Healthcare Improvement Scotland

Primary Care Phased Investment Programme

Considering Continuity of Care Webinar

25 February 2025

Leading quality health and care for Scotland

NHS SCOTLAND

Phased Investment Programme Webinar

Housekeeping

Cameras and mics have been disabled.

Please note, **we will be recording this session.**
The chat box will not be visible during the recording.

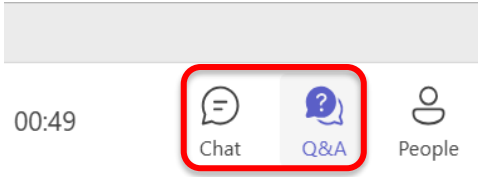
<u>To use the session **Q&A**:</u>

a. The session Q&A is found next to the chat function on the upper left of the screen

b. To ask a question click on the drop, down and click ‘Ask a question’

Please note: the Q&A function should be used for questions only, and discussion held in the Chat.

a.



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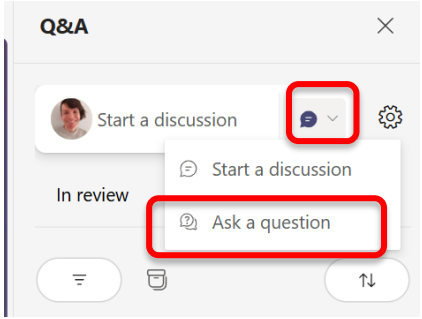
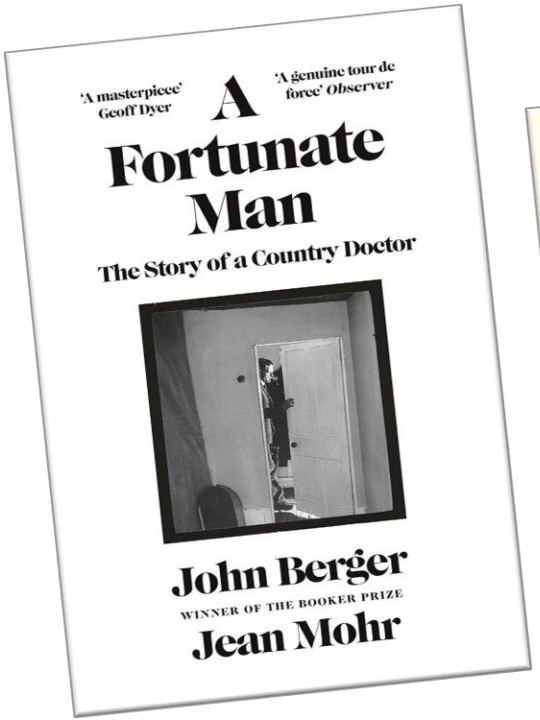
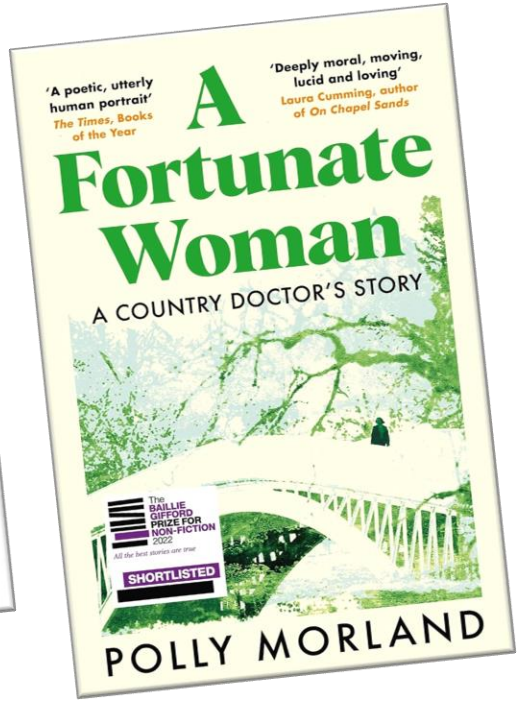


