Version: V2.1

Improving Continuity

A Toolkit for GP practices

Compiled by Continuity of Care Project Managers: Julia Martineau and Jo Knight

About the toolkit

Improving Continuity of Care in General Practice

The Health Foundation awarded 5 project sites funding to explore how continuity of care could be improved in General Practice, with the Royal College of General Practitioners as learning partners.

The learning from 2 of those sites (Bristol and South Cumbria practices) is captured in this toolkit. There is no single way to improve continuity nor are 2 GP practices identical. This 6-step toolkit aims to guide practices through an improvement journey to make tailored changes (small or large) to increase continuity of care with their patients.

Improvement tools (collated and shared within the NHSE Quality Service Improvement and Redesign (QSIR) programme) have been tailored for improving continuity of care in this toolkit.

Morecambe Bay Primary Care Collaborative

Dr Hugh Reeve, GP Lead
Jo Knight, Project Lead

onecare

Dr Jake Lee, GP Lead
Julia Martineau, Project Lead

Navigating the toolkit

3 Sections to the toolkit

Throughout the toolkit lookout for hyperlinks, which are there to help you to navigate steps and resources within the toolkit itself. Hyperlinks are blue underlined font, when you hover over them you will see the pointer to the link.

The toolkit is divided into 3 main sections, clicking on the icons below (or on the left hand side of each slide) will take you to the start of the following sections:

6 Steps: The guided approach to improving continuity
(practices usually find they can make an improvement in a 6-month period)

Resources: Helpful tools and editable templates to support the steps.
Download links identified by will take you to our download webpage, with your selected download displayed at the top of your view

GP Practice Stories: Examples of what others have done
Here you will find a link to a number of practices who have shared their story

Should you wish to print a copy of the toolkit, we recommend you only print the 6 steps section (pages 7-25).

Welcome

An Introduction from the GP Leads

"Welcome to the Continuity of Care Resource Toolkit. We hope you'll find the resources useful for your journey to improving continuity of care. These are tried and tested resources, gathered from practices in and around Bristol and Morecambe Bay who took part in The Health Foundation Continuity of Care Programme between 2019 and 2021.

Our thanks go to our practice colleagues for their support. We also thank our patients for their contribution in completing surveys, and developing an online patient leaflet and an animation that you can display on your website or in the waiting room and for their work in creating a guide for a practice's patient participation group to use.

To support staff colleagues, the Tool includes quality improvement tools that can be used to improve continuity of care and help you with any other improvement projects your practice undertakes.

For those practices using EMIS, you may like to try the One Care Usual GP Tool to measure continuity levels both at a practice and at a GP level. For those looking to work as a group or Federation of practices, you may wish to develop a Dashboard like the Morecambe Bay project to measure and monitor continuity.

We wish you every success with your continuity of care journey".

Dr Jacob Lee and Dr Hugh Reeve

Keys to Success

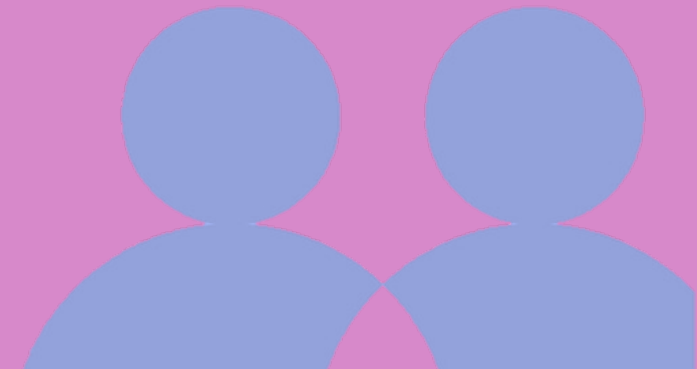
What key elements are needed to improve continuity of care

- Clinical and an operational lead
- A practice culture of Continuity of Care (staff and patients)
- Patient involvement and support
- Tailored approach (this includes starting your journey at the right step for you - use the 6 step tracker)
- Start small and build on success

Think Continuity; It's Safer and Effective

6 Steps

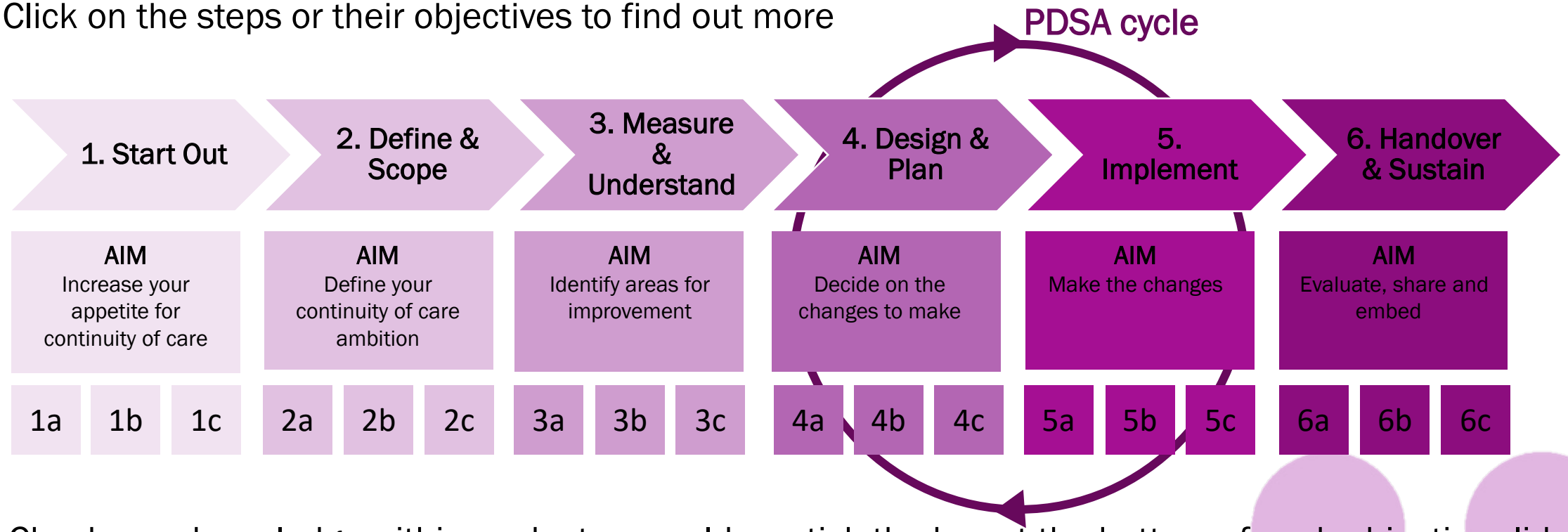
To improving Continuity of Care



Overview

Our approach to improving continuity of care is divided into 6 steps. These 6 steps are from NHSE 6 Stages to Project Management.

Click on the steps or their objectives to find out more



Check your knowledge within each step, could you tick the box at the bottom of each objective slide? If not, work through the questions with the help of the resources.

The one page overview and 6 Steps Tracker resource can help you to know where to start, and help you to keep track of where you are on your improvement journey. The download can be ticked and saved or printed out.

Step 1: Start Out (1 of 3)

Increase your practices appetite for improving continuity of care

1a. Increase understanding of continuity of care and how this fits with the practice vision

Use the questions below to assess current level of understanding:

- What is continuity of care? What are the different types? How does that differ from quality of care?
- Does the practice have a vision (aspirations for the practice)? If not you may wish to create one. How does the continuity of care ambition fit with this?
- Can the practice see clear benefits to increasing continuity of care in their practice for staff and patients?
- How is the practice fulfilling its accountable GP requirements set out in the standard GMS contract? (sections 7.7B and 7.9 in V1.0 December 2020)

Key Resources:

- What is continuity of care
- Types and Approaches
- Creating a practice vision
- Benefits of continuity of care
- Why continuity of care
- Suggested Reading

☑ We understand what continuity of care is and how this sits in our practice

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 1: Start Out (2 of 3)

Increase your practices appetite for improving continuity of care

1b. Understand the practice's current level of continuity of care and generate enthusiasm for continuity of care

Use the questions below to assess current level of understanding:

- What are the general views (of staff and patients) towards continuity of care at the practice?
- Have you got potential champions of continuity of care at the practice both clinical and non-clinical?
- Is there resistance to continuity of care or change?

Key Resources:

- Benefits and barriers activities
- Types and Approaches for improving continuity
- Continuity But…

☑ We understand the practice's current state and enthusiasm for continuity of care

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 1: Start Out (3 of 3)

Increase your practices appetite for improving continuity of care

1c. Explore where you might go with continuity of care

Use the questions below to assess current level of understanding:

- What have others done?
- What is the level of change you wish or have capacity to undertake? What factors influence your readiness for change? What's going on within or impacting on the practice? Are you in the midst of change? What is the practice doing that could dove tail with continuity of care?
- What do you have already that you can build upon? What complements continuity of care or may cause a challenge for your practice? What type of continuity of care would you wish to improve upon? Using the outputs of 1a and 1b.

Key Resources:

- GP Practice Stories
- Exploratory Questions
- Types and Approaches

☑ We understand where the practice may improve continuity of care

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 2: Define & Scope (1 of 3)

Define your practice's Continuity of Care ambition/goal

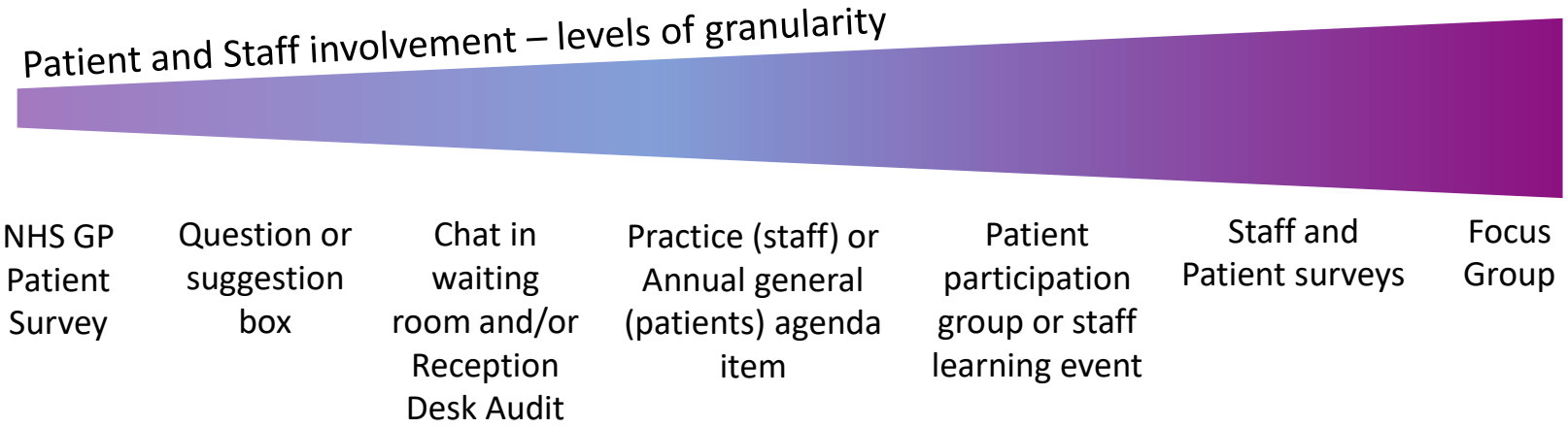
2a. Canvas opinion about the practice and its continuity of care

Use the questions below to assess current level of understanding:

- What do patients say about your practice and its continuity?
- What do staff think about continuity at your practice?

