possible
- The project team believed that to sustain these changes in the longer term:
  - Processes established for continuity will require dedicated time for data analysis
  - Sustained messaging to all staff about continuity and periodic sessions during staff
    development meetings to reinforce awareness of the value of continuity and how to
    achieve it is needed
  - The practice also intends to develop feedback arrangements from staff and patients
    about whether continuity processes require modification due to changes in the design
    and delivery of services in response to Covid-19 and through the recovery period.

B. Glossary and abbreviations

askmyGP: An online consultation and workflow system which aims to manage patient demand whilst promoting treatment by the responsible GP.

Basecamp: An interactive site where project teams can discuss ideas and emerging insights with one another.

BNSSG: Bristol, North Somerset and South Gloucestershire: the area in which One Care and Pier Health projects reside

CCG: Clinical Commissioning Group, the body that is responsible for the commissioning decisions in the area.

Conditional continuity: Where a patient interacts with the same health care professional for matters relating to a specific condition.

EMIS: An electronic patient record system and software used in primary care, acute care and community pharmacy in the United Kingdom.

Episodic continuity: Where a patient interacts with the same health care professional for an episode of time or care.

GP: General Practitioners treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.

Heartsink: Where the health care professional feels that they can no longer bring any new insight to the patient's care or the relationship breaks down.

i-PARIHS: Promoting Action on Research Implementation in Health Services; a framework to assess implementation.

IAU: Improvement Analytics Unit, which are the quantitative evaluation partner.

Informational continuity: Where clinicians have access to accurate, up-to-date, patient records and patients are not required to repeat their symptom history to multiple clinicians.

Longitudinal continuity: Where a patient interacts with the same health care professional for a long period.

Managerial continuity: Where handovers of care between clinicians, teams and organisations are timely and efficient, and patient's needs, and preferences are respected and met at every step in their journey.

MDT: Multidisciplinary, a term used to describe input from people with different skills.

Micro-team: For this evaluation, micro-teams are different configurations of a team working to manage patient care. This may comprise of two or three GPs in a 'buddy group' or may utilise skills of other members of the team and include nurses, pharmacists, paramedics and administrators/care navigators.

OPR: Own Patient Ratio, which calculates the proportion of list-holding GP's consultations that are with their own patients

PCN: Primary Care Networks, are configurations of multiple General Practices commencing in 2020.

PDSA: Plan, do, study, act, is part of the model for improvement that enables users to test out changes on a small scale, building on the learning from the test cycles in a structured way before full implementation.

PPG: Patient participation groups which consist of volunteers for each local practice, who meet regularly to support and challenge changes and test out new ideas.

Practice Management and Administration Team: For this evaluation, encompasses all non-clinical staff; practice manager, receptionist, care navigator, administrative assistant, business manager etc.

QSIR: The Quality Service Improvement and Redesign course helps participants in the use of tried and tested improvement tools, and featured approaches, as well as encouraging reflective learning.

Relational continuity: Where clinicians develop a therapeutic relationship with patients that spans various health care events, resulting in the accumulated knowledge of the patient and care that is consistent with the patient's needs.

RCGP: The Royal College of General Practitioners who support the programme as learning partners but more widely provide resources and guidance for General Practice.

SLICC: The St Leonard's Index of Continuity of Care (SLICC) calculates the proportion of face-to-face consultations that are with patients' personal doctor.

UPC: The Usual Provider of Care (UPC) index, which calculates the proportion of consultations that are with the doctor most frequently seen.

Wider Clinical Team: For the purpose of this evaluation, this term encompasses all non-GP clinical support staff; nurses, healthcare assistants, paramedics, pharmacists etc