Continuity of Care in General Practice





Guest Speakers

Dr Carey Lunan

Senior Medical Advisor on Health Inequalities and Mental Health/ GP Chair of Scottish Deep End Project / Honorary Senior Clinical Lecturer Edinburgh University

Dr Kieran Sweeney

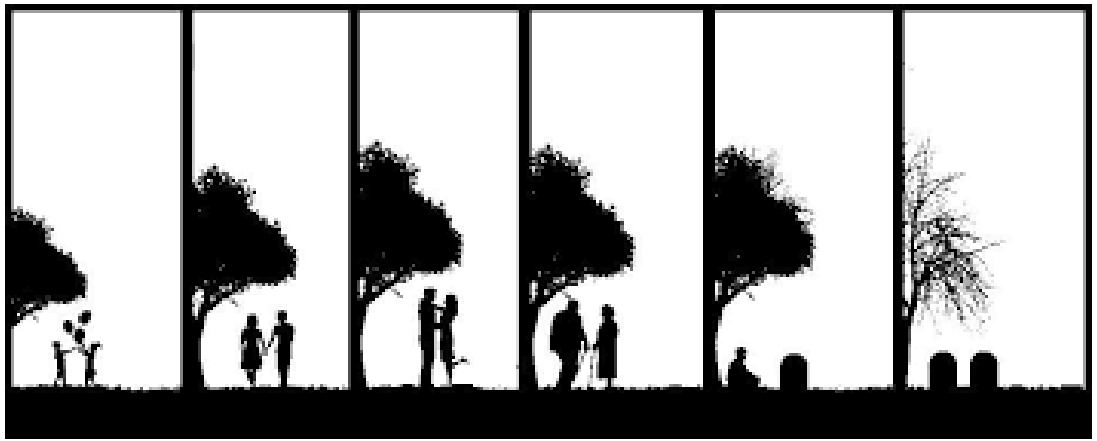
Academic GP, Wellcome PhD Fellow, University of Edinburgh

Continuity of Care:

Evidence base, challenges and opportunities in our modern general practice landscape

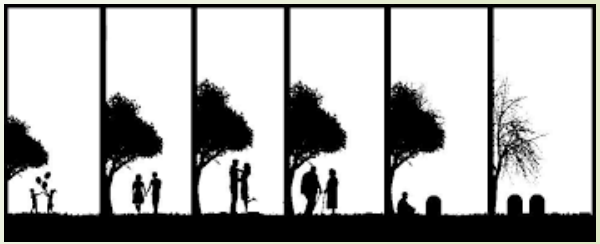
Dr Carey Lunan

Senior Medical Advisor
Scottish Government

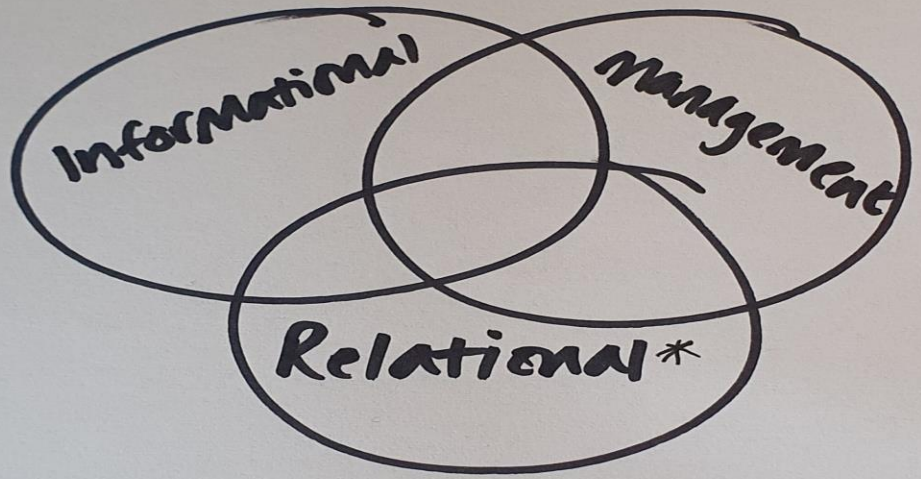


A whistlestop precis of..