Key Resources:

- Patient and Staff Survey
- Focus Groups
- Waiting Room Chat
- Reception Desk Audit
- NHS GP Patient Survey
- Working with your PPG



☑ We understand what patients and staff believe is important in continuity of care

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 2: Define & Scope (2 of 3)

Define your practice's Continuity of Care ambition/goal

2b. Investigate the data and the processes that may help or hinder continuity of care

Use the questions below to assess current level of understanding:

- What does the demographic data tell you about your practice and potential challenges? e.g. high student, deprivation, older populations
- What is different about the GPs at your practice, who are good at achieving continuity of care?
- What particular cohorts of patients would benefit from continuity of care?
- What does the practice do that encourages/discourages continuity of care? Consider where information about a patient flows and the way GPs work e.g. teams/buddy

Key Resources:

- National GP profiles
- GP differences
- Cohorts that benefit
- Process mapping

☑ We understand what is happening within the practice that helps/hinders continuity of care

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 2: Define & Scope (3 of 3)

Define your practice's Continuity of Care ambition/goal

2c. Gain consensus on what you are aiming for and share

Use the questions below to assess current level of understanding:

- What is the practice continuity of care aim we are starting with? What are your main areas of focus e.g. cohorts of patients, types of continuity, personal list/micro team/buddy approach?
- How will you share the aim and gain agreement? How are you documenting the aim so everyone in the practice understands it e.g. driver diagram? Who needs to sign it off?
- Who is going to lead on delivering this aim? Consider having both a operational and clinical lead and involving staff to represent a whole practice approach

Key Resources:

- Project proposal

☑ We have an aim and agreement to work towards improving continuity of care

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 3: Measure & Understand (1 of 3)

Identify your improvement measures and listen to what the data is telling you now

3a. Understand the measures of continuity care and how to use them

Use the questions below to assess current level of understanding:

- What are recognised measures of continuity of care? UPC, COCi, SLICC
- Which measure will be the best for our practice and our continuity of care aim? Consider the continuity of care types and ways of working options
- Which tool will help our practice measure continuity of care?
- What is our level of continuity of care now?

Key Resources:

- Glossary of Key Measures
- Usual GP Tool

☑ We understand our level of continuity of care and have a way of measuring it again

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 3: Measure & Understand (2 of 3)

Identify your improvement measures and listen to what the data is telling you now

3b. Review all* the data to identify focus areas for improvements

Use the questions below to assess current level of understanding:

- Where do we sit when we benchmark our practice?
- Why do our patients choose continuity of care?
- What are the characteristics of patients with better continuity of care?
- Which of our GPs have better continuity of care?
- Why do some of our GPs have better continuity of care?
- How does the data support/change our aim?

Key Resources:

- Benchmarking your data
- *Results from data collected within steps:
  - 2a
  - 2b
  - 3a

☑ We understand our practice data and we have identified focus areas to achieve our aim

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 3: Measure & Understand (3 of 3)

Identify your improvement measures and listen to what the data is telling you now

3c. Agree relevant measures as a baseline and to continually capture throughout your improvement journey

Use the questions below to assess current level of understanding:

- What measures will we repeat? And when? Qualitative (2a) and quantitative (3a)
- Who will be responsible for capturing the measures and updates?

There may be more measures that you capture as part of Step 4

Key Resources:

- Repeating and Reflecting

☑ We understand what data we will measure now, during and later

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 4: Design & Plan (1 of 3)

Explore your options for continuity and decide on a plan

4a. Identify possible changes to achieve your aim

Use the questions below to assess current level of understanding:

- What have you learnt so far about your practice? Vision, benefits/barriers, opportunities, and data
- What have others done?
- What are all the ideas your practice has to improve continuity of care (all ideas welcome, big, small, innovative, different, random)
- What of the ideas would achieve your aim?

Key Resources:

- Idea Generation
- Practice Stories

☑ We have identified ideas that will achieve our aim

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 4: Design & Plan (2 of 3)

Explore your options for continuity and decide on a plan

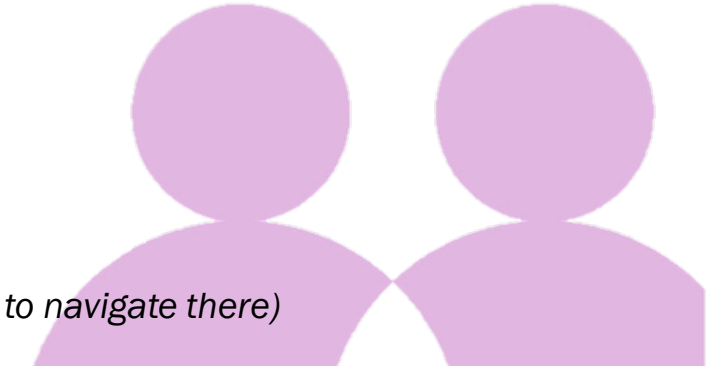
4b. Prioritise the changes and identify where to start

Use the questions below to assess current level of understanding:

- What level of potential impact will the changes have?
- How easy will the changes be to implement? Enthusiasm, cost, speed of implementation, skills/resources, willing volunteers
- What ideas could be made easier to achieve? Could ideas be more achievable if you prioritised certain cohorts
- What ideas will you take forward and in what order?

Key Resources:

- Ideas Sorting Grid
- Resources to Support Change
- Communication Materials



☑ We know which change/s we are starting with

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

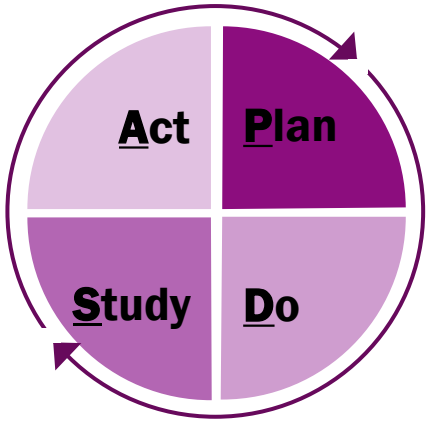
Step 4: Design & Plan (3 of 3)

Explore your options for continuity and decide on a plan

4c. Design and share the practice plan for the change/s (PDSA: Plan)

Use the questions below to assess current level of understanding:

- What is the overall plan for the change ideas being taken forward, include owners and timeline
- Identify ideas that you need to take forward as a PDSA (Plan, Do, Study, Act)
- Identify ideas which can be implemented without a PDSA, use Step 5 questions to assess progress and impact



Key Resources:

- Planning
- PDSA

"**PDSA cycles** enable you to test out changes on a small scale, building on the learning from each cycle in a structured way before wholesale implementation. It gives stakeholders the opportunity to see if the proposed change will succeed . It is a powerful tool for learning from ideas that do and don't work. This way, the process of change is safer and less disruptive for patients and staff". QSIR

☑ We have a plan of action for our change/s

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 5: Implement (1 of 3)

Implement your planned changes, study the change and act on the results

5a. Test the changes in the plan in the order decided (PDSA: Do)

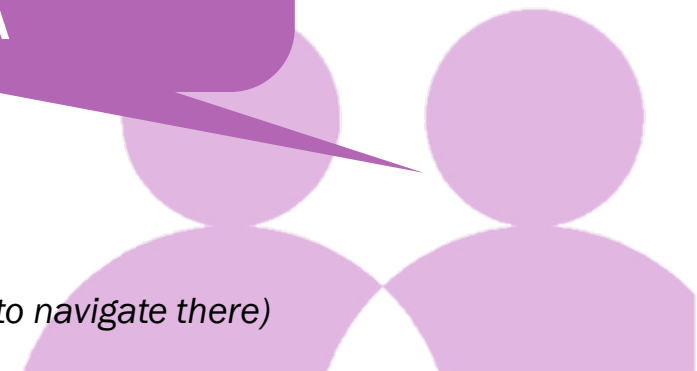
Use the questions below to assess current level of understanding:

- What is happening, is it on track?
- What is being collected (recorded or observed)?
- What is the data starting to show?

Key Resources:

- PDSA

Step 5a is all about implementing your change - the 'Do' of PDSA



☑ We have made a change and recorded the results

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 5: Implement (2 of 3)

Implement your planned changes, study the change and act on the results

5b. Reflect on what happens at each change and its contribution to your aim/goal and its measures (PDSA: Study)

Use the questions below to assess current level of understanding:

- What actually happened? Did the plan go as planned?
- What did the data show?
- How does it compare to the prediction? Was it a positive or negative impact?
- What was learned? What went well and didn't go so well?

Key Resources:

- PDSA

☑ We know if the change was an improvement

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 5: Implement (3 of 3)

Implement your planned changes, study the change and act on the results

5c. Decide to tweak, scrap or embed each change (PDSA: Act)

Use the questions below to assess current level of understanding:

- It worked well, How do we scale up and/embed? - Move to Step 6
- It worked but needs some changes, What modification are needed? Return to 4c
- It didn't work and it needs to stop? Why didn't it work? - Pick another change identified in 4b
- Are we ready to move to another PDSA? - Pick another change identified in 4b

Key Resources:

- PDSA

☑ We have made a decision on how to respond to the PDSA outcome

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 6: Handover & Sustain (1 of 3)

Evaluate and share improvements you have made and embed the changes

6a. Reflect on your improvement journey

Use the questions below to assess current level of understanding:

- What do your before and after quantitative measures tell you?
- What do your staff and patients think now?
- What did you learn along the way?
- What would you do differently with hindsight?
- What further improvements do you wish to make?

Key Resources:

- Repeating and Reflecting
- After Action Review

☑ We know the difference our changes have made and what we have learned

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 6: Handover & Sustain (2 of 3)

Evaluate and share improvements you have made and embed the changes

6b. Ensure the good work is not undone, continued and built upon

Use the questions below to assess current level of understanding:

- How have the processes that have been changed been embedded? e.g. staff induction/training/procedures
- How will you continue to listen to staff and patients? Consider how they communicate suggestions and share their experiences
- How will you continue to monitor continuity of care data?
- What could further challenge continuity of care and how will you respond? Assess potential future risks e.g. practice merger
- How will you continue to beat the drum of continuity of care? Reflect on 6a's further improvements. Watch out for new research and share.

Key Resources:

- Sustainability Model

☑ We have built continuity into business as usual

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Step 6: Handover & Sustain (3 of 3)

Evaluate and share improvements you have made and embed the changes

6c. Share your learning/achievements with others

Use the questions below to assess current level of understanding:

- What were your main achievements?
- What and how will you share within your team and your practice?
- What and how will you share with your patients?
- What and how will you share in your local area? e.g. other practices/PCN
- What and how will you share more widely? e.g. newsletters, press releases, social media ideas

Key Resources:

- Pixar Framework
- Press Release Key Components
- Practice Story Key Components

☑ We have shared our achievements and are connected into the continuity of care community

Remember to look at the matrix of resources for more ideas/further help (use the tool icon on the left, to navigate there)

Resources

Useful tools and templates

Resource Contents

Resources within the toolkit by step (stating available downloads)

All Steps: Overview

All	6 Steps Tracker (6 Steps Tracker pdf you can tick and save)
All	Glossary of Key Terms

Step 1: Start Out

1a	What is Continuity of Care
1	Types and Approaches (Micro-team guide)
1a	Creating a Practice Vision
1a	Benefits of Continuity of Care
1a	Why Continuity
1a	Suggested Reading (reading documents)
1b	Continuity But (Concerns to Continuity Answered)
1b	Benefits and Barriers Activities
1b	Sticky Notes
1b	Fishbone (blank template)
1b	Benefits Diamond 9 Activity (templates and explanation of benefits)
1c	Exploratory Questions

Step 2: Define & Scope

2a	Patient and Staff Surveys (printable, online set up and analysis)
2a	Focus Groups (questions, patient information and analysis)
2a	Waiting Room Chat (script and template)
2a	Reception Desk Audit (audit)
2a	NHS GP Patient Survey
2a	Working with your PPG (guide and presentation)
2b	National Profiles
2b	GP Differences
2b	Cohorts that Benefit (Frequent Attenders, Power of 3 resource)
2b	Process Mapping (guide and electronic template)
2c	Project Proposal (template)
2c	Pixar Framework (examples)
2c	Continuity Driver Diagram

Step 3: Measure & Understand

3a	Glossary of Key Measures (Measures explained)
3a	Usual GP Tool (Tool and guide)
3b	Benchmarking Your Data
3c	Repeating and Reflecting

Step 4: Design & Plan

4a	Idea Generation (6 thinking hats)
4b	Ideas Sorting Grid
4b	Resources to Support Change
4b	Communication Materials (video, leaflet, social media ideas)
4c	PDSA (recording template
4c	Planning (template)

Step 5: Implement

5	PDSA (recording template)

Step 6: Handover & Sustain

6a	Repeating and Reflecting
6a	After Action Review (ground rules)
6b	Sustainability Model
6c	Pixar Framework (examples)
6c	Press Release; Key Components
6c	Practice story; Key Components

Links to:

6 Steps Tracker

6 Steps Tracker
(Download a pdf version you can tick and save)

Check off your progress against the statements within each step

PDSA cycle

1. Start Out	2. Define & Scope	3. Measure & Understand	4. Design & Plan	5. Implement	6. Handover & Sustain
AIM Increase your appetite for continuity of care	**AIM** Define your continuity of care ambition	**AIM** Identify areas for improvement	**AIM** Decide on the changes to make	**AIM** Make the changes	**AIM** Evaluate, share and embed
☐ 1a. We understand what continuity of care is and how this sits in our practice	☐ 2a. We understand what patients and staff believe is important in continuity of care	☐ 3a. We understand our level of continuity of care and have a way of measuring it again	☐ 4a. We have identified ideas that will achieve our aim	☐ 5a. We have made a change and recorded the results PDSA	☐ 6a. We know the difference our changes have made and what we have learned
☐ 1b. We understand the practice's current state and enthusiasm for continuity of care	☐ 2b. We understand what is happening within the practice that helps/hinders continuity of care	☐ 3b. We understand our practice data and we have identified focus areas to achieve our aim	☐ 4b. We know which change/s we are starting with	☐ 5b. We know if the change was an improvement PDSA	☐ 6b. We have built continuity into business as usual
☐ 1c. We understand where the practice may improve continuity of care	☐ 2c. We have an aim and agreement to work towards improving continuity of care	☐ 3c. We understand what data we will measure now, during and later	☐ 4c. We have a plan of action for our change/s PDSA	☐ 5c. We have made a decision on how to respond to the PDSA outcome PDSA	☑ 6c. We have shared our achievements and are connected into the continuity of care community

Statements within the Plan Do Study Act (PDSA) cycle will need to be repeated for each change

Links to:

1a

What is Continuity of Care

Aim: Brief information of continuity of care and its importance

What is Continuity of Care?