C. Addressing the evaluation questions

Evaluation Questions	Addressed in:	Informed by:
For patients:		
How has patient awareness of continuity changed?	Chapter 2 outlines the interventions used to engage patients.	Patient surveys, patient interviews and focus groups, insights from staff within the practice through engagement at learning workshops, interviews, focus groups and surveys.
Has continuity of care increased for patients?		
What approaches were used to engage patients?	Data and analysis are presented in Chapter 4 and 5 relating to these questions.	
What were the advantages and disadvantages of participation for different patient groups?		Local project team reports.
What has been the wider learning about patients views on continuity of care and how do these vary across different groups?		
For the workforce:		
What approaches have been used to engage staff?	Chapter 2 outlines the interventions used to engage staff.	Insights from staff within the practice through engagement at learning workshops, interviews, focus groups and surveys.
What were the advantages and disadvantages of participation for different staff?		
What has been the wider impact on the workforce?	Data and analysis are presented in Chapter 4 and 5 relating to these questions.	Local project team reports.
What has been the wider learning about staff views on continuity of care and how do these vary across different groups?		
For others in General Practice and the wider health and care system:		
What approaches worked best for improving continuity of care?	Chapter 8 presents new learning from the work structured around different themes.	Insights from staff within the practice through engagement at learning workshops, interviews, focus groups and surveys.
How has the project contributed to our understanding of what continuity of care means?		Local project team reports.
What are the benefits and unintended consequences of attempting to improve continuity of care?	Chapter 5 outlines the benefits and consequences	
What factors affect the success and spread of continuity of care improvement interventions?	Chapter 7 explores the spread of continuity	
What resources are required to improve continuity of care?	Section 6.10 presents a summary of the resources required.	

D. Evaluation tools

D.1 Staff survey

The Health Foundation   CONTINUITY OF CARE IN GENERAL PRACTICE   M M MOTT MACDONALD

Your Practice is currently working with The Health Foundation to test different approaches to increase continuity of care for patients. Mott MacDonald has been commissioned to evaluate the programme and understand if, and how, improvement approaches can be used to increase continuity of care. This includes understanding your current views on continuity of care and how these may change over the next 18 or 24 month period.

Continuity of care is considered within relational, managerial and informational domains. The focus of the Programme is on relational continuity, where clinicians develop a therapeutic relationship with patients that spans various health care events.

The survey should take no more than 10 minutes to complete. The information that you give us will remain completely anonymous.

YOUR JOB ROLE

1. What best matches your job role?
a. General Practitioner ☐
b. Wider Clinical Team ☐
c. Practice Management and Administration ☐

2. For each of the statements below, how, if it all, often do you feel this way about your job?

	Never	Rarely	Sometimes	Often	Always
a. I am very satisfied with my job	☐	☐	☐	☐	☐
b. I am enthusiastic about my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. To what extent to you agree or disagree with the following statements about your job?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I am able to do my job to a standard that meets my personal expectations	☐	☐	☐	☐	☐
b. I always know my work responsibilities	☐	☐	☐	☐	☐
c. Our working practices allow me to be responsive to the needs of patients	☐	☐	☐	☐	☐
d. Our working practices allow me to know the patients (i.e may be systems, processes or ways of working)	☐	☐	☐	☐	☐
e. Changes in my job in the last year have led to better patient care	☐	☐	☐	☐	☐
For clinical staff:					
f. My professional skills are used to the fullest	☐	☐	☐	☐	☐
g. Our working practices allow me to involve patients in decisions about their care	☐	☐	☐	☐	☐
h. I trust the judgement of my clinical colleagues	☐	☐	☐	☐	☐
	1	2	3	4	5

4. To what extent to you agree or disagree with the following statements about your job?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I feel supported by my colleagues and fellow workers	☐	☐	☐	☐	☐
b. I can share my thoughts and ideas	☐	☐	☐	☐	☐
c. I feel that I can speak up about a problem without repercussions	☐	☐	☐	☐	☐
d. There is open communication between team members across all levels	☐	☐	☐	☐	☐
e. I have time to carry out all my work safely	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

STRATEGIC PRIORITIES

5. Please choose the three priorities which you think are most important and rank them.
Place a number in the box on a scale where, 1 = most important and 3 = least important. See example for guidance.

		Example
a. Extending access	☐	☐
b. Increasing continuity of care	☐	2
c. Expanding roles within the team (i.e pharmacists, paramedics, social prescribing)	☐	3
d. Expanding services available locally (i.e physiotherapy, outpatients)	☐	1
e. Digital first care (i.e to manage appointments/view medical record via an online platform)	☐	☐
f. Primary care networks (i.e working with other practices as clusters)	☐	☐

6. Are there any other important strategic priorities in your workplace?

Yes ☐   If yes, what
No ☐   are they?   _____

YOUR VIEWS ON CONTINUITY

7. How important do you think it is for patients to have continuity of care within General Practice?

	Very	Mostly	Somewhat	A little	Not at all
a. For all patients	☐	☐	☐	☐	☐
b. For a particular group of patients	☐	☐	☐	☐	☐
c. What would be the characteristics of patients within this group?			_____		

8. What do you think are the main advantages of continuity of care?

9. What do you think are the main disadvantages of continuity of care?

10. What changes do you think could happen in your practice, or General Practice more widely, to increase continuity of care for patients?

