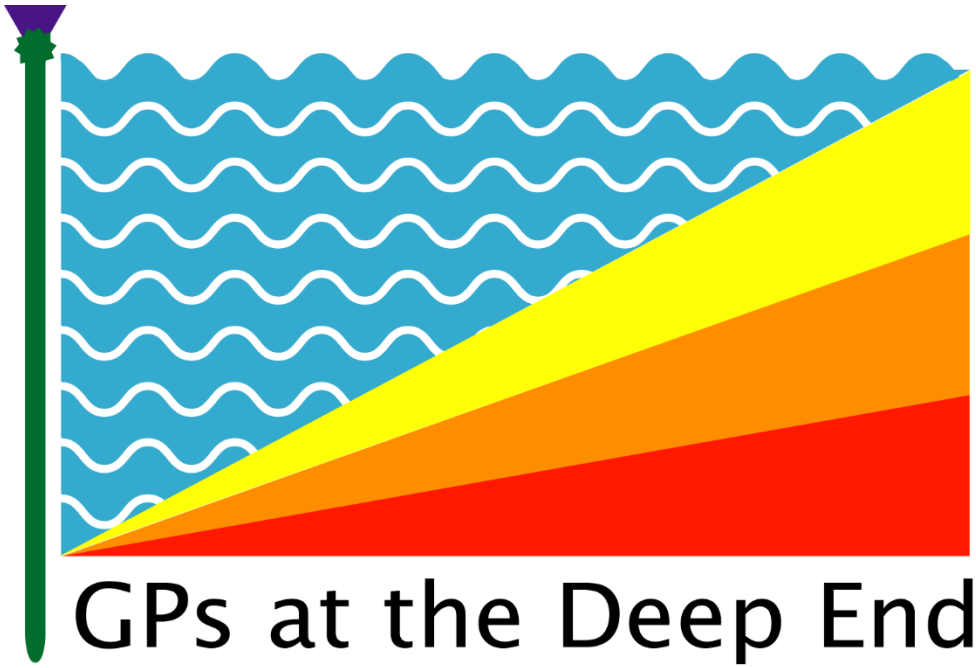

Deep End Report 42

What can General Practice do to Strengthen Continuity of GP Care for those who Need it Most?

On Tuesday 25 June 2024, the Deep End GP group hosted an in-person roundtable discussion on relational continuity of GP care for vulnerable and deep end populations. The discussion reviewed the strong evidence base and the challenges to implementing this, before focusing on possible solutions.

October 2024

Executive Summary

Background and Context
Continuity of care is fundamental to effective healthcare, emphasizing long-term patient-provider relationships. Despite strong evidence supporting its benefits – such as enhanced clinical outcomes, patient satisfaction, and reduced healthcare utilization – continuity of care is often underprioritized in Scotland's GP practices. This report, based on a Deep End roundtable discussion held on June 25, 2024, examines barriers, facilitators, and recommendations for improving continuity of care, particularly for vulnerable populations.

Importance of Continuity of Care
Continuity of care is especially vital for managing chronic conditions, mental health issues, and complex healthcare needs, particularly among vulnerable groups such as trauma survivors, the elderly, and marginalized communities. High continuity of care is associated with better patient outcomes, reduced mortality rates, and improved trust between patients and GPs. It has been shown to improve job satisfaction, helping to address the challenge of recruitment and retention.

Barriers to Continuity of Care
Several systemic and cultural barriers impede continuity of care:

- **Structural Challenges**: Larger general practice teams, declining GP workforce, and the increased use of locums undermine personal continuity. Workload is also recognised to be increasing across the whole general practice team.
- **Policy Limitations**: Current GP contracts emphasize access over continuity, deprioritizing long-term patient relationships.
- **Burnout and Emotional Labour**: GPs managing complex cases face high emotional demands, leading to burnout and avoidance of long-term patient care.
- **Cultural Shifts**: Societal emphasis on immediate access to care and digital healthcare disrupt traditional continuity of care.

Facilitators of Continuity of Care
Effective organizational structures, digital tools, and education can enhance continuity of care:

- **Micro-Teams and Personal Lists**: Assigning patients to small teams fosters stronger GP-patient relationships.
- **Digital Tools**: GP software systems and asynchronous consulting platforms can support continuity of care by facilitating continuous engagement.
- **Training and Support**: Emphasizing continuity of care in GP training and providing ongoing emotional support for GPs are essential for maintaining high-quality care.