It is when the patient sees the same GP (or members of a clinical team) repeatedly over time. Good quality care improves health outcomes and continuity of care is a crucial component of quality of care. General Practice is uniquely placed to provide continuity of care.

Seeing a clinician that you know and trust – who knows and cares about you
Kevin Haggerty, GP Weston Super Mare

Why does Continuity of Care Matter?

- Patients don't need to repeat their story
- Patients are more satisfied and more likely to have a good relationship with their GP
- Patients are less likely to go to A&E or be admitted to hospital
- Patients are more likely to follow advice and take positive steps to look after their health
- Patients are more likely to receive good quality of care
- Evidence shows consultations are more efficient, safer and more satisfying for patient and clinician

I find it reassuring to know that a GP has an overview of my healthcare
David Shelton, Patient, The Family Practice

Is Continuity of Care Suitable for Everyone?

It is not essential for every single problem, particularly urgent ones, but if patients see their usual GP on 50% of occasions, and a GP is responsible for the patient 100% of the time, and the patient knows which GP is ultimately responsible for their care, both patient and GP will reap the benefits of continuity of care.

Links to:
1a
1b
1c

Types and Approaches

Aim: To support the practice in deciding their approach

Types of Continuity of Care

Relational

- Building good patient-professional relationships that benefit both the patient and the professional

Episodic

- GP/team provide continuity of care during an episode of ill health

Informational

- Good record keeping and information to help others to understand the patient and their conditions

Managerial

- Co-ordinating a patient's care especially when a team of/many professionals are involved

Decide on your approach for Improving Continuity of Care

Patients	Workforce
All Whole practice approach to continuity	**GP** One GP with overall responsible for a patient
OR	**OR**
Cohort/s Groups of patients who would most benefit from continuity Cohorts that benefit	**Micro-Team** GP and Buddy/ies OR multi-disciplinary team Micro-team guide

Links to:

1a

Creating a Practice Vision

Aim: Develop a practice vision to align continuity with

The vision needs to be clear so everyone can understand it. The more people involved in creating it, the more people will feel they have ownership of it. Be inspiring and use emotive language to demonstrate the vision. The vision should be a compelling vision of the future but the vision will not achieve itself.

Effective visions have 6 key characteristics:

- **Imaginable:** They convey a clear picture of what the future will look like.
- **Desirable:** They appeal to the long-term interest of those who have a stake in the enterprise.
- **Feasible:** They contain realistic and attainable goals.
- **Focused:** They are clear enough to provide guidance in decision making.
- **Flexible:** They allow individual initiative and alternative responses in light of changing conditions.
- **Communicable:** They are easy to communicate and can be explained quickly.

Source: QSIR Tool Creating a Vision

How to create a vision:

1. **OUTCOMES** Describe what you are going to achieve
2. **DOING & BEING** What are people and organisations doing and how are they behaving differently in the future
3. **HOW WILL IT FEEL** Use words and picture to express how it will feel to be in this new future
4. **BRING IT TO LIFE** Communicate the vision so it has meaning to others
5. **GUIDING VALUES** What values will this new future hold AND use to guide us on the journey

> Vision without action is merely a dream. Action without vision just passes the time. Vision with action can change the world.
> Joel A. Barker

Links to:

1a

Benefits of Continuity of Care

Aim: Overview of the evidenced benefits of continuity of care

When they receive continuity of doctor care, patients:	
Are more satisfied	Baker and Streatfield (1995) Baker et al (2003) Adler et al (2010)
Are more likely to follow medical advice (adherence)	Warren et al (2015) Chen et al (2013)
Are more likely to take up offers of personal preventive medicine	O'Malley et al (1997) Christiakis et al (2003)
Are more likely to have a good doctor patient relationship with their GP	Mainous et al (2001) Ridd et al (2011)
Are more likely to receive good quality of care	O'Connor et al (1998) Romano and Segal (2015)
Are less likely to need to go to A&E	Brousseau et al (2004) Van den Berg et al (2016)
Are less likely to need a hospital admission, particularly for ambulatory care sensitive conditions	Barker et al (2017) Bankart et al (2011)
Are likely to live longer	Maarsingh et al (2016) Pereira Gray et al (2018)
Have more cost effective healthcare (including meaning funding available for other things)	Starfield (1994) Weiss and Blustein (1996)

When continuity of doctor care is provided, doctors:	
Have an 'accumulated knowledge' about the patient. Doctors use such accumulated knowledge both for diagnosis and to tailor their advice.	Hjortdahl & Borchgrevink (1991) Hjortdahl (1992) Ridd et al (2011)
Report that continuity enables them to provide a 'higher-quality' care. GPs are then rewarded with more professional satisfaction through doing a better job.	Ridd, Shaw, & Salisbury (2006)
Have improved problem recognition and quality of management for long term conditions	Saultz and Lochner (2005) Drivsholm and de Fine Olivarius (2006)
Have reduced conflicts of responsibility , particularly reducing the 'collusion of anonymity' where succession of clinicians only deal with what is immediately most pressing	Freeman and Hughes (2010)
Contribute to the reduced the use of specialist care, A&E, emergency admissions and outpatient appointments	Hansen et al (2013) Katz et al (2015)
Reduce costs e.g. prescriptions and tests	Weiss and Blustein (1996) Saultz and Lochner (2005)
Reduce cases of avoidable significant harm	Avery et al (2020)

A good introduction to continuity is shared by Sir Denis Pereira Gray in the Improving Continuity: The Clinical Challenge (2016)

Links to:

1a

Why Continuity

Infographic on what happens when there is continuity of care

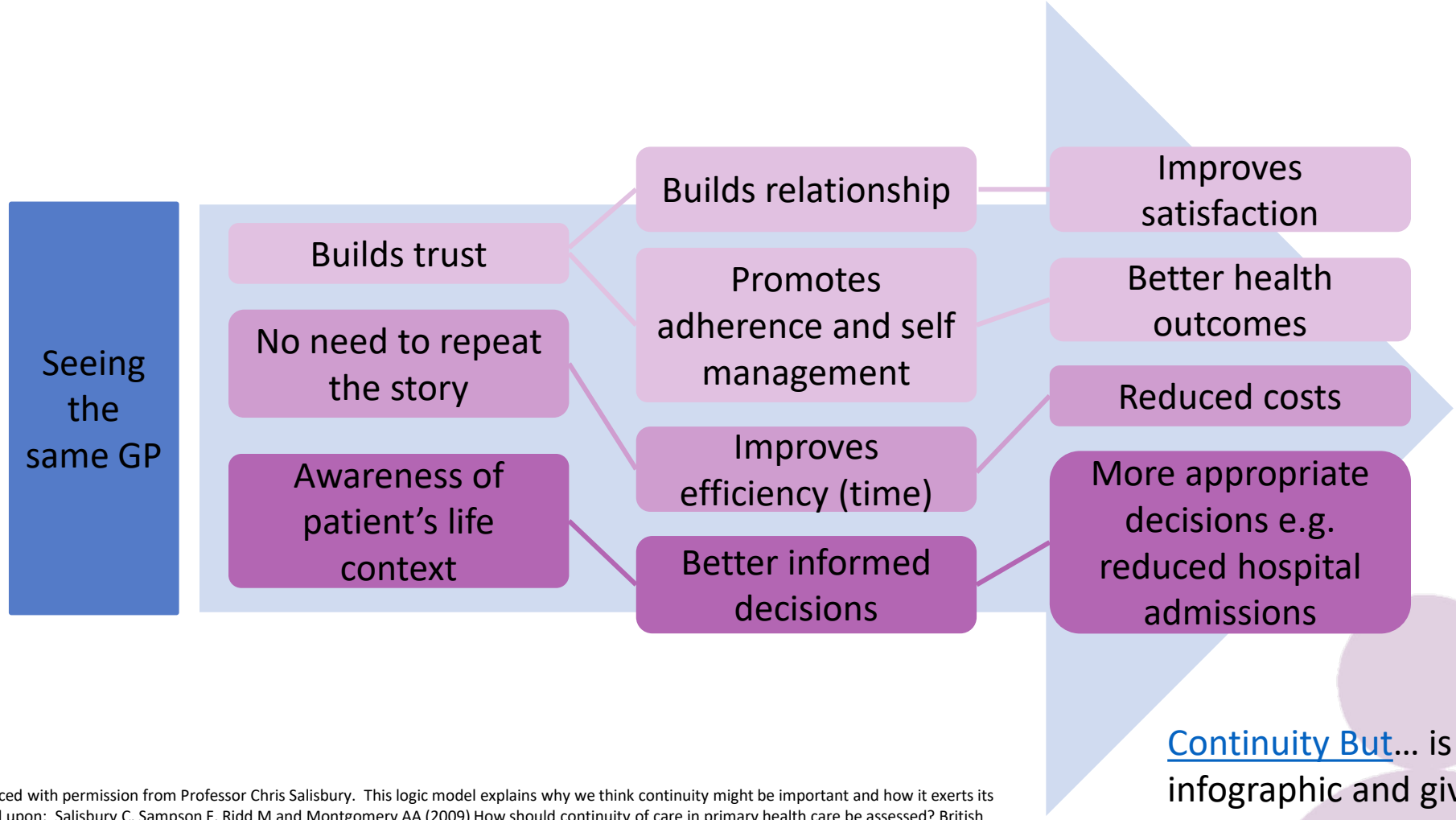


Image reproduced with permission from Professor Chris Salisbury. This logic model explains why we think continuity might be important and how it exerts its effects is based upon: Salisbury C, Sampson F, Ridd M and Montgomery AA (2009) How should continuity of care in primary health care be assessed? British Journal of General Practice 59 (561): 134-141. Available from: https://bjgp.org/content/59/561/e134

Continuity But... is based on this infographic and gives you some suggested responses to questions

Links to:

1a

Suggested Reading

Aim: Introduction to Continuity of Care

Continuity of care and the patient experience by The Kings Fund (2010)
It explores why continuity is important in general practice, and what it looks like from both patient and staff perspectives.

Improving access and continuity in general practice by The Nuffield Trust (2018)
A research summary covering practice and policy lessons. Rebecca Rosen, co-author, led on the Valentine Project and their resources are shared within this Toolkit.

Improving continuity: THE clinical challenge by InnovAiT (2016)
Great introduction for practices, uses summary tables on key points by Prof Sir Denis Pereira Gray. Sir Denis led the St Leonard's project and their resources are included in this Toolkit.

Guidelines for continuity of care by RCGP (2019)
The precursor to this Toolkit, it provides a good overview on improving continuity in general practice.

