Continuity of Care Quality Improvement Project
GMS Quality Improvement Framework 2025/26

Aims

The aim of the continuity of care project is to enhance quality assurance processes by highlighting the importance of relational continuity in practice as a marker of high-quality care. Practices will be asked to use Quality Improvement methodology to inform adaptations to strengthen continuity of care and to report progress to collaboratives and health boards. This will be a 5-year Quality Improvement Project with a review by the GMS Quality Committee in the 3rd year to establish whether it continues into years 4 and 5. The purpose of this project is to refocus and educate practice staff about the benefits of continuity of care and then understand how to implement lasting positive changes for their individual patient populations.

Specific Objectives

1. **Improve Clinical Outcomes:** Improve patient and carer experience, increase uptake of preventive interventions and reduce preventable morbidity and mortality by enhancing relational Continuity of Care, focusing on value-based healthcare approaches.
2. **Address Health Inequalities:** Prioritize relational continuity for vulnerable populations, including those with complex needs, to reduce disparities in healthcare access and outcomes.
3. **Enhance Practice Operations:** Embed relationship-based care into workflows by adapting appointment and triage systems, extending consultations for complex cases, and leveraging IT infrastructure to support continuity.
4. **Support Strategic Alignment and Evaluation:** Encourage GP practices, clusters, and health boards to measure continuity of care as a key enabler of Welsh Government strategies such as Prudent Healthcare, Value-Based Healthcare, and NHS Sustainability.

Background

Continuity in primary care literature is mainly viewed as the relationship between a single practitioner and a patient, that extends beyond specific episodes of illness or disease. For the purposes of this project, we will be focusing on the relationship between a patient and their GP within an individual General Practice setting. Continuity is different from coordination of care, although better coordination follows from continuity. It is often believed that to achieve continuity a trade-off is required with the accessibility of healthcare providers. However, recent research (Kajaria-Montag et al., 2022) reveals that increased GP continuity is significantly associated with the reduction of requests for appointments. Demand can be reduced though GP continuity. There are some high continuity general practices in the UK where there is no trade-off.
Two themes distinguish continuity from other healthcare attributes - these elements are care of an individual patient and care delivered over time. Both elements must be present for continuity to exist, but their presence alone is not sufficient to constitute continuity.

Continuity is not an attribute of providers or organisations. Continuity is how individual patients experience integration of services and coordination. Many measures focus on chronological patterns of care without directly measuring experienced continuity or those aspects of care that translate into connected and coherent care (https://pmc.ncbi.nlm.nih.gov/articles/PMC274066/, n.d.)
This concept is crucial for ensuring high-quality care and better patient health outcomes.
Patient outcomes are enhanced by the development of trust, mutual respect and co-production with their clinician. It leads to a better understanding of the patient's ideas, expectations, family circumstances and community structure in which the patient is living. This ultimately gives the opportunity for a therapeutic relationship to flourish enhancing the overall patient experience. GP continuity leads to a progressive increase in the mutual trust between a patient and their GP (Mainous et al., 2001). All qualified doctors receive a basic level of trust from patients, but the deeper level of trust has to be earned, and continuity is the single commonest way in which this occurs.

When considering continuity of care there is always a complicated interplay between the finite resources and capacity the individual surgery has to offer; versus the demands, needs and access requirements of the specific demographics of patients they serve. Access is challenging at the best of times and prioritisation of services is complex. Whilst maintaining good access to healthcare is a founding principle of the NHS, a singular focus on improving speed of access to a workforce with finite capacity can have unintended negative consequences of deprioritising continuity of care. The purpose of this project is to refocus and educate practice staff about the benefits of continuity of care and then understand how to implement lasting positive changes for their individual patient populations.

A key aspect of Professional Collaborative and Cluster working is to support GP practice teams to identify changes that can be implemented in wider health board systems that will increase access, enhance patient experience and improve job satisfaction for GP teams.

The Evidence Base

The evidence base underpinning the importance and value of continuity of care between a patient and their GP is substantial. This is a summary of the benefits of Continuity of Care, provided by the team at St Leonards Research Practice in Exeter (https://www.continuitycounts.com/).