- The definitions
- The evidence base
- The current challenges/barriers
- Opportunities/levers for change



Continuity definitions



* relational continuity is not the same thing as relational care

It’s complicated…

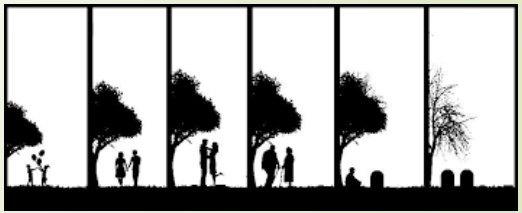
“a paradox of problems in accessing general practice, in which the demand on general practice both creates and hides unmet need in the population. Data show how reactive rules to control demand have undermined important aspects of care, such as continuity. The layers of rules and decreased continuity create extra work for practice staff, clinicians, and patients. Complicated rules, combined with a lack of capacity to reach out or be flexible, leave many patients, including those with complex and/or unrecognised health needs, unable to navigate the system to access care. This relationship between demand and unmet need exacerbates existing health inequities”.

A paradox of problems in accessing general practice: a qualitative participatory case study - PubMed (nih.gov)

The published evidence base? Relational GP*/patient continuity:

- Better patient satisfaction
- Development of trust (impacts on wider system trust)
- Adherence to medical advice and prescribed medication, less waste.
- Uptake of personalised preventive medicine.
- Better quality of care
- Reduction in workload in practices

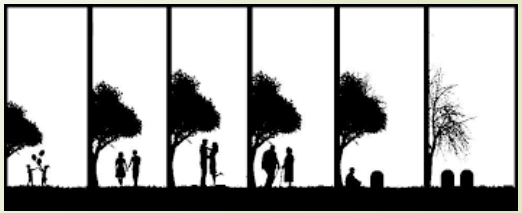
*Likely that many of these impacts would also be shown with GPN/patient continuity



The evidence base (continued)

- Lower rate of attendances at emergency departments
- Fewer admissions to hospital
- Lower costs in whole health systems, less overuse of medical procedures
- Lower death rate in patients
- Reduced complaints and litigation
- Clearer responsibility/accountability
- Better able to address health inequalities

Continuity of care may be the treatment itself.