Continuity Suggested Reading

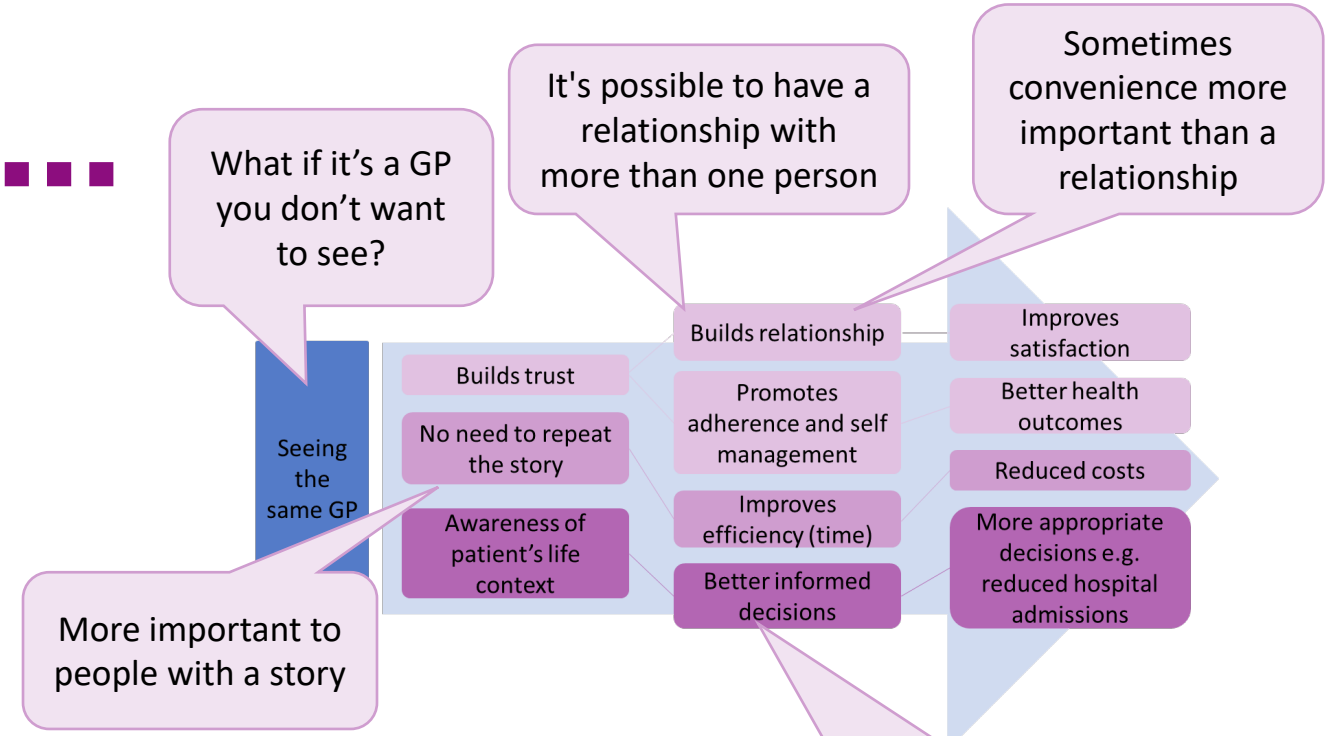
Links to:

1b

Continuity But...

Aim: Responses to barriers

Based on the Why Continuity infographic



Barrier	Response
What if it's a GP you don't want to see?	Patients can choose the GP they wish to see, providing the GP has capacity. As a practice you can change the field that holds Usual GP name to reflect this.
More important to people with a story	Everyone has a story, continuity of care is building up a picture of the patient and establishing trust with your GP.
It's possible to have a relationship with more than one person	Yes it is, many practices share the care of their patients with colleagues either in Buddying to cover leave or Micro-teams when other professionals are involved.
Sometimes convenience more important than a relationship	Yes, if the condition is acute patients may need to see a GP sooner than they can see the GP they have continuity with, good informational continuity is important to support this.
Why does seeing the same GP lead to better informed decisions?	Continuity of care enables a GP to be responsible for a patient, rather than a patient circling around a number of GPs dealing with what is presented rather than the whole story.

Concerns to Continuity Answered

Links to:

1b

Benefits and Barriers Activities

Aim: Capture current thinking of continuity of care within the practice

The suggested activities below will help to generate discussion and a steer of where to go next, use as many as you like depending what you are trying to capture. Listen for resistance.

Activity	Why would you use this activity?	How would you use this activity?
Sticky Notes	Very simple activity that enables quieter participants to have a voice with no direct personal challenge to suggestion/opinion. The activity will give you an insight into the participants views, when grouped under headings you can see where to focus attention e.g. for barriers focus on the biggest group of views	• Ask a question e.g. What are the benefits to continuity; what are the barriers to continuity; How does our practice help/encourage continuity (who drives continuity); What prevents/hinders continuity at our practice. • Ask everyone to write their answers on separate sticky notes and put in a central place. • The facilitator puts into groupings with participant input for all to see.
Benefits Diamond 9	This activity identifies which continuity of care benefits are of most value to the participants. It also asks for ideas on what the practice could do to encourage and facilitate continuity of care	• Instructions on the Diamond 9 resource.
Fishbone	Is a visual way to look at cause and affect.	• At the head of the fish state your problem e.g. Continuity is difficult to achieve/establish and maintain. • Then think of the causes for your practice (using sticky notes gives flexibility to move ideas around), like those on the example fishbone. You might find it useful to ask the *5 whys.*

Links to:

1b

Sticky Notes

Aim: Capture benefits or barriers to continuity of care/its improvement

RECEPTION	Patient doesn't know their usual GP – *Remind them*	Patient already has a favourite GP – *Ensure that's the GP in the Usual GP Field*	Patient wants to be seen quickly – *Patient education on benefits of waiting to see usual GP but it is patient choice*	Patient happy to see any GP – *assign the GP who has seen the patient most recently*
GPs	We have mostly part time GPs – *micro-teams likely to be way forward*	GPs have holidays – *not aiming for 100% cover, identify key patients and do handover*	We use locums – *the response depends on level of locum cover e.g. micro-team approach*	GPs don't have time – *evidence shows continuity saves time*
PATIENT	Don't have time to explain it to the patient – *can provide patient leaflet and script*	Patients needs urgent slot – *assuming it is urgent*, then *urgency trumps continuity*	Patients don't want to wait and may complain – *patient education*	We just had care navigator training – *having checked with Trainer it will fit with current process*
OTHER	Can't correct all the patient records, there's too many – *we can break it down into manageable chunks*	Checking usual GP is time consuming (patients ask if they want to see a particular GP) – *is there an explicit check or is this left to chance*	We haven't got time to check and maintain – *there are workflow efficiencies that come with CoC process*	

Example using the question:
"What is stopping you?"

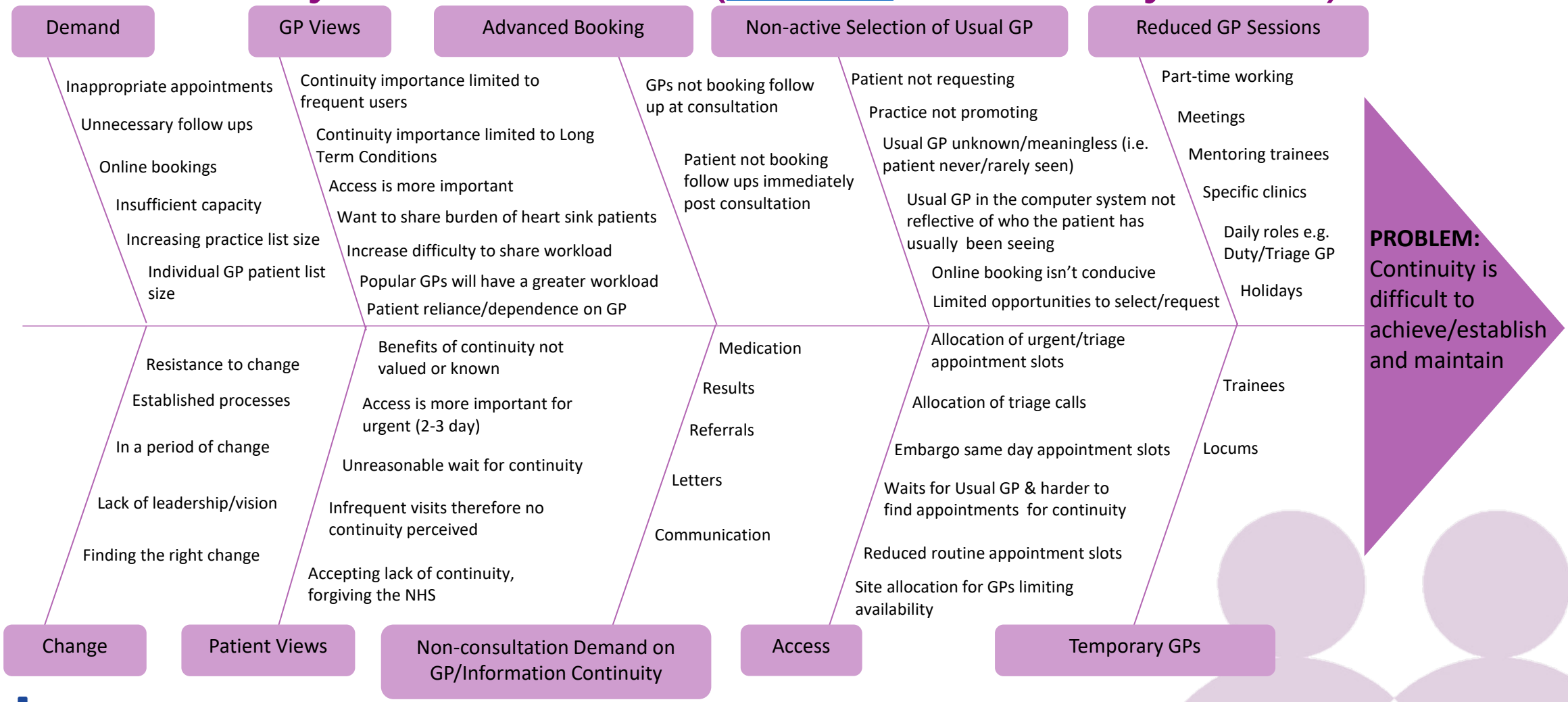
6

Links to:

1b

Fishbone

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



Fishbone Diagram (blank template)

Links to:

1b

Benefits Diamond 9 Activity

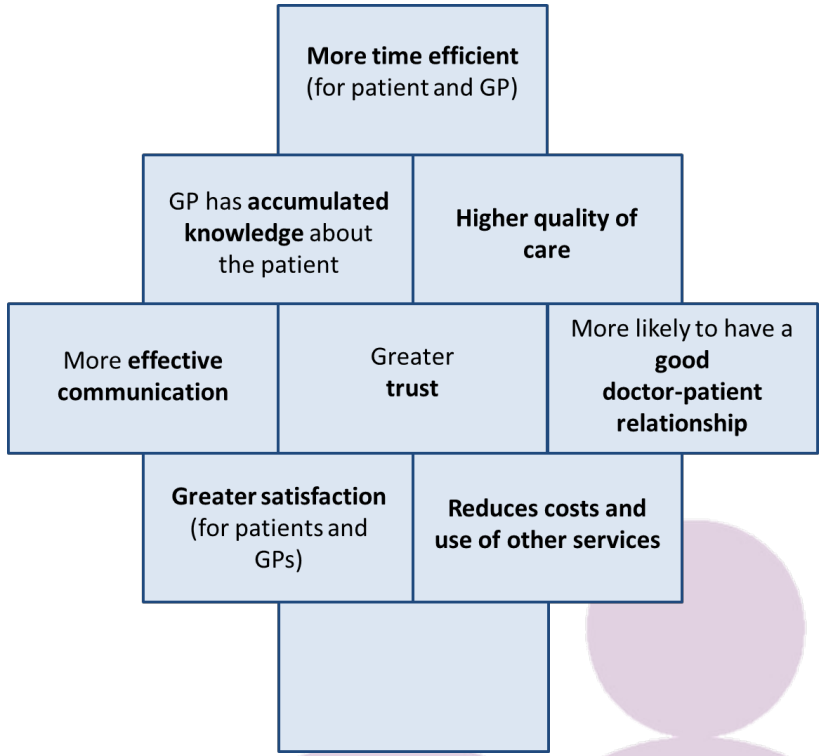
Aim: Benefits activity to generate discussion and engagement

The diamond 9 activity is an interactive activity for staff, to increase their understanding of the benefits of continuity of care and help identify opportunities to improve continuity of care.