1. **Better patient satisfaction**
   Several studies show that more continuity of doctor care is significantly associated with better patient satisfaction. (Fan et al., 2005; Adler, Vasiliadis and Bickell, 2010)
2. **Developing trust between patients and their GPs**
   Continuity of care GP care is associated with patients developing trust in a doctor they get to know. This reduces anxiety and provides a sense of security. (Mainous et al., 2001; von Bültzingslöwen et al., 2006)

3. **Adherence to medical advice and prescribed medication**
   Patients follow medical advice significantly more when they have continuity with their GP. The trust that develops through a good GP- patient relationship ensures more effective treatment and less waste (Youens et al., 2021) Continuity of GP care is associated with significantly better adherence by patients. (Dossa et al., 2017)
4. **Uptake of personal preventive medicine**
   Continuity of GP care is associated with significantly better uptake of personal preventive medical advice. (O'Malley et al., 1997; Christakis et al., 2000)
5. **Better quality of GP care**
   GPs with continuity identified more patients needing statins. (Youens et al., 2021) GPs made better, life-saving decisions with suspected meningitis when they knew the child and family.(Granier et al., 1998). Patients with dementia with GP continuity have reductions of delirium and incontinence, and fewer hospital admissions. (Delgado et al., 2022)
6. **Patients forgiving GPs after moderate mistakes**
   All human beings make mistakes. Lings et al. (Lings et al., 2003) found that patients who have received good continuity of care previously will forgive GPs who make moderate mistakes, with implications for time spent on complaints and litigation.
7. **Reduced collusion of anonymity**
   Clarity of responsibility and continuity reduces the risk of patients becoming lost between clinicians. (Freeman and Hughes 2010)
8. **Reduction in workload in practices**
   Patients consulting their regular GP reconsult after a significantly longer interval than if they consult another GP. The Cambridge Business School estimates that for patients with ≥4 consultations in 2 years, GP continuity could save 5.2% of GP appointments. (KajariaMontag., et al 2022)
9. **Lower rate of attendances at emergency departments**
   Patients receiving GP continuity of care are significantly less likely to attend accident and emergency departments. (Kohnke and Zielinski, 2017; Ride et al., 2019)
10. **Fewer admissions to hospital**
    In Canada (Menec et al., 2006) and in the UK (Barker et al., 2017) many studies have shown that patients with good continuity of GP care are significantly less likely to be admitted to hospital, particularly for older patients with ambulatory care sensitive conditions. Hospital admissions are one of the most expensive NHS costs.
11. **Lower costs in whole health systems**
    Good continuity of GP care was associated with lower costs across the whole health system. (De Maeseneer, 2003; Bazemore et al., 2018)
12. **Lower death rate in patients**
    Two systematic reviews show that better continuity of GP care is associated with a lower death rate in patients. (Pereira Gray et al., 2018; Baker et al., 2020) A dose-response relationship, which adds considerable scientific weight to the findings, has been shown between continuity and mortality. (Sandvik et al., 2021)

As the evidence base is almost exclusively for relational continuity between a GP and their patient, this QIF project will only focus on that relationship rather than the wider multidisciplinary team. At present there is a lack of evidence that the same benefits accrue with other health professionals (Sidaway-Lee et al., 2024). However, we anticipate that by improving continuity of care between a patient and their GP, the whole multidisciplinary team will benefit.

Areas for Quality Improvement Project Activity

Practices that have high rates of continuity of care have systems that seek to maintain continuity of care for their whole population. This maximises the benefits to their patients and to their own practices.