CONTINUITY INITATIVES

Your GP practice has been recently become involved in the [Local name of project] supported by The Health Foundation.

11. Are you aware of this project?

Yes ☐

No ☐ If 'no', please proceed to question 13

Unsure ☐ If yes or unsure, please describe what your practice is doing?

_____

12. In the context of your practice and this project, to what extent do you agree or disagree within the following statements?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. The practice leadership team is committed to this project	☐	☐	☐	☐	☐
b. There is a consistent shared understanding of the project	☐	☐	☐	☐	☐
c. All members of the practice team are committed to the project	☐	☐	☐	☐	☐
d. The appropriate resources are available to deliver the project	☐	☐	☐	☐	☐
e. The appropriate training is available to deliver the project	☐	☐	☐	☐	☐
f. I know who to direct questions to about this project	☐	☐	☐	☐	☐
g. Practice systems will support delivery of the project	☐	☐	☐	☐	☐
h. The practice is proactive is embedding change and improvement	☐	☐	☐	☐	☐

13. What other factors do you think will contribute to the success or failure of this project?

14. Is there anything else that you would like to tell us on this topic?

D.2   Patient Survey

CONTINUITY OF CARE IN GENERAL PRACTICE

Your General Practice is currently working with The Health Foundation to test different ways to increase *continuity of care* for patients. Mott MacDonald has been brought in to gather feedback on your views about this.

Continuity of care is when you see the same GP and form a therapeutic relationship with them. It means that you know each other well.

The survey should take no more than 10 minutes to complete. The information that you give us will remain completely anonymous.

I am completing this survey on behalf of:
Myself ☐
Another patient (e.g as parent/guardian/carer) ☐   → Please answer on behalf of the patient and their appointment history.

YOUR LOCAL GP SERVICES

Please consider your experience over the last 12 months when answering questions in this section.

Q1 How many times have you had an appointment with a GP within your practice in the past 12 months? ☐

Q2 Is there a particular GP you usually prefer to see or speak to?
Yes, for all appointments ☐
Yes, for some appointments ☐
No ☐
There is usually only one GP ☐

Q3 How often do you see or speak to your preferred GP?
Almost or almost always ☐
A lot of the time ☐
Some of the time ☐
Never or almost never ☐
I have never tried ☐

Q4 How many times have you seen your preferred GP in the past 12 months? ☐

YOUR THOUGHTS ON CONTINUITY OF CARE

Q5 How important do you feel that it is to see the same GP?

5 4 3 2 1
☐ ☐ ☐ ☐ ☐
Very important   Not at all

Q6 By seeing the same GP, how much do you agree or disagree with the following statements:

Strongly agree   Strongly disagree
5 4 3 2 1

	5	4	3	2	1
They know my medical history	☐	☐	☐	☐	☐
They know me as a person	☐	☐	☐	☐	☐
They are responsive to my needs and concerns	☐	☐	☐	☐	☐
I feel that I know them	☐	☐	☐	☐	☐
I feel involved in decisions about my care	☐	☐	☐	☐	☐
I would wait longer for an appointment to see them	☐	☐	☐	☐	☐
I feel confident to take an active role in my health and wellbeing	☐	☐	☐	☐	☐

Is there anything else that is important to you about seeing the same GP? ☐

Q7 There may be times when your preferred GP is unavailable and you may be seen by another member of the team. When this happens, how much do you agree or disagree with the following statements:

	Strongly agree				Strongly disagree
	5	4	3	2	1
They know my medical history	☐	☐	☐	☐	☐
They know me as a person	☐	☐	☐	☐	☐
They are responsive to my needs and concerns	☐	☐	☐	☐	☐
I feel that I know them	☐	☐	☐	☐	☐
I feel involved in decisions about my care	☐	☐	☐	☐	☐
I feel confident to take an active role in my health and wellbeing	☐	☐	☐	☐	☐

