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Promoting Continuity of Care in General Practice

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RCGP Royal College of General Practitioners

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The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general practice and to act as the voice of GPs on issues concerning education, training, research and clinical standards. Founded in 1952, the RCGP has over 41,000 members committed to improving patient care, developing their skills and promoting general practice as a discipline.

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This policy paper was compiled with the help of a working group of RCGP Council Members and Fellows of the RCGP, in consultation with the RCGP practice nurses, practice managers and Patient Partnership groups. It is endorsed by the Council of the RCGP.

The vignettes have been based on material we received from our advisory group. Where we have used real people's stories as a basis for the vignettes and have been unable to seek their specific permission, we have taken care to anonymise or fictionalise the stories to protect their identity by changing medical and personal detail, and combining material from similar stories together. We are grateful to the patients who gave us material from their own experience to illustrate the human aspects of the points we make in this policy paper. We hope we have described them with the respect they deserve. At the same time, we are confident that anyone who thinks he or she recognises him or herself in the vignettes is mistaken, as these were written to describe scenarios that are not unique or person specific.

The paper draws heavily on recent work by Professor Freeman for the King's Fund as part of its Inquiry into the Quality of General Practice in England.[1]

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At the heart of general practice is the relationship GPs have with patients. We provide them with lifelong care.

Patients want personalised care from a GP they know and who knows them. This is the best, most cost-effective way to deliver health services.

Prof. Steve Field CBE FRCP FRCGP
Immediate Past Chair of Council, RCGP, 2010

1 Introduction

Health outcomes and cost-effectiveness of health care are improved by good primary care when it is delivered by GPs working in multidisciplinary teams. Primary care should be local, accessible and familiar. In this paper we discuss the evidence that the key to effective care is the relationship between clinician and patient, the therapeutic relationship. Its power was recognised by the earliest physicians. It implies more than technical skill. It involves palpable caring as shown by compassion and commitment. It is the trust that the patient has in his or her physician that underpins the power of the relationship. This trust becomes stronger over time as the doctor and patient grow to know each other better through experience.

Continuity of care is a means to this end. By continuity we mean both the extent to which a person experiences an ongoing relationship with a clinician and the co-ordinated clinical care that progresses smoothly as the patient moves between different parts of the health service. These two aspects of continuity support each other but are not the same. Patients want their care to be personal (focused on their individual needs and circumstances) and want to feel that the clinician knows them and their cases, so that they can trust their judgement and advice. They also expect their care from all clinicians to be joined up and co-ordinated.

In today's world there are many issues related to the way we wish to live and work that make the building of such relationships more difficult. In addition it appears that recent policy changes, intended to improve quality of care in the National Health Service, have had the unforeseen consequence of reducing continuity of care.

Personal doctoring and continuity of care are proven determinants of healthcare quality. Patients value continuity of care in seeing a doctor or nurse who they know and trust.[2,3] They need information on which to base their choice, experience of consulting with a number of clinicians before exercising their preference, and the chance to build trust in a caregiver over time.

The Royal College of General Practitioners (RCGP) promotes and values continuity of care. We note its positive effect on the safety and effectiveness of health care. We know that many of our patients like it. The importance of continuity and how GPs can promote this are a key part of GP training.

Continuity of care remains an essential element of modern general practice and is a prerequisite for high-quality consultations and effective management. There is also evidence that personal continuity, as opposed to organisational continuity, is associated with greater patient satisfaction with care and more efficient use of resources.

***The Future Direction of General Practice* (RCGP, 2007)**

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The GP–patient relationship to be maintained and improved

GPs deliver personalised and continuous care for patients and their families. We want to improve patients' access to high-quality care even more. We call on politicians to recognise the importance of the practice list – it strengthens the relationships that GPs have with their patients and allows them to target care to those who need it most.

***Leading the Way* (RCGP, 2010) ***

GPs are key to the future of the NHS because they are trusted by their patients. … trust reinforced through continuity of care directly improves healthcare outcomes.