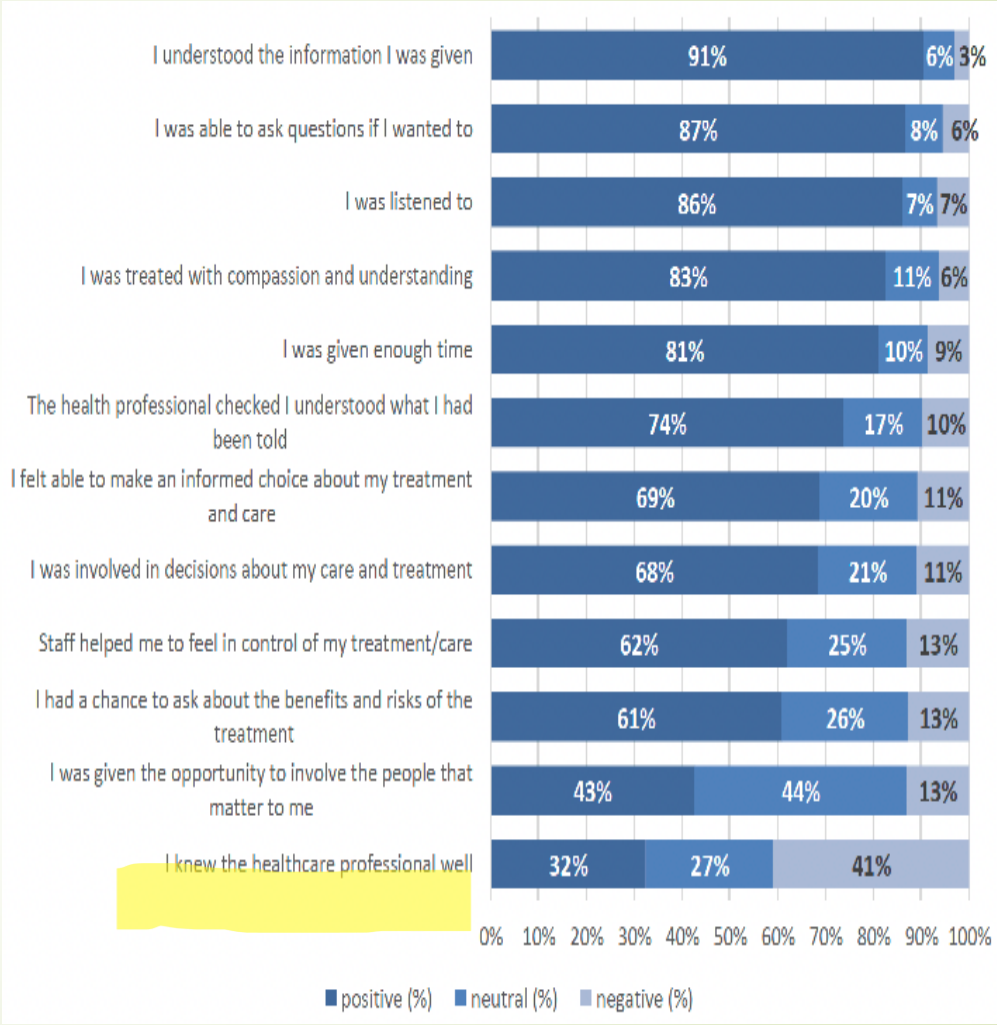



continuity of
care

Compelling evidence, but…

- **Fall** in continuity of care in recent years in UK general practice.

- Scottish HACE survey 2020-2021 specifically asked about relational continuity



Health and Care Experience Survey: results 2019/2020 - gov.scot (www.gov.scot)

- 2024 HACE survey published May 2024
- Relational continuity no longer measured
- Replaced with informational continuity

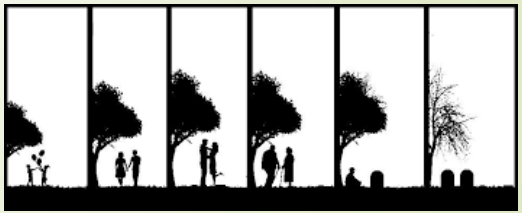
Health and Care Experience Survey 2023/24: National Results - gov.scot (www.gov.scot)

RCGP tracking survey 2023

- Conducted annually in March
- 1855 respondents across UK (9% in Scotland)
- Over three in five (63%) of GPs said that delivering relational continuity of care is the factor that motivates them the most about working in general practice.
- 53% of GPs said they are not able to deliver relational continuity care in the way they want and that would meet their patients' needs.

- Relational continuity has not just fallen in general practice, but across the whole of the NHS

- General practice is not the ‘worst offender; but the impacts are disproportionately greater because of the scale and longevity of patient encounters.

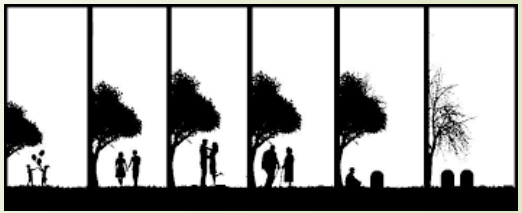


So how do we make the most of the workforces we have, based on the evidence we have, to support relational continuity of care for those who need it the most?