Recommendations for Strengthening Continuity of Care

1. **Policy Levers**: Introduce contractual incentives to prioritize continuity of care for vulnerable groups. Invest in data collection and develop targeted interventions for populations most in need. More equitable allocation of resource and workforces to general practices serving populations with higher levels of need.

2. **Practice-Level Interventions**: Promote micro-teams and trauma-informed support for practitioners. Engage in quality improvement initiatives and monitor continuity of care using tools like the Usual Provider of Care (UPC) and St. Leonard's Index of Continuity of Care (SLICC).
3. **Research and Evidence Building**: Evaluate the impact of interventions, including digital tools, and reframe definitions of access to include relational factors. Integrate patient co-design into primary care improvement planning.
4. **Education and Training**: Incorporate continuity of care principles into GP training and support early career GPs in gaining experience with relational continuity.

Conclusion

Improving continuity of care is crucial for enhancing the quality of GP care, particularly for vulnerable populations. Addressing systemic barriers through targeted interventions, supportive policies that bolster GP capacity and address workload, and improving education and training are some of the key factors that will ensure that continuity of care remains a priority in Scotland's healthcare landscape, ultimately improving patient outcomes and satisfaction.

FULL REPORT

1. Introduction

Continuity of Care (COC) represents a cornerstone of effective healthcare, rooted in the values of primary care systems across the globe[i]. Relational continuity of care, defined as care which prioritises a long-term patient-provider relationship, is particularly vital for the management of chronic conditions, mental health issues, and for populations with complex healthcare needs[ii].

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

This Deep End report is based on a roundtable discussion held on June 25th, 2024, exploring the barriers, facilitators, and recommendations for enhancing COC within General Practice (GP) settings in Scotland.

BACKGROUND

2. Continuity of Care: Definition and Evidence

COC is one of the seven core values highlighted by the Nordic Federation of General Practice[iv], reflecting its importance across different healthcare systems. COC is also one of Barbara Starfield's '4 Cs' (along with first Contact, Comprehensiveness and Coordination) as a foundational principle for high-quality primary care. In Scotland, however, there has been a noticeable gap in embedding COC into everyday GP practice. Despite the robust evidence base supporting COC and its well-documented benefits, it remains underprioritized in Scotland's healthcare system, particularly in the evolving landscape of GP contracts and Primary Care Improvement Plans (PCIPs). A recent comprehensive briefing paper considers the evidence-base for continuity of care and its delivery within the Scottish general practice policy and delivery landscape[v].

Continuity of Care can be categorized into three forms:

- Informational Continuity: Ensures that high-quality information follows the patient across different healthcare encounters. This includes both written and verbal communication, critical for maintaining a coherent treatment plan.
- Management Continuity: Involves having a coordinated plan for patient care, with clear agreements on roles and responsibilities among healthcare providers. This ensures that the patient's care is seamless, even when multiple professionals are involved.
- Relational or Personal Continuity: Focuses on maintaining a long-term patient-provider relationship, fostering trust and therapeutic alliances. Unlike relational *care*, which can be episodic, relational *continuity* emphasizes ongoing engagement with the same

healthcare provider over time. **Continuity of GP care in the context of this discussion should be understood as referring to relational continuity.**

Continuity of care is a foundation for relational care more broadly, which includes other skills such as sharing of power and building mutual trust. Many of the benefits of continuity of care derive from this building of relational care, which is particularly relevant in Deep End communities because it mitigates the negative impact of wider community experiences and encourages engagement[vi]. Continuity therefore operates at a level of community relationships also, especially at this time of MDT working, and supports community engagement with GP services[vii].

Relational COC can be measured using several methods for monitoring and improving its implementation. These include the Usual Provider of Care (UPC) tool, which measures patient-level continuity by calculating the percentage of appointments a patient has with the same GP, particularly for those seen more than twice in a year, and St. Leonard's Index of Continuity of Care (SLICC) tool, which assesses practice-level continuity by evaluating the percentage of consultations that occur with a patient's named GP over a specified period.