YOUR GP PRACTICE

Q8 We would like to understand how you feel about the care currently provided at your GP practice. How much do you agree or disagree with the following statements:

	Strongly agree				Strongly disagree
	5	4	3	2	1
They know my medical history	☐	☐	☐	☐	☐
They know me as a person	☐	☐	☐	☐	☐
They are responsive to my needs and concerns	☐	☐	☐	☐	☐
I feel that I know them	☐	☐	☐	☐	☐
I feel involved in decisions about my care	☐	☐	☐	☐	☐
I feel confident to take an active role in my health and wellbeing	☐	☐	☐	☐	☐

Q9 How, if at all, does your practice promote continuity of care?

Posters ☐
Leaflets ☐
Videos in reception or waiting areas ☐
Online booking/AskMyGP ☐
Information from reception team ☐
Letters to my home ☐
Conversations with practice staff ☐
Social media ☐
GP practice website ☐
Word of mouth ☐
Not at all ☐
Other:

Q10 Overall, how would you describe your experience of your GP practice?

Very good ☐
Fairly good ☐
Neither good nor poor ☐
Fairly poor ☐
Very poor ☐

Q11 Is there anything else that you would like to tell us on this topic?

SOME QUESTIONS ABOUT YOU

Q12 What is the name of your GP practice?

Q13 Are you male or female?

Male ☐
Female ☐
Other ☐
Prefer not to say ☐

Q14 How old are you?

Under 16 ☐
16 to 17 ☐
18 to 24 ☐
25 to 34 ☐
35 to 44 ☐
45 to 54 ☐
55 to 64 ☐
65 to 74 ☐
75 to 84 ☐
85 and over ☐
Prefer not to say ☐

Q15 Which of the following best describes what you are doing at present?

Full-time paid work ☐
Part-time paid work ☐
Full-time education ☐
Unemployed ☐
Permanently sick or disabled ☐
Fully retired from work ☐
Looking after the family or home ☐
Doing something else ☐
Prefer not to say ☐

Q16 What is your ethnic group?

White ☐
Mixed/ multiple ethnic groups ☐
Asian/ Asian British ☐
Black/African/ Caribbean/Black British ☐
Other ethnic group ☐
Prefer not to say ☐

Q17 Is English your first language?

Yes ☐
No ☐
Prefer not to say ☐
If no, what is?

FUTURE PARTICIPATION

The information that you have given us in this survey will remain anonymous. If you would be happy to speak to us in the future about the experiences of your GP practice, please complete below:

Name

Telephone

Email address

This survey has been developed in line with the Market Research Society (MRS) Code of Conduct and the Data Protection Act. No individual or groups of individuals will be identifiable through analysis or reporting.

If you have any questions or feedback about the survey, please contact Emma Torrance on emma.torrance@mottmac.com.

D.3 Topic guides

D.3.1 Interviews with project leads

<table>
<tr><td>1. Introductions</td></tr>
</table>

- Welcome

- Introductions from project site team

- Introductions from Mott MacDonald team

- Brief overview of the evaluation

- Purpose of the meeting - and how this conversation informs process/ evaluation protocol.

Notes:

We have gathered context from the Programme and background docs to minimise requests and will ensure we do this going forward. However, for this initial meeting, it is important to hear some of this context from you firsthand.

<table>
<tr><td>2. Your local project</td></tr>
</table>

Drivers for your project

- What specific CoC issue are you trying to address and why?

- What difference/changes are you trying to achieve?

- Does this build on work you have already done or is this a new priority area?

CoC specific approaches

- What are your planned approaches and activities to achieve these outcomes?
- How did you select these approaches to prioritise?

For each approach:

- What are its key aims and objectives?

- How would you categorise these? *(Relational, managerial, relational)*

- Talk me through the key elements of this? *(Target population, number of patients)*

- How many practices are adopting this approach?

- What resources have you determined you will need for each? Are these existing resources or do you need to secure additional resources? *(Inputs)*

- What are your timelines around this approach? *(Key milestones, phases)*

- How will effectiveness be measured? What potential benefits or consequences do you anticipate? *(Outputs, outcomes, impacts)*

- What plans or ideas do you have on evaluating these?

Delivery and governance

- What governance arrangements have you put in place/ are you putting in place to oversee the development and delivery of the project?