However, as a practice you may feel that establishing continuity of care for your whole population is unachievable for you, so you may wish to focus on individuals who benefit most from relational continuity of care, for example:

- Individuals with significant mental health challenges
    - Approximately 1 in 4 adults in Wales experience mental health challenges annually
- Vulnerable people – including homeless people, asylum seekers and refugees, individuals discharged from the criminal justice system
- Older adults with frailty
    - Wales has a higher proportion of older adults compared to other UK nations, with 21.3% of the population aged 65 or older (compared to 18.6% in England)
- Patients with complex long-term conditions or multiple morbidities
    - An estimated 33% of Welsh adults live with at least one long-term condition, and 12% have multiple chronic conditions
- Populations living in socio-economically deprived areas
    - Wales experiences significant socio-economic disparity
    - These communities face higher rates of chronic illness, lower life expectancy and significantly lower healthy life expectancy

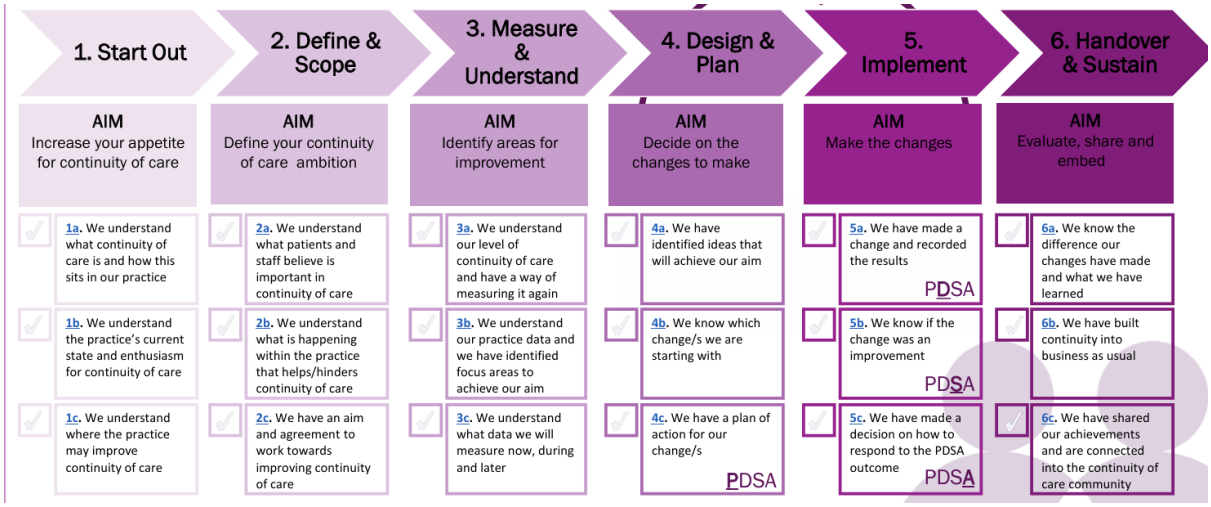
This approach to prioritising continuity for those with the greatest needs has been described as ‘proportionate continuity’. Burden of disease projections in Wales show that all of this is projected to grow over the next 20 years; finding effective ways to support these groups of patients is key to long term NHS sustainability. By focusing on these demographic characteristics, the QI project will ensure that practices are clear what actions are needed to ensure relational continuity reaches those with the most to gain, addressing their unique healthcare needs while promoting equity and sustainability in general practice. However, this approach may not realise all the potential benefits for your practice that Continuity of Care can bring.

The RCGP Continuity of Care Toolkit

RCGP has developed a toolkit with extensive resources that practices can use to educate staff and patients about continuity of care (https://elearning.rcgp.org.uk/mod/book/view.php?id=12895). The toolkit supports practices to investigate their population and practice needs, then develop a plan to make positive changes and evaluate the outcomes. The toolkit is free to access and covers a wide range of tools from patient surveys through to process mapping tools.

Continuity of Care Quality Improvement Project Year 1

In year 1 each practice should use the step-by-step process to evaluate their current standing and then look at steps to improve. As this is a 5-year QI Project we would expect practices to have achieved a minimum of stage 3a by the end of the first year.



There are several ways to measure continuity of care within practices, including the Usual Provider of Care (UPC), St Leonard's Index of Continuity of Care (SLICC) and the modified SLICC. Due to the imminent switch to SNOMED and the ongoing process of practice migrations to EMIS, we have been unable to provide a robust set of templates and tools to measure continuity of care for all practices. We will be working with DHCW to develop these resources in time for practices to move into year 2 and complete their first PDSA cycle with measurements of Continuity of Care.

We therefore recognise that the first year of the QI initiative will be one of research, preparation, and education of patients and staff.