There is a strong association between high continuity of care indices and improved patient and system outcomes, providing a robust and compelling evidence base for relational continuity of care, especially between a patient and their GP. This has been extensively reviewed elsewhere [viii]

- **Patient and Job Satisfaction:** Continuity leads to better patient satisfaction and job satisfaction among GPs, as it builds trust and facilitates personalized care.
- **Improved Adherence and Preventive Medicine:** Patients are more likely to adhere to medical advice and prescribed medications, reducing waste and increasing the uptake of personalized preventive measures.
- **Enhanced Quality of Care:** COC is associated with better overall quality of care, as GPs who know their patients well can make more informed and effective clinical decisions.
- **Reduced Workload and Healthcare Utilization:** Practices with strong COC experience reduced workloads, fewer emergency department visits, lower hospital admission rates, and overall lower costs within the healthcare system.
- **Lower Mortality:** Evidence indicates that COC in General Practice can lead to lower mortality rates, while poor continuity is associated with higher risk of mortality, at least in older adults, highlighting its critical role in patient safety.
- **Litigation Rates:** Evidence also indicates that COC is associated with reduced complaints, and less litigation, associated with better patient satisfaction.

Box 1 Evidence for Relational Continuity of Care

[ix] [x] [xi] [xii] [xiii] [xiv] [xv] [xvi].

DISCUSSION

3. The Importance of Continuity of Care for vulnerable and deep end populations

3.1 Trust and Relationship Building

Trust forms the bedrock of the patient-doctor relationship. A GP who sees the same patient over multiple consultations gains deeper insights into the patient's medical history, social background, and behavioural patterns, which are critical for accurate diagnosis and treatment. Trust is not only about clinical competence but also about the relational dynamics that develop over time. Patients often perceive GPs who know them well as more empathetic, leading to higher patient satisfaction and better adherence to medical advice.

Group members spoke from their own experience of having to earn authority and trust. Rather than being able to take this for granted, particularly with the most vulnerable, they had to prove themselves over time. Patients would evaluate them and could "*tell if you're being authentic*". This was especially impactful in keeping trust at times when patients and clinicians disagreed: "*a good diagnosis builds trust for future advice*". Health literacy could also be influenced gradually over the long term, for example supporting people to learn how to self-manage their health and symptoms: "*you can nudge people over years*".

3.2 Improved Clinical Outcomes

COC enhances clinical outcomes through better decision-making and more personalized care. GPs familiar with their patients' histories can make informed decisions quickly, reducing the need for redundant tests and unnecessary referrals. Over time, a GP can observe subtle changes in a patient's condition, enabling early intervention in cases where a new or worsening condition might otherwise go unnoticed.

The group also reflected that decision-making improves when stories and patterns can be observed, with improved recognition of what is normal or not normal, leading to reduced investigations and earlier recognition of warning signs. GP education and learning is also strengthened because outcomes of decisions, referrals and treatments are known (continuity feedback loop). Patients also value continuity highly (but it was noted they also want speedy access).

3.3 Trauma-Informed Care

In cases involving trauma, COC is crucial. Patients who have experienced trauma, abuse, or violence often require a stable, trusting relationship with their healthcare provider to feel safe enough to disclose sensitive information. COC allows GPs to build this trust incrementally, facilitating a more accurate and compassionate approach to care.

The group reflected that GP practices are more likely to be experienced as a safe space, a "*little home*", and that not having to repeat stories and being able to build trust gradually are central to trauma-informed practice. Patients would use minor ailments as "*opening gambits for disclosing difficult issues*", sometimes over multiple consultations. The doctor could also provide "*a holding relationship*" which was intrinsic to the care given. Continuity of care was seen as *the treatment,* not just the mode of treatment, for those who have experienced relational injury and who struggle to trust.

3.4 Vulnerable Populations Benefit Most

Certain populations derive the most benefit from COC:

- People who have survived abuse, trauma, violence, relational injury
- People with neuro-divergence or learning disability

- Communities with low trust in mainstream services (e.g. travellers, newly arrived communities, marginalised communities)
- People who struggle to navigate (systems and relationships)
- Elderly and frail people
- Homeless people
- Young people (but most have never experienced COC)

For these populations, consistent GP care can mean the difference between receiving timely, appropriate care and falling through the cracks of a fragmented healthcare system. COC helps ensure that their complex needs are met comprehensively and sensitively. The universal benefits of COC for everyone were also recognised.