Set up: Divide the practice team into groups (2-6 people) with a set of 9 cards/sticky notes with 8 different benefits written on them and 1 left blank.

Instructions:

1. Ask each group to order the benefits of continuity in the order of their importance – the top position is the most important. There is no right or wrong order, there will be debate and discussion and this should be encouraged as this is the main purpose of the activity. There is a blank card for the group to add a benefit they feel is missing. Start by placing one benefit on the diamond template, it can be moved as the discussion develops.
2. At the end the group should be able to identify their top 3 and why, share their benefit (the one they filled in) and why; and share any benefits that caused more discussion i.e. benefits they disagreed with or didn't understand how it could be a benefit.
3. Ask each individual to consider how the practice could encourage and facilitate continuity of care. They could discuss in pairs e.g. clinical and non-clinical pairings and share with the team. Recording ideas for all to see what we could be doing differently, including challenges and quick wins.
4. Use the information to identify potential changes/improvement that can be set out in your project proposal and be considerations when you start planning.



Benefits Diamond 9 Activity
(templates and explanation on benefits)

Links to:

1c

Exploratory Questions

Aim: Finding out what might impact on your continuity journey

Questions you might ask	Points to consider
Has there recently been or is there a practice merger planned?	Significant changes may impact on continuity including opportunities for continuity but also factors like staff change fatigue.
What is the patient population of the practice and is it multi-site?	The larger the practice, the relevant field on the computer system will be updated opportunistically e.g. when the patient attends an appointment.
Is this a multi-site practice?	Is there a central reception function. Do GPs rotate across sites? Do patients have appointments across sites?
How stable is the GP team?	Patients from larger practices (equivalent to 7 full time GPs) are on average less likely to see the same GP. If the practice has a high use of locums, this will impact on continuity.
What is the range of GP sessions?	If the majority of GPs work less than 6 sessions per week, a micro-team or GP and Buddy approach may be the solution.
Does the practice use 'personal lists' and maintain an accurate 'usual GP' field on EMIS?	Practices with good levels of continuity usually work to personal lists and have accurate 'usual GP' field.
What is the patient churn?	How long patients stay at a practice will affect continuity. For example, continuity for a student population.
How do patients book appointments and which appointments?	The booking process is key to continuity. Does your process direct patients to their usual GP e.g. reception staff check or use of tool such as Ask My GP.
How long are your appointments?	Varying appointments length may be useful in providing continuity for more complex patients.
What is the average waiting time for an appointment?	Long waiting times often means patients will see the next available GP rather than wait to see usual GP. Talking with patients in the waiting room will give a good indication of how long patients would wait to see their preferred GP.
Is there a multi-disciplinary team in place e.g. pharmacists, physiotherapist, social prescriber working out of the practice	If patients are shared across a team, think how the team as a unit is able to provide continuity e.g. the patient sees the same physiotherapist.
Is this a training practice?	The way patients book to see a trainee GP will impact on continuity for example are appointments booked under a named GP.
Does the practice have a highly functioning Patient Group?	The Patient Group can offer insights and support on how to improve continuity.

Links to:

2a

Patient and Staff Surveys

Aim: Understand opinion about the practice and its continuity of care

The continuity surveys help you to canvas opinion from patients and staff about the practice and its continuity of care. The survey results will give you an indication of the level of continuity experienced and how important continuity is perceived to be. The surveys are useful to repeat and reflect for a before and after assessment; can help you to identify areas to improve upon; indicate appetite for change.

	Patients	Staff
Purpose	To gather information on patients reported levels of continuity; its importance to them; their views on the benefits of continuity, their practice and its promotion of continuity, in order to inform and measure impact of any change. It can also be used to recruit to focus groups.	To gather staff views on their understanding and opinions on continuity for both the practice and its patients. It also includes current levels of workload, job satisfaction, team culture and awareness of the project/improvement. To inform and measure impact of any change, and reflect if these factors impact on the extent of change
Methods of collection	• Online • Paper	• Online • Paper
Support for understanding	• The types of patients who want continuity and their current levels • Relationship between continuity and overall satisfaction with their GP practice • Indication of barriers to improve continuity	• The importance of continuity for patients and the practice • Understanding the perceived advantages and disadvantages
Before and after comparison	• Improvement in reported levels of continuity • Change in views of the importance and benefits of continuity • Increase in promotion of continuity • Increase in overall satisfaction with the GP practice	• Increase in job satisfaction • Change in team culture and workload

Patient Survey (paper and online set up) and Analysis Template

Staff Survey (paper and online set up) and Analysis Template

Links to:

2a

Focus Groups

Aim: Understand patient views on continuity of care in more detail

A focus group is a small group of 8-10 patients who come together to discuss a topic (in this case Continuity of Care) in more detail sharing their experiences and the story behind answers that would be gathered from a questionnaire/survey. Patient words/stories are an insight into behaviours and are a powerful tool in shaping your improvement journey and bring practice staff and patients with you.

Recruitment:

You can recruit patients from advertising the group at the practice, through practice social media/website or via your PPG and asking for volunteers. f you are using the Patient Survey patients can voluntarily offer to participate further providing contact details, this method was most successful in Morecambe Bay. Aim to over recruit to 12, as patients may be unable to attend on the day.

The session & its results:

1 hour focus groups can be run face-to-face or virtually and it is advised these are recorded via video/audio device for the purpose of compiling the themes and quotes anonymously. The following downloadable resources will support you to run and analyse a continuity of care focus group:

6

Continuity Focus Groups (Questions, Patient Information and Analysis Templates)

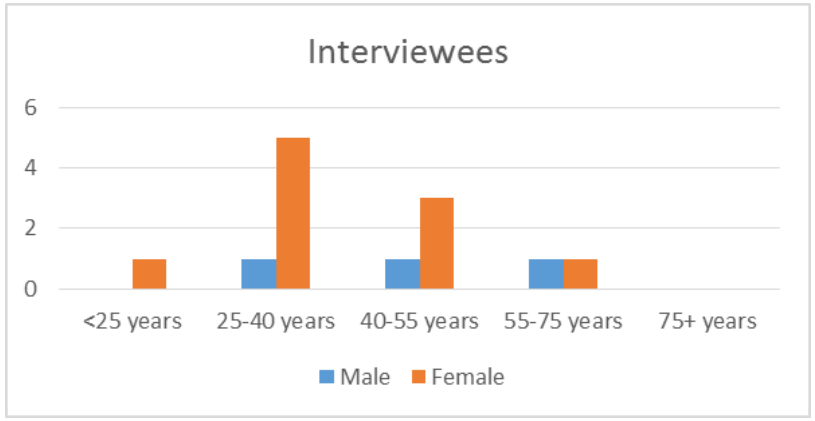
Links to:

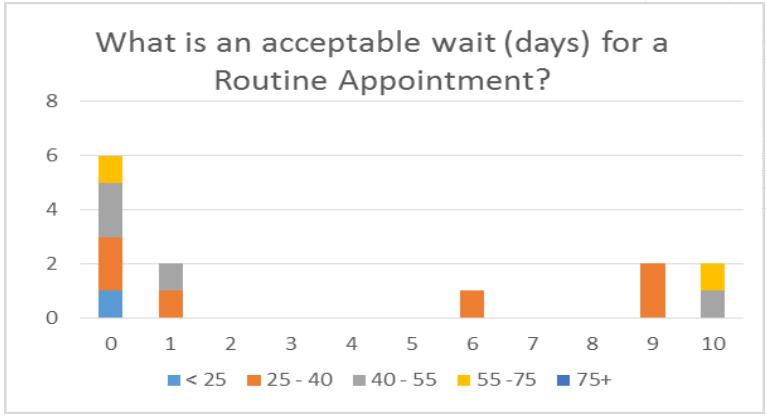
2a

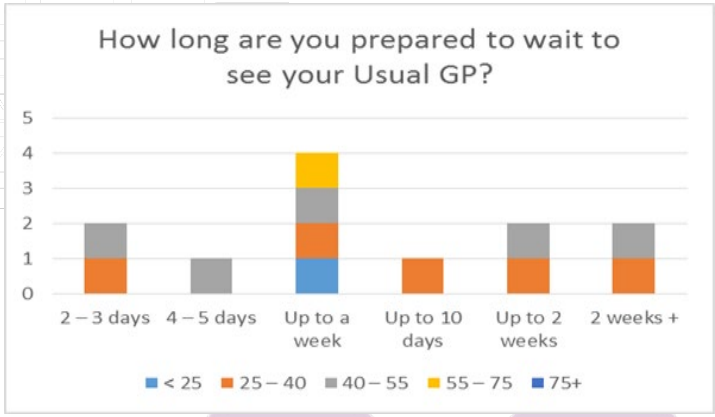
Waiting Room Chat

Aim: To gather the views of patients in the waiting room

Practices have found chatting with patients in the waiting room can be insightful. The results from one practice is shared below. Notice the difference in the results between what patients view as 'an acceptable wait' for a routine appointment and what is an acceptable wait to see their usual GP. The results were shared with the Practice's Participation Group and staff to help support the practice's ambition to improve continuity of care.







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Waiting Room Chat (script and template for the interviewer to complete using patient's words)

Links to:

2a

Reception Desk Audit

Aim: Audit patient behaviours when booking appointments

Understanding why your patients choose not to book with their own GP can be useful.

- Download the template which was used to undertake a short audit by the Reception Team for 1 week.
- The findings helped the practice to understand why patients chose not book with their own GP and therefore what changes were needed to enable and support continuity.

Many patients did not know their GP so we have worked on improving that

We now include the GP name on the text appointment reminder

It generated an opportunity to talk about continuity of care with our patients

Reception Desk Audit (template)

Links to:

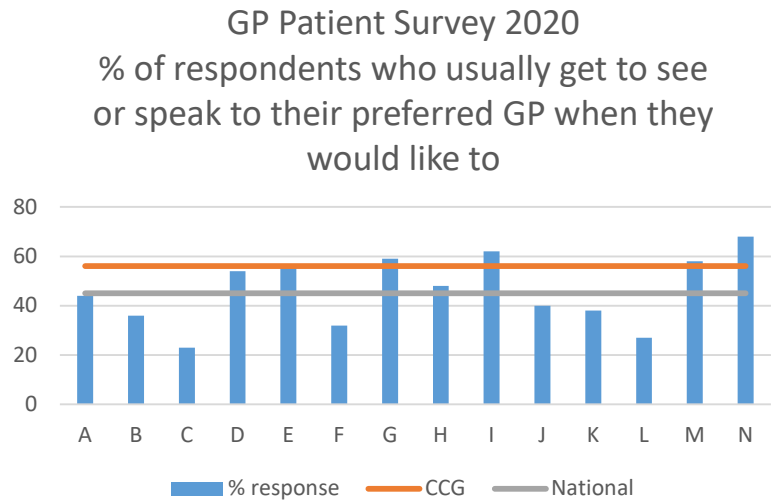
2a

NHS GP Patient Survey

Aim: Understanding patients views on continuity

NHS GP Patient Survey 2020

- Check your practice score on the question asking respondent if they usually get to see/speak to their preferred GP when they would like to.
- Use the built-in comparator tool to see other practice results
- View results as part of wider work on patient views.
  e.g. Practice K is below average on the Patient Survey but had very positive feedback from The Health Foundation Continuity of Care Survey and Waiting Room Chats.



Who gets in?

The Health Foundation Report on what the 2020 GP patient survey tell us about access to general practice.

You can also use this data to see if your changes have improved your practice score by repeating and reflecting

Links to:

2a

Working with your PPG

Aim: Engaging with your Patient Participation Group (PPG)

NHS England's ambition is to strengthen patient and public participation to include everyone who uses health and care services. At One Care we proactively work with patients through our One Care Patient Group and with the practice PPGs.