***The Next Steps* (RCGP Wales, 2008) †**

In order to deliver effective primary care GPs need to be expert generalists. Each consultation has exceptional power to manage healthcare costs, for example when the effective management of disease risk is negotiated, and when prescribing and referral decisions are made. GPs contribute to the safety of their patients' care by avoiding unnecessary and potentially harmful investigations and treatments. They also manage the uncertainty inherent in the early presentation of health problems by arranging expectant care. In addition, GPs act as gatekeepers for the patients' entry into more specialised care, using their expertise to direct patients to where they will receive the most benefit and at the right time.

GPs understand the complex set of circumstances that accompany individuals and their healthcare history. It is through their professional training and a relationship built on trust and continuity that GPs act as gatekeepers to other NHS services. This saves the NHS money by preventing wasted out-patient assessments, unnecessary investigations and hospital admissions.

***The Next Steps* (RCGP Wales, 2008)**

Why offer this policy paper now?

Quality and effectiveness of health care and value for money are prime concerns for the NHS, and the RCGP supports these. This includes an emphasis on commissioning primary care and care closer to home.[4] The NHS reforms emphasise the importance of healthcare quality,[5] effective commissioning and patient choice.[6] These policies have presented both opportunities and challenges to GPs in their approaches to providing care for their patients.[7]

* www.rcgp.org.uk/pdf/1146-1510_Political_Manifesto_Web_key_documents.pdf

† www.rcgp.org.uk/college_locations/rcgp_wales/initiatives_and_projects/next_steps.aspx

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With these reforms under discussion in an exceptionally challenging economic climate, we believe it is timely to remind policy-makers of the importance and power of the therapeutic relationship.

There is plenty of evidence that many of these strengths (in terms of health outcomes and use of resources) attributable to primary care depend on an effective and long-term therapeutic relationship with a freely chosen primary care doctor.

Yet recent policy, socio-demographic and cultural changes threaten the personal relationship between an individual and the GP by making it harder to achieve such a relationship.

We offer this paper as a reminder of the importance of continuity of care and as an aid to its understanding and promotion.

It is aimed at policy-makers, both national and local, health service managers and GP practices.

Why should policy-makers read it?

It is important to encourage therapeutic relationships in primary care as central to its effectiveness. Any aspect of health care to be promoted through policy should be monitored through measurement. But it is very difficult to measure the quality of a human relationship.[8] Continuity of care is a key process through which therapeutic relationships are built and maintained. Continuity has been the subject of much research both in the UK and internationally. Ways of measuring it do exist, although these may need to be adapted to be of practical use in health service delivery.

Policy-makers can then appreciate and support the preference of GPs and the majority of their patients for the opportunity to build and maintain a therapeutic relationship over time.

We will show that increased continuity of care by GPs gives:

- better health outcomes
- more satisfied patients
- cost control.

This works through promoting:

- trust in the clinician and in his or her advice
- personalised decisions on appropriate care
- more effective care outside hospital
- better targeting of expensive interventions to those most likely to benefit
- limited use of interventions that have a significant harm rate
- better acceptance of self-limiting illness
- emotional support.

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I trust my GP totally but that has been built on a positive regard for one another as equal partners in managing my health – my GP holds the medical knowledge but I hold the knowledge of how I feel and live with my conditions day to day.

Member of the RCGP Patient Partnership Group

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2 What is continuity of care and why does it matter?

'Seeing a doctor you know and trust' is a traditional and continuing value and feature of general practice or family medicine.[7] The role of the GP is to provide personal care to individuals, acting as their trusted agent and guide through the experience of illness and improving their health.[9] In this way the GP makes a powerful contribution to the safety of their patients.[10]

Trust is built through repeated encounters over time and recommendation by family and friends. It is longitudinal continuity, together with the doctor's demonstrated competence, that encourages that trusting relationship.

As a concept, continuity has been difficult to study because it can mean different things to different people. It has given rise to much enquiry throughout our healthcare system and internationally. A number of different types have been recognised by researchers and teachers. Continuity of care is about care experienced by individual patients – not populations – over time. We shall use the simplest definition, which reduces the concept to its essentials, *relationship continuity*‡ and *management continuity*,§ because without attention to both these aspects, patients will not experience the care they want.