3.4 Staff Recruitment and Retention

Continuity of care improves job satisfaction and builds a sense of responsibility and accountability to patients, which helps to retain the primary care workforce. It is attractive to doctors joining the profession, and is recognised to be a significant factor for why many young doctors choose General Practice as a career. Loss of continuity of care therefore damages recruitment and retention, making it more likely for GPs and other health care professionals to move between practices or to alternative careers.

4. Barriers to Relational Continuity of Care

4.1 Systemic and Structural Challenges

- **Large Teams and Focus on Access**: The current trend toward larger general practice teams, driven by an emphasis on quick access to services, can dilute the personal connection between patients and individual GPs. This structure often prioritizes speedy availability over continuity, which, while beneficial in some respects, can lead to a disjointed care experience. Vulnerable and complex patients then disengage from seeking help or medical advice, because of lack of trust or other relational barriers, creating a missing population who we know should be accessing health care but who are not, or who are accessing health care at a late stage so that opportunities for early intervention are missed. As a result, **the focus on access over continuity creates *and hides* unmet needs.**

- **Declining GP Workforce:** The number of GPs is decreasing, while the patient-to-GP ratio continues to rise, straining the capacity for maintaining COC. The increasing reliance on locums and trainee GPs and the shift away from personal lists, where patients were consistently seen by the same GP, has undermined relational continuity. Frequent changes in the healthcare provider make it challenging for patients to develop long-term relationships with a single GP, leading to potential gaps in care and loss of important contextual knowledge about the patient.

- **Contractual and Policy Limitations**: The 2018 GP contract and subsequent PCIPs do not prioritize COC, focusing instead on other aspects of care, such as access and transactional efficiency This lack of emphasis on COC has led to its gradual de-prioritization in practice management and care delivery. For example, sustainability of service delivery and safe practice have been prioritised by measures such as reducing working hours of individual clinicians to achieve better work-life balance, at the expense of continuity of care.

- **Increased Use of Telephone Triage and 'On the Day' Services:** While these approaches may improve access, they often do so at the expense of continuity, as patients may see different providers at each visit. These changes have been driven by high rates of missed appointments when pre-booked (correlates with length of time to appointment) and by high levels of perceived urgency of presentations to GP, high demand driven by health levels of health anxiety, low health literacy and high levels of distress and distress intolerance.

- **Fragmentation due to MDT Models:** The move towards multidisciplinary team (MDT) models, while beneficial in some respects, can fragment care and reduce the likelihood of patients seeing the same provider consistently. This is compounded by the shift towards measuring and prioritising transactional aspects of care across the NHS. Seeing different members of an MDT for different healthcare issues works less well for those with more complex health and social issues, where relational COC (and overall coordination of care) has been shown to be particularly important.

- **Medical and GP education:** Continuity of care is not emphasised or adequately taught in GP or undergraduate training. There is increased medicalisation of GP training with less understanding of the biopsychosocial model and the human / contextual factors in primary care. It can be very difficult for early career GPs to build up continuity of care experience during their training and early years.

4.2 Emotional and Professional Burnout

- **Emotional Labour**: Providing COC is emotionally demanding. GPs who develop long-term relationships with their patients often take on significant emotional labour, which can lead to burnout. This risk is particularly high when dealing with patients who have complex medical or psychosocial needs, such as those affected by trauma. The emotional toll of continuously managing these cases can make GPs wary of engaging deeply with patients over extended periods, especially if COC is not 'signed up to' by the whole practice, or if there is a lack of psychological support to work in this way.

- **Avoidance of Continuity**: In some cases, GPs might deliberately avoid COC as a coping mechanism to manage the stress and emotional burden of their work. This avoidance can lead to "collusion of anonymity," where multiple people involved in care-giving all assume that the ultimate responsibility is being held by someone else. Neither the GP nor the patient forms a meaningful connection, or a sense of 'ownership', potentially compromising the quality of care.

4.3 Societal and Cultural Shifts

- **Cultural Shift towards 'Access is King':** There is a prevailing culture, driven by political, public, and professional expectations, that prioritizes immediate access to care over continuity, regardless of how clinically urgent – or otherwise – the condition is.) This further complicates efforts to maintain long-term patient-provider relationships.