This broad approach allows each practice to develop quality improvement projects that are unique to their situation rather than being too prescriptive. However, for those practices that require more support or focus, a menu of project options is attached at Appendix 1

Practice Level requirement of the QI Project

- Practices will have a named QI Project lead clinician.
- There is access within the practice to the RCGP Continuity of care tool kit..
- There is 'whole practice' sign up to continuity principles and application.
- Educational needs of staff and patients are addressed to explain the rationale that continuity is at least as important as access.
- Practices will review internally monthly.
- Practices will discuss progress with their collaborative quarterly.
- Practices will work through the key areas described above.
- There is explicit acknowledgement that any benefits will take around two years to manifest in terms of improved outcomes, reduced practice workload etc, and will be proportional to the scale of the improvement.
- Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2026 summarising progression of the project.

Collaborative Level

- Practices to share aggregate practice-level data.
- Discuss, share best practice, and consider adaptation of QI processes across collaborative.
- The Collaborative lead should bring themes for discussion to the wider cluster professionals.
- The Collaborative should consider introducing collaborative initiatives to benefit the delivery of improved interventions in identified behaviours.
- The Collaborative should escalate suggestions for system-wide improvement to Pan Cluster Planning Group for consideration of improved commissioning or inclusion in IMTP process.

Health Board Level

- Health Boards to ensure practice completion is verified against agreed indicators via completion of a nationally agreed poster template at the end of year 1.
- Health Boards will collate outcomes to allow thematic review at a national level at the end of each year of the project.

DHCW Level

- Develop a PCIP tile for displaying required data and for practice upload of project materials for verification purposes
- Develop templates and digital tools to assist practices in the measurement of mSLICC

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Appendix 1

Suggestions for Quality Improvement projects
Objectives and Targets for Quality Improvement over the 6 key areas

Note these are aimed to be suggestions and are not prescriptive. They detail projects for a full PDSA cycle and not what would be expected within Year 1 of the project. It is only included due to previous requests for guidance on the types of projects to be undertaken in previous QI cycles. There are plenty of suggestions via the RCGP toolkit on improving continuity of care. We would recommend that practices set realistic timeframes and specific goals to suit the needs of their staff and patients. The outcomes need to be demonstratable to be able to share at cluster and health board level. Tools are provided to support this via the RCGP toolkit.

Define Continuity goals and Demographics

Objective:
- Set practice-specific continuity goals tailored to demographic data

Sample plan:
- Set up personal patient lists or identify one or more high-priority patient cohorts (e.g., frail elderly, socio-economically deprived) – 3 months
- Set improvement target to raise the mSLICC for these groups
- Reassess mSLICC, reflect on any changes and plan for next intervention.

Measure and understand improvement measures

Objective:
- Use metrics to benchmark and track continuity improvements

Sample plan::
- Establish baseline data for the mSLICC
- Establish baseline patient satisfaction
- Set improvement target to raise the mSLICC
- Reassess to monitor change in mSLICC and patient satisfaction within 12 months
- Critically evaluate findings and create plan for the following 12 months

Design options for Continuity and Plan Implementation

Objective:
- Implement operational changes to enhance continuity of care using PDSA cycle

Sample Plan:
- Assess baseline staff and patient satisfaction

- Adopt new interventions (e.g., micro-teams, continuity-focused triage systems)
- Reassess baseline staff and patient satisfaction and analyse
- Critically evaluate findings and create plan for the following 12 months

Implement Changes, Study Results and Act

Objective:

- Evaluate the effectiveness of interventions to reduce hospital admissions for ambulatory care-sensitive conditions using PDSA cycle

Sample plan::

- Assess baseline rate hospital admission in target cohort
- Adopt new interventions
- Assess hospital admission rate in 6,12- and 18-months' time
- Publish a report on outcomes and lessons learned
- Ensure effective changes are embedded into routine practice
- Create practice plan for the following 12 months

Appendix 2

Resources for practices wanting to learn more about continuity of care, its benefits and implementation. Includes patient information leaflets and guides to improvement and adoption.

https://www.continuitycounts.com

https://elearning.rcgp.org.uk/mod/book/view.php?id=12895