Working with patients is a key element in improving continuity of care:

- To hear the patient view on continuity at a practice level (PPGs differ in their views reflecting the community in which the practice is based)
- To check clarity of messaging on continuity of care communication material
- To gather their experience and their expertise as a patient at the practice
- To garner their support with some of the tasks e.g. encouraging patients to complete surveys

6

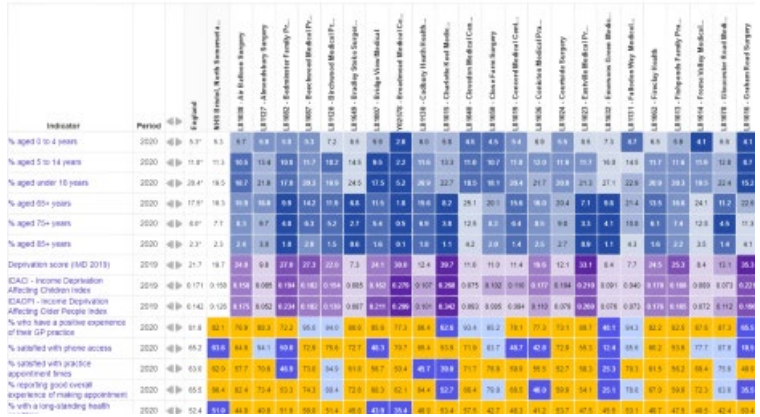
Patient Participation Group (guide and presentation designed for a PPG Chair to deliver continuity of care session to their PPG)

Links to:

2b

National Profiles

Aim: Understanding your patient demographic



National Practice Profiles

Public Health England data on individual practices, summary profiles for PCNs and practice comparisons with CCG, PCN or England available here.

Joint Strategic Needs Assessment (JSNA)

Statistics & Data | Evidence Based | Health & Well-being | National Data Profiles

- Looks at wider social factors that impact on people's health and wellbeing, e.g. housing, employment. It gives key statistics for your area, compared with national data.
- It looks at the health, and behaviours which affect health, such as smoking, diet and exercise.
- It draws together data from several sources to tell the story about a local population.
- All JSNAs differ in their layout.

To find your JSNA, use an internet search engine e.g. JSNA Bristol or JSNA Morecambe Bay

6

Links to:

2b

GP Differences

Aim: Investigate why GPs are different – prompting questions

Do you have a GP in your practice who has higher levels of continuity than other colleagues? If you do, it is useful to find out why that is:

- Does the GP have a special interest in mental health/complex patients?
- Does the GP have a great bedside manner?
- Is the GP proactively encouraging patients to return to see them? How?
- Is it because colleagues have had absences/extensive leave periods so score is high in comparison?
- Is this a long standing GP with well-established patient relationships who are more willing to wait to see their GP.

Links to:

2b

Cohorts that Benefit

Aim: Share GP views on some patient cohorts

Cohort	Considerations
Frequently Attending Patients	• National average is 6 appointments per year but >9 per year would exclude patients, particularly young children, who have a high number of appointments with minor illness where access and convenience is valued over continuity. • Practices need to set at a level that is manageable and gives most value for them. • The Usual GP Tool frequent attenders tab will help practices set an appropriate target. • Need to work through patients on an individual bases with GP colleagues, excluding those who are high users due to dressing or methadone or having acute episode or who have a number of comorbidities. Frequent Attenders, Power of 3 resource
Palliative Care	• Continuity is desirable although many cases are managed by palliative care/DN teams and have a care package. • Likely to be reasonably well documented and have continuity in place but if not could start quickly.
Frailty	• Patient with Frailty Index >0.36 and a Rockwood Score 7-9 would be suitable as likely to be extremely vulnerable and in high need of continuity. It is useful to further define this group to include home visiting consultations or risk admission score or multi-morbidity. • Using the Low Frailty Index score may be misleading as a patient can have high score but be independent and happy with less continuity. • The Cohort of Patients may change as it only takes a single deficit to be severe to render a patient extremely vulnerable and in high need of continuity.
Polypharmacy	• Diabetic patients can have at least 5 items so set the parameter higher at >8 or >10 items. • Exclude certain dressing and appliances to prevent inflating the item figure artificially. • Take a pragmatic approach perhaps focus on patients at particularly high risk such as those receiving 10 or more regular medicines together with other unfavourable factors (e.g. a contraindicated drug where there is potential for drug–drug interaction; or where medicine taking has proved a problem in the past). • Assess the opportunity to provide continuity as a micro-team including the GP and practice pharmacist. • The Kings Fund Polypharmacy and Medicines Optimisation is a useful document in understanding Polypharmacy.
Older Patients	• Age on its own is not a good indicator of continuity of care need as some elderly are fit and resilient. • Use age with another marker e.g. care home or housebound.
Mental Health	• These patients often straddle other cohorts; e.g. the frequent attender cohort.

Links to:

2b

Process Mapping

Aim: Understand practice processes and how they impact on continuity

Understanding what actually happens (not just what is supposed to happen) within processes by breaking them down step by step you can begin to understand the challenges and opportunities for continuity of care, as well as identify duplication.

Processes that are useful to map and why it is useful to look at:

How to Map a Process

Process		Key things to look for (most relate to navigating for relational continuity; informational and managerial continuity to support accumulated knowledge)
	Booking Appointments (all routes)	Understand how continuity of care encouraged/honoured (if requested); The message given to patients regarding continuity; How the Usual GP is used/not; The access/availability of GPs including popular GPs and how that impacts the process; Patient manipulation of the system (an indication it doesn't work for them); The pressures staff are under and how that impacts on the process; The level of reception triage; Repetition and efficiencies
	New patient registrations	Understand the difference between Registered GP and Usual GP within the patient record; Process for recording both; How the Usual GP is chosen (background method/monitoring); What is in the patient welcome pack i.e. the message given to patients on continuity/access to the GPs There were some discrepancies between what was understood by practices and what happens in EMIS / vision and system one on patient registration you might find useful too. EMIS Vision and System One New Patient Registration process
	Clinic Diary Set Up	Understand the balance between the workforce (GP sessions and commitments including Student/Trainees, Locum use); How capacity is divided up (to resource different sites, specific clinics, triage and the variation of appointment types); The level of forward planning of the sessions
	Test Results	Understand how tests are received (automatic or manual direction - many senior partners are the default); Who reviews and when, including cover for GPs; How Test results are relayed to patients (admin, any/own GP) and sufficient information to avoid unnecessary appointments; Identify any duplication/problems
	Prescriptions	Understand the level of online and paper repeat prescriptions and how these are directed; Turnaround time, how has it been decided and the impact on continuity; Process for Acute and Hospital Prescription requests in terms of who they are directed to and why
	Workflow	Understand what correspondence is recorded to patient notes and what requires review before recording in the notes; How correspondence requiring review is directed e.g. referring GP, usual GP field, GP last seen, GP most seen; Accuracy of the Usual GP field i.e. can it be relied upon; Problems or safety concerns e.g. cover for leave, delays in acting on results; Inefficiencies with repetition or re-direction

Links to:

2c

Project Proposal

Aim: Outline what the practice is doing to share with others

Having a project proposal enables you to be clear on the intention and rationale of the continuity of care improvement in order to share for practice awareness and agreement. A project proposal sets the scene and you may like to include an overview of the following:

- **Who:** are the named clinical and operational leads for the project?
- **Why:** are you doing it? What are the expected benefits?
- **What:** is the aim(s)? Is it Specific, Measurable, Achievable, Relevant and Timely?
- **When:** will it start? And when will you move through the 6 steps (as supported by the toolkit)?

Continuity Project Proposal Template

Other useful toolkit resources:

- The Pixar framework is a good story telling tool to outline the intention and rationale
- A driver diagram visually shows how changes link back to aims and objectives

Links to:

2c

6c

Pixar Framework

Aim: Share your aim and hopes for continuity of care

Taking people with you on your improvement journey is really important in making your change sustainable. Sharing your aims and plan for your improvement is key, but not everyone is excited about aims and plans, a story can sometimes create a more impactful image of what you are trying to achieve.

The Pixar framework is a storyboard formula you can follow to share your continuity of care aims, hopes and plans just like a project proposal or share what happened (good for after action reviews).

	Finding Nemo
Once upon a time	There was a widowed fish named Marlin who extremely protective of his only son, Nemo.
Every day	Marlin warned Nemo of the ocean's dangers and implored him not to swim far away.
One day	In an act of defiance, Nemo ignores his father's warnings and swims into the open water.
Because of that…	He is captured by a diver and ends up as pet in the fish tank dentist in Sydney.
Because of that…	Marlin sets off on a journey to recover Nemo, enlisting the help of other sea creatures along the way.
Until finally	Marlin and Nemo find each other, reunite, learn that love depends on trust.

	Improving continuity of care
Once upon a time	**Why are you in the current position?** e.g. The government decided it was important to be able to see a GP quickly at almost any time of day, seven days a week.
Every day	**What is the impact of the current situation?** e.g. It became harder to see your usual GP as speedy access to care was prioritised.
One day	**What have you decided to do?** e.g. The practice decided to prioritise continuity of care for…
Because of that…	**What will the plan change?** e.g. Patients are encouraged to see the same GP by…
Because of that…	**What is the anticipated impact for patients and staff?** e.g. Patients reported to be more satisfied and GPs found it easier to co-ordinate care.
Until finally	**What is the overall aim you plan to achieve?** e.g. Continuity of care levels increased, consultations were more efficient, and all benefitted from the change.

Pixar Framework Examples

Links to:

2c

Continuity Driver Diagram

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

Vision

In order to achieve this aim...

Add your practice vision

Aim

Add your SMART aim including target group

Primary Driver

We need to ensure...

- Increased number of **patients** choosing continuity of care
- Increased encouragement by **staff** for patients to receive continuity of care
- Improved efficiencies within **practice** systems to support continuity of care

Secondary Driver

Which requires...

- Increased patient understanding of the benefits of COC
- Reducing the wait for continuity of care
- Increased clinical encouragement for continuity
- Reasonable consultations lengths or frequency to build a relationship
- Increased opportunities within processes that staff follow for continuity
- Increased staff understanding of benefits of COC
- Improved digital record in practices' management systems
- Improved co-ordination of patient care
- Improved patient flow within practices
- Reduced variation in capacity

Tertiary Driver

Which requires...

- Increased and enhanced promotion of continuity of care (understanding the benefits for both patients and staff)
- Fair distribution of patients across the clinical team e.g. Usual GP, micro-team
- Increased understanding of practice and GP level continuity of care data and patient feedback
- Review and change of consultation approach
- Efficient booking processes (appointment/home visits/follow up/reviews) that promote continuity in place
- Consistent data recording and review to support clinical shared care

Possible Changes/Ideas

Ideas to ensure this happens

- Own evidence of the benefits
- Generic promotion of continuity Targeted
- patient promotion of continuity Patients
- and Staff briefings/sessions Usual GP re-
- allocation modelling tool Team/Buddying
- Considerations/Guide Dashboards and
- Searches to analyse External data sources
- Patient and Staff feedback
- Digital Solutions for triage and consultation
- Management of target groups
- Length of consultation
- Clinic diary set up and appointment types
- Review booking process
- EMIS / Vision and System One coding,
- filters and alerts
- Reviewing and benchmarking data
- Standardised recording
- Up-to-date 'Usual GP' field

How will I know we've made a difference?

- Increased levels of continuity (UPC/COCi/SLICC)
- Increased patient satisfaction
- Increased staff satisfaction and efficient processes
- Increased clinician satisfaction
- Balanced GP workload
- Reduction in consultations for high attenders

Driver Diagram

Can support your project proposal and idea generation

6

Links to:

3a

Glossary of Key Measures

Aim: Outline Continuity of Care Key Measures (to benchmark, or to reflect and repeat)

Usual Provider of Care (UPC)

This measure of how often a patient has seen the **same GP** (most frequently seen or 'Usual GP' field) over a period of time, the measure is for **each** patient who has had 2 or more consultations.

Calculates who the patient has usually been seeing over a period of time displayed as a fractional percentage. e.g. From 10 consultations the patient saw GP A 50% of the time (ABABABBAAC) = UPC 0.5

Continuity of Care Index (COCi)

This is a measure of dispersion of visits, using the frequency of visits to each care provider. It rewards having fewer providers which makes it a useful measure for **micro-teams.**

Calculates the number of providers, number of visits per provider and total number of visits to all providers in a given period. If the sequence of visits is AAAABBBC then the COC is 0.32, while if the sequence of visits is AAAABBCC, the COC is 0.29. Note both have same UPC (0.50).