- **Digital Healthcare and Information Access**: The rise of digital healthcare platforms and the proliferation of health information on social media have changed the dynamics of patient care and expectations. Patients are increasingly "shopping around" for healthcare advice and services, which can disrupt the continuity of their care with a single GP.

Additionally, the growth of digital influencers in health complicates the traditional patient-doctor relationship, often undermining the GP's role as the primary source of medical guidance.

- **Digital Poverty and Health Literacy**: On the flip side, digital poverty and low health literacy can also act as barriers to COC. Patients who lack access to digital tools or who struggle to understand health information may find it challenging to navigate a healthcare system that is increasingly digitally dependent, leading to fragmented care.
- **Time Poverty**: Many patients, particularly those with demanding work schedules or caregiving responsibilities, experience 'time poverty,' which limits their ability to consistently attend appointments with the same GP. This issue is compounded by the fact that healthcare services are often not structured to accommodate such patients, further eroding COC.

5. Facilitators of Continuity of Care

5.1 Organizational Structures and Practices

- **Personal Lists and Micro-Teams**: Assigning patients to personal lists or small micro-teams within a practice can enhance COC by ensuring that patients see the same GP or small group of clinicians consistently. This approach fosters stronger relationships and better care continuity.
- **Role of Reception Staff and Care Coordinators**: Receptionists and care coordinators play a pivotal role in maintaining COC. By effectively encouraging and explaining the benefits of COC to patients, managing appointments and patient interactions, they can help ensure that patients see their designated GP, thus reinforcing continuity.
- **Team Dynamics and Communication**: In multidisciplinary teams, effective communication and teamwork are crucial for maintaining COC. Small teams that communicate well and have strong internal relationships are better equipped to provide continuous, coordinated care to their patients.

5.2 Digital Tools

- **GP Software Systems**: GP software systems can be used to track patient encounters to support COC. One suggestion put forward was for colour-coding of visits by clinician to easily visualise level of continuity or fragmentation of care, use of the 'usual GP' facility, or placing alerts in the record.
- **Asynchronous Consulting**: Digital tools that facilitate asynchronous consulting (e.g., email or app-based communication) can also support COC by allowing patients to maintain contact with their GP outside of traditional appointment times. This flexibility can be particularly beneficial for patients with time constraints.

5.3 Education and Training

- **Incorporating COC into GP Training**: Emphasizing the importance of COC during GP training can help instil its value in new GPs. Training programs should include modules on the benefits of, and evidence-base for COC, strategies for managing long-term patient relationships, and the emotional aspects of providing continuous care. Consideration could also be given to clinical placements in practices that support COC.

- **Emotional Support for GPs**: Providing GPs with adequate emotional support, such as through reflective practice sessions or peer support groups, can help mitigate the burnout associated with providing COC. This support is particularly important for GPs who work with vulnerable populations or those with complex needs.

5.4 Policy and System-Level Initiatives

- **Adopting Nordic Principles**: The adoption of the seven Nordic principles of General Practice in Scotland could reinforce the importance of COC at a systemic level. These principles emphasize the holistic and continuous nature of GP care, which could drive policy and practice changes[xvii].

- **Proportionate Continuity Principle**: Incorporating a Proportionate Continuity principle into the Expert Medical Generalist role could help ensure that COC is provided in a manner that is proportionate to the needs of individual patient and is prioritised for those who are knows (based on the evidence) stand to benefit from it the most, such as those with complex or long-term conditions.

RECOMMENDATIONS

6. How can Continuity of GP Care for Vulnerable Populations be Strengthened?

6.1 Policy Levers

- **GP Workforce** The root cause of the decline in relational continuity of care in Scotland has been the attrition of the GP workforce – most obviously apparent when compared with the growth in the hospital specialist workforce – and the prioritisation of funding for specialist and acute services in the NHS in Scotland over the past two decades. This is compounded by the distribution of primary care funding which does not account for the additional health needs of vulnerable populations, leading to an 'inverse care law'[xviii]. This has come at high financial cost to the NHS, and to patient care, outcomes and satisfaction with the health service. Unless and until this is addressed, policy levers will be limited in their impact.

- **Contractual Incentives**: Winning hearts and minds will not be enough to tackle deeply rooted inequalities in primary care – contractual levers including potential incentivisation of continuity of care for the most vulnerable in society are likely to be essential. This approach could involve rewarding practices that demonstrate high levels of COC through improvements in their continuity scores. Given the potential for unintended consequences adequate safeguards will also of course be essential.