‘proportionate continuity’

Who benefits the most?

- Older
- Frailer
- Multiple morbidities
- Complex long-term conditions
- Mental health and addiction problems
- People living in poverty
- (everyone).



Can it be measured?

- Yes.
- More later..

Current landscape of general practice, and challenges to relational continuity

- Rapidly growing MDT model (almost 5000 new colleagues ☺)
- Declining GPN workforce (although ANP workforce increasing)
- Declining GP workforce (FTE, headcount)
- Rising number of patients registered per GP
- Decline of personal lists systems
- Rise of telephone triage and ‘on the day’ service
- Increase in less-than-full-time in clinical practice
- ‘Emotional labour’ of relational care
- Culture of (speed of) ‘Access is King’ (political, public, ?professional)

Continuity and Access – opposing or complimentary principles?

- Relationship between continuity and access is complex – dependent on factors such as need, demand, capacity and prioritisation
- Maintaining **timely** access is important, but a singular focus on **speed** of access can have unintended consequences for relational continuity
- Access to care is a pre-requisite to be able to provide continuity
- But when relational continuity improves, access also improves
- Perhaps a widening of the definition of 'access' would be useful, so that it is not just about speed, or activity levels, but is about access to relationships.

How can continuity of care be achieved in the modern general practice landscape?

What this means in practices?

INFORMATIONAL CONTINUITY (high quality info transfer)

For all patients. Good record keeping (clarity, accountability, info sharing)

MANAGERIAL CONTINUITY (agreed coordinated plan and accountability)

For patients with more complex conditions. Time to meet, discuss, learn, plan, document

RELATIONAL CONTINUITY (longitudinal care relationships)

High priority cohorts. Named clinicians/buddy systems/microteams for those who most need relational continuity

How can continuity of care be achieved in the modern general practice landscape?

What this means for systems?

TEACH continuity – training, exposure, support for all healthcare professionals

MEASURE continuity – and track improvements

UNDERSTAND what continuity means in an MDT context – research, Demonstrator work

ENGAGE patients and teams in why continuity is important

IMPROVE through existing quality mechanisms eg HIS, Clusters

INNOVATE – use of digital to support the relational

INCENTIVISE through contractual levers

PRIORITISE in NHS Reform plans, CMO workstreams etc

Measuring continuity in general practice

Dr Kieran Sweeney

Key messages

- To improve continuity, we need to be able to measure and monitor it

- There are two simple techniques to measure continuity using data from practice records: SLICC and UPC

- Continuity measures are becoming integrated on regional and national dashboards, but practice level measurements may provide more detail

UPC

For patients who consulted 3 or more times in the past year, what proportion of their consultations were with their most-seen doctor?

UPC

- List of all patients with 3+ consultations
- Looking back 12 months
- What was the count for each doc at the practice?

Patient ID	Dr Jones	Dr Smith	Dr Sethi	Dr Booth	Total	UPC
1……	3	0	1	1	5	3/5 = 60%
2……	0	4	1	1	6	4/6 = 66%
3……	1	2	1	1	5	2/5 = 40%
4……	…	…	…	…	…	…
5……	…	…	…	…	…	…
6……	…	…	…	…	…	…
					UPC score	52%

SLICC

What proportion of all consultations in the past month were with the patient’s named doctor?

SLICC

- List of all consultations in 1 month
- Who was it with?
- Who was usual doc?