- Do you have dedicated project management support and/or what does this look like?

- Do you need any additional specific resources to support implementation?

- Have there been any challenges in establishing these? (Securing time, resources, recruitment)

- Are there any other strategic priorities (or competing pressures) being implementing locally which could affect the project? What impact do you perceive these might have?

- What are your local decision making timelines regarding the sustainability/ continued funding of these approaches?

Culture and leadership

- Describe the current leadership arrangements?

- Tell me about the level of engagement of practices into the project?

- How are practices or groups of staff are working together (if relevant)?

Stakeholders and engagement

- Who are your key stakeholder groups?

- How did you involve different stakeholders in the development of your bid submission for the Health Foundation funding?

- What partners are involved locally?

- How do you plan to engage patients?

- How do you plan to engage staff?

Note: Use pre-prepared stakeholder mapping as prompt for discussion.

Progress to date

- Tell me about any additional progress to date?

- Have there been any aspects of set up to date which have been more challenging than you initially anticipated, or which have limited progress? How have you overcome these barriers?

- What future barriers/ challenges do you consider you may encounter? How are you pre-empting these?

- At this stage what do you consider some of the critical success factors have been (or will be) in terms of making progress and implementing your approaches?

3. The evaluation

The evaluation

- Overview of the key stages of the evaluation and how we will work with the IAU and EWG

- Project site specific plans or ideas on evaluation (beyond the quantitative agreed with IAU)

- Discussion of research questions to inform evaluation

- Discussion as to local application of methods which could be used to answer research questions:

  – Staff – survey, focus groups, individual interviews

  – Patients – surveys, focus groups, accessing existing patient engagement groups

  – Clinical audit tool

  – Other

- Co-producing the evaluation protocol – next steps and timescales.

Note: Use pre-prepared stakeholder mapping as prompt for discussion.

Working together

- Will agree an evaluation project site lead who will lead communication with nominated project lead.

- Review timelines together and discuss:

  – When evaluation activities will have most impact

  – Frequency and mode of regular catch ups along the programme

  – Any high-pressure time periods of which the evaluation will need to be cognisant.

---

4. Next Steps

- Agree evaluation protocol

- Other next steps

D.3.2   Baseline Staff Interviews and Focus Groups

Key questions

1. Continuity of care in General Practice

- What does continuity of care mean to you?
- What do you feel are the advantages and disadvantages of increasing continuity of care? For patients? For you and your colleagues?

2. Project

- What has your practice been doing to increase continuity of care for patients?
- What has your role been in trying to increase continuity of care? How did you come to be involved?
- What impact has the project had on your day-to-day role? Is that positive or negative?
- Do you have any reflections on how the project has been working? Why? Have there been any challenges you have had to overcome?

3. Staff

- How have you and fellow staff members been engaged? Do you have any reflections on how this has been working? Why? Have there been any challenges you have had to overcome?

Prompts: discuss the project at regular staff meetings, volunteered to get involved.

4. Patients

- How have you been engaging patients for the project? Do you have any reflections on how this has been working? Why? Have there been any challenges you have had to overcome?

Prompts: receptionists encouraging patients to see the same GP, GPs highlighting continuity during consultations.

- Do you feel that there are any early patients impacts from the project?

Prompts: happier patients, less repeat tests, more admin organisation, patients waiting longer for appointments, GP heartsink or burnout.

5. Enablers and barriers

- At this stage what do you consider some of the <u>critical success factors</u> have been (or will be) in terms of making progress and implementing your approaches?

Prompts: leadership, understanding aims of the project, commitment, resources, training

- Is there anything specific to this practice that you think is a challenge or enabler to increasing continuity of care?

Prompts: deprivation, locums, challenge to recruit, a triage system, AskMyGP, leadership.

6. Reflections

- If you could change anything about the project, what would you change?
- Has this experience changed your appetite for getting involved with changes or improvements within the practice?

D.3.3 Summative Staff Interviews and Focus Groups

Key questions

1. What (and how) has your practice been doing to increase continuity of care for patients?

- What has your practice been doing to increase continuity of care for patients?
  - Has your focus been on increasing continuity for all patients or for specific patient cohorts? What has informed this decision?
- What has your role been in trying to increase continuity of care? How did you come to be involved?
- How has the pandemic impacted the actions you were taking to increase continuity?
- How have you and fellow staff members been engaged in the project? Do you have any reflections on how this has worked? Why? Have there been any challenges you have had to overcome?
- How have patients been engaged? Do you have any reflections on how this has worked? Why? Have there been any challenges you have had to overcome?