- **Targeted Continuity of Care**: It is possible that an 'inverse continuity law' exists, where those most in need of COC are least likely to receive it, given the complexities of negotiating access to care. Understanding this dynamic could inform targeted interventions to achieve proportionate continuity, which focuses on those who benefit most, such as older adults, individuals with multiple morbidities, and those with mental health or addiction issues, to ensure that vulnerable populations receive the proportionate continuity they need.

- **Data Collection and Accessibility**: Invest in routine data collection on COC and ensure that this data is readily accessible to primary care teams. High-quality COC data can help

practices identify areas for improvement and track the impact of continuity on patient outcomes. This is an essential prerequisite for measuring and monitoring improvements in COC.

- **Scottish Chief Medical Officer (CMO) Subgroup on Continuity:** This established subgroup could play a key role in advocating for policy changes that prioritize COC within the Scottish healthcare system, with a particular recognition of its importance in improving health equity.

6.2 Practice-Level Interventions

- **Promote Micro-Teams and Personal Lists**: Encourage the adoption of micro-team structures and personal lists within GP practices to facilitate COC. This approach should be supported by clear practice policies and effective use of reception staff and care coordinators. Implementing strategies to ensure patients are consistently allocated to the same GP or a small team of providers can enhance relational continuity.
- **Promote Trauma-Informed Support for Practitioners**: This should recognise the emotional labour associated with long-term patient care and relational continuity for vulnerable people.
- **Quality Initiatives:** Engaging in quality improvement collaboratives, such as those supported by Healthcare Improvement Scotland (HIS) and the Royal College of General Practitioners (RCGP), can promote best practices in COC. Utilizing GP clusters to share best practices and engaging with the broader NHS reform agenda can create an environment that supports continuity.
- **Staff and Patient Engagement:** Enhancing communication and engagement with both staff and patients about the importance of COC can foster a culture that values long-term relationships.
- **Measurement and Monitoring:** Regularly measuring and monitoring COC using tools like UPC and SLICC can help practices track progress and identify areas for improvement.

6.3 Research and Evidence-Building

- **GP Services Redesign:** The Phased Implementation Demonstration sites, GP Collaborative and other national initiatives present an opportunity to evaluate the impact of PCIP implementation on continuity of GP care and to develop a research and evidence base for COC in non-GP MDT roles. Given the importance of COC to patients, building in patient co-design and lived experience to primary care improvement planning is likely to result in higher priority being given to COC.
- **Evaluate Digital and Asynchronous Tools**: Conduct studies to evaluate the effectiveness of digital tools and asynchronous consulting in supporting COC. These studies should assess patient satisfaction, health outcomes, and the impact on GP workload and emotional well-being.
- **Redefine Access**: The definition of GP access should be widened from simple demand and availability to include 'relational access' which takes into account human factors and other barriers to accessing effective care for those with hidden and unmet needs.

- **Health and Care Experience (HACE) survey.** The question *"I knew the healthcare professional well"* previously gave an indication of perceptions of relational care. In the 2020-2021 Scottish HACE survey, this question had the lowest positive and the highest negative score regarding the experiences of the consultation. The question has been dropped from the 2024 HACE survey, so that there is now no question relating to relational continuity. This should be reinstated.

6.4 Education and Training

- **GP Specialist Training:** GP trainees should become familiar during their training with the evidence-base for better outcomes and relational continuity of care, how this can be measured, the challenges with delivering relational continuity in the current climate, and practical measures to improve the continuity of care which they can provide.

- **Early career GPs:** Opportunities to ensure that early career GPs have experience of relational continuity should be encouraged.

7. Conclusions

Continuity of Care is integral to the quality and effectiveness of healthcare delivery in General Practice. While there are significant challenges to maintaining COC, particularly in the current healthcare environment, there are also numerous opportunities to enhance continuity through targeted interventions, policy reform, and cultural shifts. By prioritizing COC, the Scottish healthcare system can improve patient outcomes, reduce healthcare costs, and ensure that those most in need receive the consistent, high-quality care they deserve.

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APPENDIX: NORDIC "CORE VALUES" OF GENERAL PRACTICE

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