List of consultations in past month	Consultation type	Doctor consulting	Usual doctor	Match?
1……	Routine FTF	Dr Jones	Dr Jones	**Yes**
2……	Urgent phone	Dr Jones	Dr Smith	**No**
3……	Routine phone	Dr Smith	Dr Sethi	**No**
4……	Routine phone	Dr Sethi	Dr Sethi	**Yes**
……	……	……	……	……
……	……	……	……	……
			SLICC score	**50%**

SLICC vs UPC

SLICC

- monthly – quick to reflect change
- but requires a personal list system

UPC

- 12-month look-back – slow to reflect change
- doesn't require personal lists

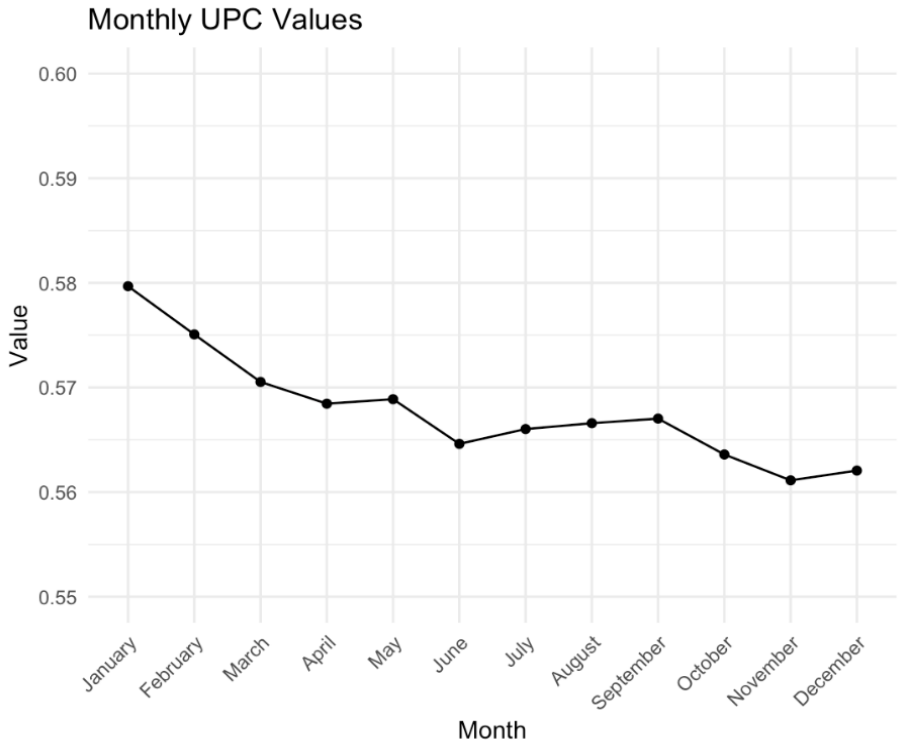
- 'Adjusted-SLICC'..?
- What is a good score?