2. Impact of actions to increase continuity of care for patients?

- What changes have you seen happening as a result of involvement in the programme or changes instigated through this?

- What impact has the project had on your day-to-day role?

    o Positive impacts. How has the project brought about these impacts?

    o Negative impacts. How has the project brought about these impacts? How have you tried to overcome these issues?

    o Do you have any evidence to support this?

- Have you heard other staff describe similar impacts to those you describe? Have others described any other impacts? Is there any evidence to underpin this?

- What impact have changes had on patients? How has the project brought about these impacts? Is there any evidence to underpin this?

3. Wider reflections

- Have there been any unintended consequences?

- Thinking back to your initial views on the potential outcomes of continuity, have your views changed? Has the pandemic had any impact on these views?

- Is there anything specific to this practice that you think has been a challenge or enabler to increasing continuity of care?

- If you could go back and change anything about the project or the activities you have undertaken, what would you change?

- Has this experience changed your appetite for getting involved with changes or improvements within the practice?

4. Legacy of change

- Will the changes implemented as part of the project continue to be embedded and built upon beyond the end of the project?

    o Are these self-sufficient or will maintenance be required and if so, what form will that take?

D.3.4   Patient Baseline Interviews and Focus Groups

Key questions
Consent form – review key issues
Warm up 1. What, if anything, does the term 'continuity of care' mean to you? - What do you think that this means? - Provide definition: 'continuity of care' is when you have your consultations with the same GP and form a therapeutic relationship with them. **Their experience** 2. Do you have a preferred GP? - If no preferred GP: Why is this?

- If yes:
    - Why do you have a preferred GP?
    - Would you wait longer to see your preferred GP? In which circumstance would you wait longer? And when would you not?

3. How important do you think it is to consistently see the same GP?

- Why do you think this?
- Are there occasions when you do not feel that it is important to see the same GP?
- What do you think are/ or would be the benefits of contacting the same GP?

4. What stops you from seeing your preferred GP?

Wider reflections

5. How, if at all, does your practice tell you about continuity of care?

- How does your practice support you seeing your preferred GP?

6. Is there anything else that you would like to tell us?

D.3.5   Summative Baseline Interviews and Focus Groups

Key questions

Consent form – review key issues

Warm up

1. What, if anything, does the term 'continuity of care' mean to you?

- What do you think that this means?

- Provide definition: 'continuity of care' is when you have you consultations with the same GP and form a therapeutic relationship with them.

Their experience

2. Over the past two years, have you been aware that your practice has been focused on increasing continuity of care?

- How have you been aware or been involved in this?

- (If relevant) do you have any reflections on how this involvement worked? Could this have been improved and if so how?

- Has your practice been in touch over this period to confirm who your accountable/ usual/ preferred GP is, or to inform you that this might have changed?

3. Do you have a preferred GP?

- If no preferred GP: Why is this?

- If yes:
    - Why do you have a preferred GP?
    - Would you wait longer to see your preferred GP? In which circumstance would you wait longer? And when would you not?

4. Over the past two years, do you feel that you have experienced greater continuity of care (by this we mean having consultations with the same GP a greater proportion of the time)?

- If yes:
    - o What has been your experience of this?
    - o What impact has this had on you?
    - o How, if at all, has this benefited you? What about this have you valued? *[Consider further questions to understand further the link between increased continuity and doctor patient relationship].*
        - ▪ Have you experienced any disadvantages as a result of this? If so, what were these? Did you share these with your practice and what action was taken?
    - o *<Consider if suitable for a patient story>*

- If no:
    - o What has been your experience of this?
    - o Has this had any impact on you?
    - o Would you value greater continuity? Why?

Wider reflections

5. The pandemic has meant that practices have adopted new ways of working; of communicating with your practice and undertaking consultations with your GP.

- If you have a preferred GP, how have these new ways of working impacted your ability to access them?

- Do you think the mode of communication has an impact on the relationship that you have with your GP?

6. Is there anything else that you would like to tell us?

mottmac.com