St Leonard's Index of Continuity of Care (SLICC)

This measure is for practices operating or moving towards personal lists, this measure is for a **group of patients** e.g. GP A's patients, Patients over 65 years of age.

Calculates what proportion of consultations patients have with their named GP, of all consultations the patients have attended

Measures Explained (a more detailed explanation with references, calculations and worked examples)

Links to:

3a

Usual GP Tool

Aim: Introduction to the Usual GP Tool

The One Care Usual GP Tool measures continuity of care at your practice, helping you to understand your levels of continuity, repeat to measure improvement and to identify changes.

To use the Tool, you will need to run 6 EMIS searches to divide GP consultations into 6 patient groups:

- Frequently Attending - attended 9 or more times in past 12 months
- Other Attenders - attended less than 9 times in past 12 months
- 1-3 years - attended over 12 months ago, but less than 24 months
- 3-6 years - attended over 36 months ago, but less than 72 months
- 6-10 years - attended over 72 months ago, but less than 120 months
- Over 10 years - have not attended in past 10 years

The results of the EMIS searches are uploaded into the Usual GP Tool to give you a user friendly way to view your data.

I think this is an excellent tool
Dr Ronan O'Connell,
Whiteladies Medical Group

The data provides a number of insights including:

- Providing continuity measures:
  - Usual Provider of Care (UPC) for most seen GP and practice
  - Usual Provider of Care (UPC) for 'usual GP' and practice
  - St Leonards Indicator of Continuity of Care (SLICC) for Frequently Attending and by GP
- Comparing your results to the range of results from other practices
- Reviewing how patients are distributed across the GP Team (based on consultation rate)
- Assessing continuity for your frequently attending patients including those who circulate through the GP team
- Which GPs may be better placed to be the patients Usual GP (there are also resources to support these changes in the toolkit)

I found the data revelatory
Dr Mark Rickenbach,
Park Surgery &
RCGP Continuity of Care Lead

One Care Usual GP Tool (tool and guide)

6

Links to:

3b

Benchmarking Your Data

Aim: Understanding what is ‘good’ in terms of continuity and my peers

Whilst improvement is about bettering where you currently are it is sometimes good to understand where others are and how much improvement could be achieved. Get in touch with fellow practices also on their continuity improvement journey.

High, Medium and Low UPC is considered:

	UPC
Low	0.39 or less
Medium	0.4-0.69
High	0.7 or more

Be careful how you compare yourselves as data can demoralise, think about how you present the data to motivate. Emphasise improving your levels for the benefit of your patients and staff.

Links to:

3c

6a

Repeating and Reflecting

Aim: Identify what measures will be repeated and when

There are a few measures recommended to help understand continuity of care at your GP practice. These measures can be repeated in order to monitor improvements or judge the impact of the change.

	Levels of Continuity: UPC/CoCi	Levels of Continuity: SLICC	NHS GP Patient Survey	Patient Survey	Staff Survey
What	Snapshot of: UPC against Usual GP or most frequent GP; and/or COC index	The proportion of patient's consultation each month that are with their Usual GP	Percentage of patients that usually get to see/speak to their preferred GP when they would like to	Reported levels of continuity; Views and values towards continuity and GP practice	Value and priority of continuity of care; Levels of workload, job satisfaction and team culture; Project Awareness
When	Start and End, then 6 Monthly	Monthly	Annually	Start and End	Start and End
Why	Impact of the change on continuity levels and ongoing monitoring	Monitor continuity with Usual GP (only useful if the Usual GP field is reflective of who patients usually sees)	Impact of the change on patients preference for continuity being met	Impact of the change	Impact of the change
Type	• Judgement measure • Quantitative	• Improvement measure • Quantitative	• Judgement measure • Quantitative	• Improvement measure • Quantitative and Qualitative	• Improvement measure • Quantitative and Qualitative
How	Usual GP Tool	Usual GP Tool	National Survey Data	Online and/or paper survey	Online and/or paper survey

You may find the Glossary of key measures helpful here

6

Links to:

4a

Idea Generation

Aim: To think creatively to generate ideas

There are several change examples within this toolkit shared within the Driver Diagram, GP Practice Stories and Resources to support change. Your staff will have many ideas to contribute too. Idea generation is about quantity, coming up with many ideas to refine, stretch and refine again. Below are some examples to gather ideas, narrow down the ideas and then stretch them. Be clear on what you are wanting to achieve (aim from 2c) and share what you know already (understanding from Step 3).

Brainstorming: Using pens, a large sheet of paper or sticky notes, encourage ideas from staff. Allow time for them to think individually. Encourage sharing in small groups to further generate ideas, one idea will spark more when shared with others. Brainstorming can also be used with:

- **Constraints:** Too much freedom makes it difficult to start, by adding a constraint e.g. it has to be done in a week, cost nothing
- **Fresh Eyes:** Different ways of looking, approaching or thinking about challenges can force a different mindset e.g. how would another company do it (Amazon, Disney) or seeing through the eyes of a patient or type of patient

Refine Your Ideas, try to reduce the ideas to some of the best ones and focus on those. Keep all ideas to return to if needed

e.g. Dot voting, ask everyone to vote using coloured sticky dots, you can give each person 1-3 dots, be clear on the reason for voting (explore more, biggest impact, like to implement)

Stretch Your Ideas, explore how can the selected ideas be adapted, changed, reshaped or combined

e.g. 6 Thinking Hats, can be used to add structure to discussions to see the idea from different perspectives

Idea Generation

6

Links to:

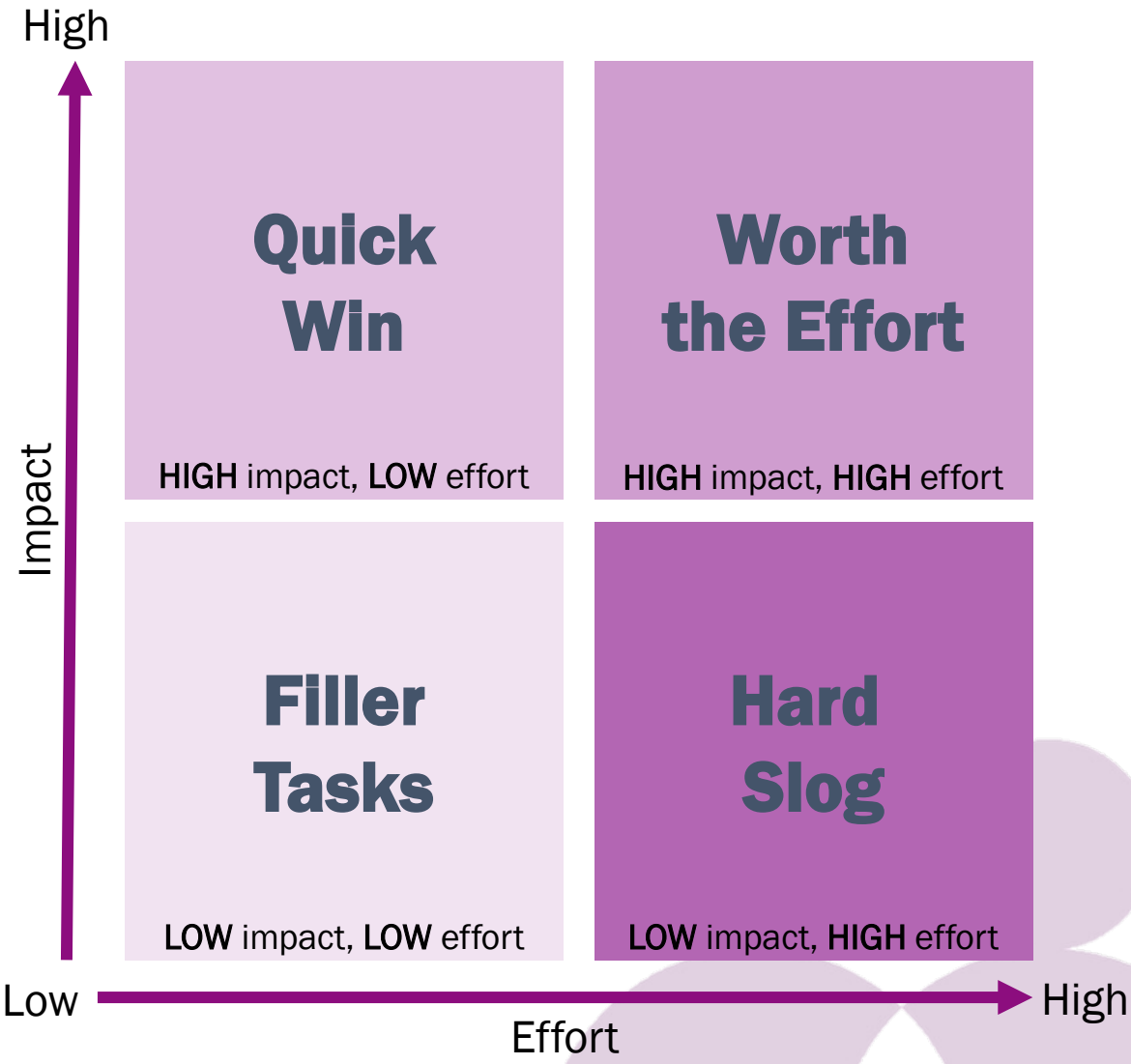
4b

Ideas Sorting Grid

Aim: To prioritise change ideas

The grid helps you to sort your ideas based on impact (to achieve your aim) and effort (to implement).

- Place your ideas on the appropriate square
- Review the ideas and consider how to increase impact and lower effort
  - Rethink the ideas within Filler tasks; What could you change that would increase its impact?
  - Can some of the Worth the Effort ideas be broken down into smaller chunks?



6

Links to:

4b

Resources to Support Change

Aim: Share resources that practices used to improve continuity of care

To improve continuity of care we identified 3 primary drivers within our Driver Diagram:

- Increased number of **patients** choosing continuity of care
- Increased encouragement by **staff** for patients to receive continuity of care
- Improved efficiencies within **practice** systems to support continuity of care

To achieve these drivers the following change ideas/resources were implemented by the Continuity of Care programme practices:

Administrative	Clinician	Technical
Reception Team Guide (hints and tips from others e.g. scripts, answerphone message)	**GP business card** naming usual GP and their working days to give to patients, used by Valentine (see their report)	**Online Consultation Platforms** that complement continuity navigation e.g. AskMyGP
Communication Materials: Animation, Leaflet, Ideas for social media	**Weekly continuity message**, some practices design and circulate their own short continuity focussed emails to their practice colleagues	Using the computer system to promote continuity (flags, prompts, templates, online booking restrictions, patient list reports)
	GP patient list reports, to sustain continuity	**Usual GP field changes/rebalanced** using Usual GP Tool
Current and Future Navigation (following changes to update the Usual GP field or flagged patient cohorts, consider processes that will support maintenance/encouragement of continuity)		

You may want to generate your own ideas too

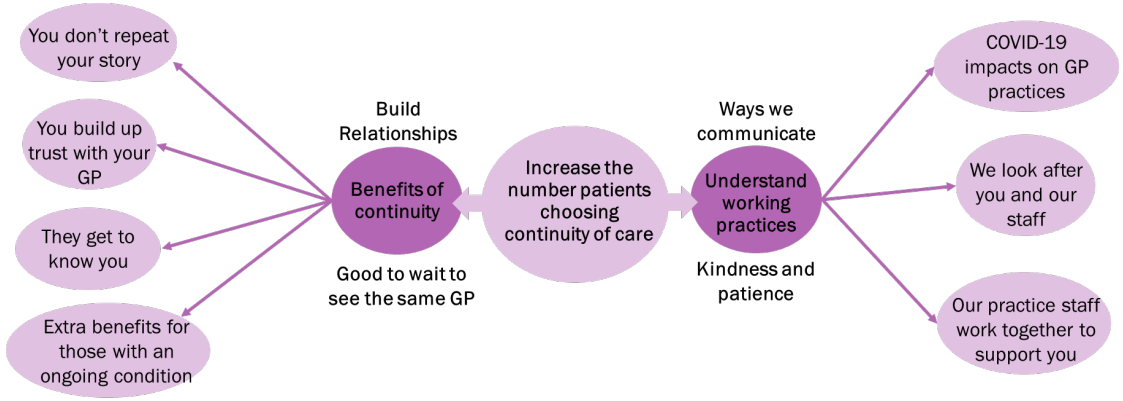
Links to:

4b

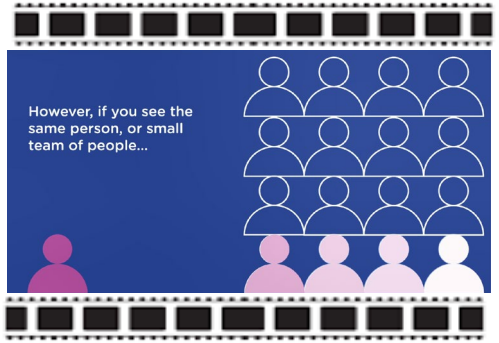
Communication Materials

Aim: To promote continuity of care to your patients

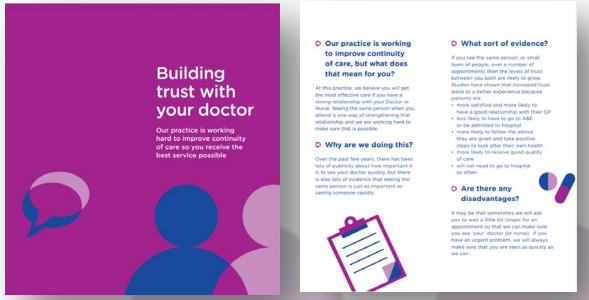
Promoting the benefits of continuity of care can help to increase the number of patients choosing continuity. Think about what key messages you want to give patients. It is important to also look at what messages are currently communicated, are these in line with the new message or contradict it?