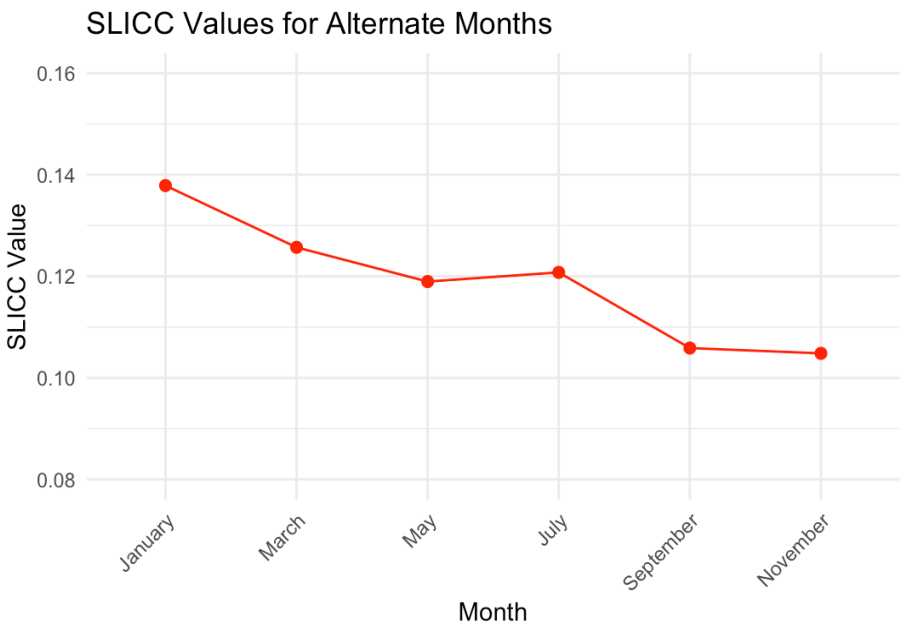
Measurement support

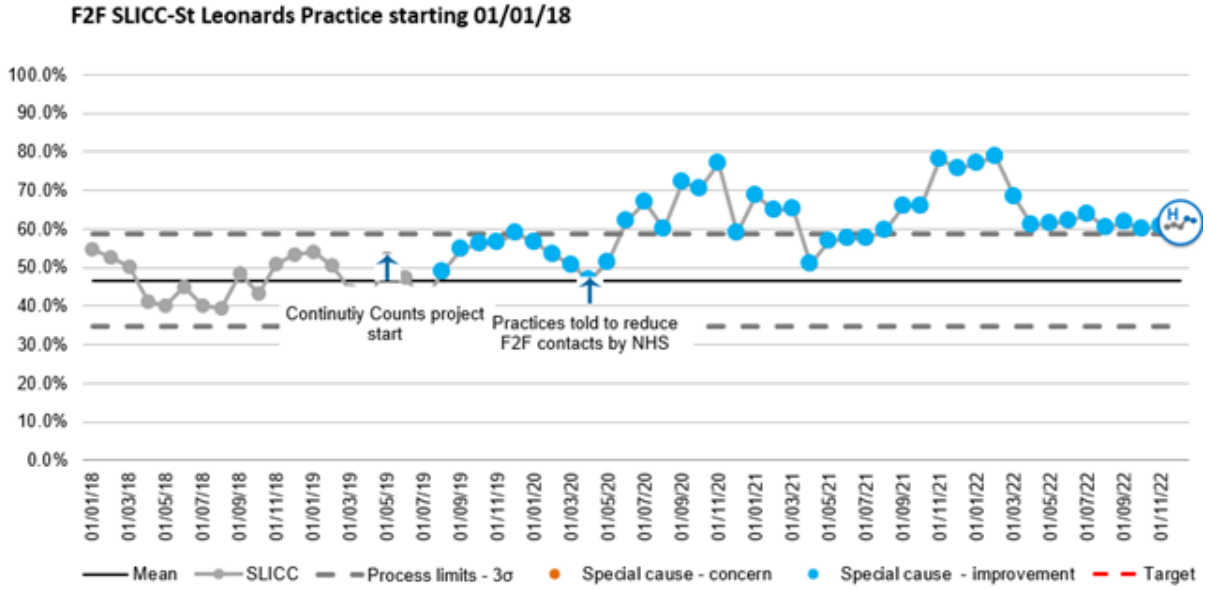
- EMIS searches and user guides
- RCGP toolkit
- Regional and national dashboards

kieran.sweeney@nhs.scot

Sofa session – challenges and opportunities


Monthly UPC Values
0.60
0.59
0.58
0.57
0.56
0.55
Value
January
February
March
April
May
June
July
August
September
October
November
December
Month


SLICC Values for Alternate Months
0.16
0.14
0.12
0.10
0.08
SLICC Value
January
March
May
July
September
November
Month


F2F SLICC-St Leonards Practice starting 01/01/18
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Continutiy Counts project start
Practices told to reduce F2F contacts by NHS
01/01/18
01/03/18
01/05/18
01/07/18
01/09/18
01/11/18
01/01/19
01/03/19
01/05/19
01/07/19
01/09/19
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01/07/21
01/09/21
01/11/21
01/01/22
01/03/22
01/05/22
01/07/22
01/09/22
01/11/22
Mean
SLICC
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Thank you!

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Healthcare Improvement Scotland

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.ihub.scot