Continuity Animation: The animation can be uploaded as a waiting room video or used on your website or social media platform.



Continuity leaflet: The leaflet can be printed for your waiting room or reception desk or uploaded to your website.



Continuity Social Media Ideas: The key messages within the ideas bank (text and images) resource can be used on your social media platforms or your website.

Continuity Communication Materials

There are other resources to support change in this toolkit too

6

Links to:

4c

5a

5b

5c

PDSA

Aim: To test out changes before full implementation

The model for improvement framework moderates the impulse to take immediate action with the wisdom of careful study via Plan Do Study Act (PDSA) testing cycles. The framework includes 3 key questions to answer before testing, these should be answered if you have worked through the steps in this toolkit.

What to do in each stage of the PDSA:

Plan: Define the change's objective, the question you want answering and/or predictions of results, considering what data collection will support this. Set out a plan to include Who; What; When.

Do: Carry out the plan, document the challenges/issues along the way, collect the data and begin analysis of the data.

Study: Compare results to predictions and reflect on the impact of the change and summarise what was learned.

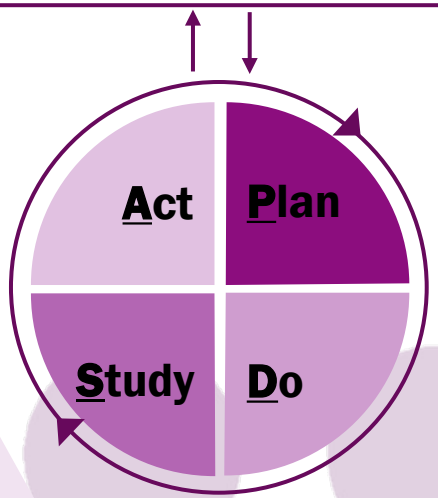
Act: Plan the next change cycle or decide whether the change can be implemented.

The model for improvement

What are we trying to accomplish? (your **aim**)	2c
How will we know the change is an improvement? (**measures**)	3c
What **changes** can we make that will result in improvement?	4b

QSIR Tips

- Plan multiple cycles to test ideas
- Test on a really small scale.
- Test with people who believe in the improvement.
- Only implement when you're confident you have considered and tested all the possible ways of achieving the change.



PSDA cycle

PSDA (Recording Template)

6

Links to:

4c

Planning

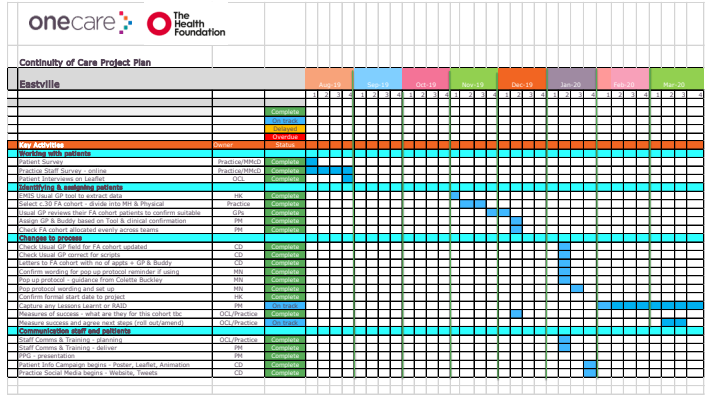
Aim: To outline what you are going to do

Why bother with a plan?

Based on the experiences of our practices, having a plan **will help you achieve your continuity goals.**

The benefits:

- Setting out the **key tasks, the timeline and who will do it** will give you the scope of the work.
- Ensures the practice team knows what is planned and can flag any omissions.
- Helps you see any **constraints, risks or challenges** to be considered or overcome.



Think of the plan as your “to-do” list. It can be as **detailed as you find useful.**

Continuity Plan Template (includes one practice’s plan)

Links to:

6a

After Action Review

Aim: To honestly reflect, capture learning and identify future improvements

After Action Reviews originate from the military, they comprise of 3 key questions being answered in an honest, safe and constructive environment. Ideally these are conducted with a wide representation of stakeholders in the same room, but information can be gathered from an open questionnaire or a combination of both.

Create the right environment:

- Clear purpose (aim) of the review
- Request honest answers when information gathering
- Ground rules for discussions

3 Key Questions	Group work example (2 activities in each)	Question examples
What happened and how did that compare with the original plan?	1. Provide the original plan/intentions/expectations OR Story (Pixar Framework) 2. Timeline of events – stakeholders reflect on their high and low point against the timeline	• **Patient:** What did you expect from [the change] and how did that differ from what you experienced? • **Staff:** How did your experience differ from the plan (provided)?
What went well that we should consider keeping/repeating?	1. Ask everyone to reflect individually on this question and write on sticky notes 2. Individuals share their sticky notes in pairs/small groups then the full group to be collated	• **Patient:** What of [the change] works/worked well for you, and why? • **Staff:** What went well when we [made the change], and why?
What didn't go so well, why and how could we do better next time?	• Individual and group reflections as above. Ensure reflections include why it didn't work and how it could be done differently with hindsight	• **Patient:** What of [the change] doesn't work so well for you? Why? How could we improve this? • **Staff:** What didn't go so well when we [made the change]? Why do you think that was? What can we learn from it/improve for next time?

6

After Action Review (Ground Rules)

Links to:

6b

Sustainability Model

Aim: To increase the likelihood the change will be sustained

The Sustainability Model and Guide supports healthcare leaders to sustain improvements. The 10 factors relating to Process, Staff and Organisation issues in the model are integrated into the 6 steps within this toolkit. They increase the likelihood of sustaining your continuity improvement. You may also wish to use the model and guide:

Sustainability Model: A diagnostic tool to identify strengths and weakness in your plan (at its start, middle and/or end) predicting likelihood of the sustainability of your improvement.

Sustainability Guide: Practical advice on how to increase the likelihood of sustainability.

Staff: Think about **training**; staff involvement and **behaviours; impact** on both administrative and clinical colleagues.

Process : How you will you **monitor** the change; how will you adapt; what are the **benefits** for patients and staff?

Organisation: Align with other initiatives at your practice and PCN

6

Links to:

6c

Press Release; Key Components

Aim: To share the impact of the practice's continuity of care journey

There are some key components that will help you to write a press release to share your improvements and their impact.

- **Good Headline:** Catchy and informative; less than 6 words; Use numbers, actions words and/or interesting adjectives; be accurate. You can add a sub heading if all what you want to say doesn't fit.
- **Consider your Audience:** Ask yourself Why will the audience care? Is this story relevant to my target audience?
- **Style:** Short and simple sentences: Avoid jargon; Focus on facts and information.
- **Structure:** Include the key information in the 1st Paragraph; Secondary and supporting information in the 2nd and 3rd.
- **Remember 5Ws:** **What** happened/is happening; **When** and **Where** did it happen, **Who** is involved, **Why** did it happen (try and get the why into the 1st sentence); Also include **How** you made the change.
- **Include a Quote:** Must sound real; Not too long. And an image if you have one.
- **End on the Right Note:** Conclude your story/pose a question for others; End the release with '###'
- **Your Information:** Provide your name, email and phone number for the editor to contact you if they need to.
- **Check it:** Run a spell check; Ask someone else to read it.

Links to:

6c

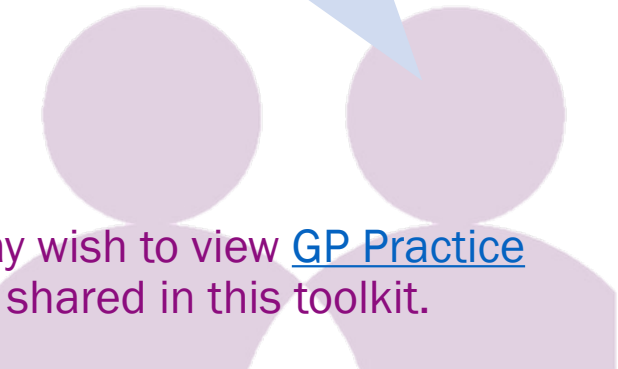
Practice Story; Key Components

Aim: To share your practice's continuity of care journey

Practices value hearing the experiences of other practices so please think about sharing your story. You might like to include:

- **Who** were the key players at your practice, who led on the change, who was affected, who benefitted?
- **What** did you do to improve continuity?
- **Where** is your practice, is it rural/city, list size, number of GPs?
- **When** did it happen and how long did it take?
- **How** did these changes come about? Did you do small steps? Were you inspired by other practice journeys?

The RCGP would love to hear of your practice's continuity of care journey and any resources you created. Please share them, find out how on the RCGP Continuity of Care Toolkit webpage.



You may wish to view GP Practice Story's shared in this toolkit.

6

Glossary of Key Terms

Aim: Outline Continuity of Care Key Terms

You may come across the various terms interchangeable with circumstances and who is using them: **Usual GP:** The GP named in the computer system

Accountable GP: Terminology used in the GP contract (also known as Responsible GP)

Personal GP: Where the practice operates personal lists, the Usual GP field in the computer system is usually maintained to reflect this.

Most Frequently Seen GP: Which GP does the patient see over a certain time period.

Registered GP: May or may not be the GP providing the care. It is the GP that the patient was registered to and is a different field to Usual GP.

GP Buddy: 2 GPs providing patient care, with 1 GP accountable

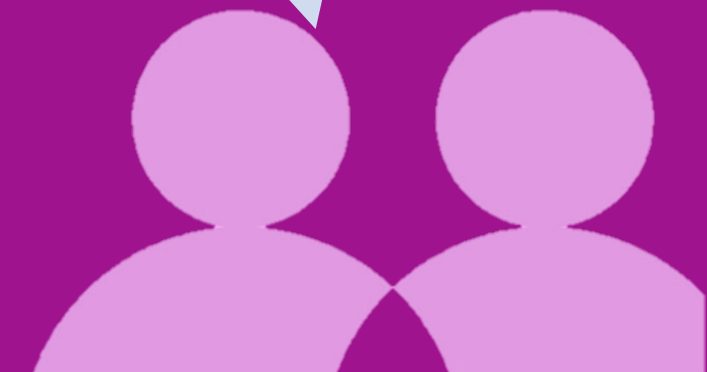
Micro-team: Team of 2 or more people providing care to a patient, including an accountable GP

GP Practice Stories

What have others done?

Please share your Continuity Improvement Journey with the RCGP to add to the GP Practice Stories online

Take a look online at examples of what other GP practices have done and find out about their continuity improvement journey.



Thank you

To all that have contributed their time and resources to this toolkit