Relationship continuity

Relationship continuity is longitudinal, personal, continuing and caring: it implies knowledge of each other within the context of the therapeutic relationship, with commitment and trust. Both doctor and patient contribute to its creation and maintenance. It can involve more than one clinician and it should be flexible over time, responding to the patient's changing needs and social context.

Management continuity

Management continuity can be thought of as the 'seamlessness' of care: perhaps better thought of as tailored care where the seams are strong and invisible – and fit the wearer. It involves co-ordination and teamwork between caregivers and across organisational boundaries. It helps the patient navigate the healthcare system as smoothly as possible. It depends on good communication and in the timely and accurate sharing of information. Such informational continuity is an essential part; the completeness, readability and availability of clinical records is very important.

‡ Also sometimes called *personal* or *interpersonal* continuity.

§ Also sometimes called *organisational* continuity.

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Together with communication skills, continuity of care is probably the most important tool of general practice. Whilst healthy people with minor health problems may not see the value of seeing a regular doctor, we show below that the success of much health care depends on effective therapeutic relationships between an individual and his or her chosen health professional. Management continuity, even a comprehensive electronic healthcare record, is worthwhile and important, but is no substitute for this.

Personal care in UK general practice

UK GPs are expert generalists[¶] who value their role in co-ordinating and integrating care designed round the needs and circumstances each patient. They deal with undifferentiated problems and illnesses that occur in different biological systems at the same time. They care for all regardless of age and gender. General practice in the UK embodies all that is recognised internationally about the advantages of a strong primary care system in health.[11]

General practice began as a personal service often supplied by practices of one or two doctors in a locality that had a registered list of patients. In the 1960s policy-makers recognised the importance of avoiding professional isolation. Safety and standards of clinical practice for doctors working in primary care were more likely to be improved under the power of peer scrutiny. In addition, practices were quick to recognise the advantages and economies of scale involved in sharing workload in grouping together and this was encouraged by the payment structure of general practice at the time. Larger practices were more likely to receive public funding for modern premises. Some doctors began to take time off during the working week in recognition of their out-of-hours commitment and more intense working days, able to rely on partners to cover their work in their absence.

The 2004 contract further reduced the emphasis on the personal relationship by awarding the contract to the practice as a whole, so patients now registered with a practice, not an individual doctor. Contracts for primary medical care can now also be offered to other healthcare providers under the Alternative Provider Medical Services (APMS) model. Here the clinicians work in managed care organisations and sometimes in irregular shifts with even less daily attendance than is the case in group practices. Patients can find such patterns hard to understand compared with the four-day working week or part-time working on regular days each week.

It is now clear that in the last few years, particularly since the drive for rapid access and the large proactive GP workload encouraged by the Quality and Outcomes Framework (QoF), that patients are finding it far too difficult to get as much relationship continuity as they would like.[12] In many practices it requires enterprise, determination and social skill to get to see your chosen doctor.[13]

¶ See WONCA definition, Appendix.

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Patients need GPs

As expert generalists who work in the communities where patients live, GPs offer integrated and co-ordinated health care. Most people with health problems have more than one, often referred to as 'co-morbidity' or multimorbidity, which can make their management challenging and complex. Many of the key health risks increase the likelihood of a number of different diseases that affect many parts and functions of the body. Patients do not think of their illnesses as things apart but as a part of their lives with which they must deal. As they struggle to make sense of their experience of illness, most turn to the GP whose specialised skills can integrate, prioritise and co-ordinate their care and meet their different and changing needs.[14]

These people with complex problems must navigate increasingly fragmented health and social care provision to get their care. There is a risk that, when patients receive different aspects of their care from different parts of the system, no one takes overall responsibility. GPs accept this responsibility and can often prevent expensive duplication of investigations or un-coordinated care from different providers.

General practice is cost-effective – the evidence

Strong primary health care is associated with lower health service costs overall, and better health outcomes. The effective management of complex conditions in primary care keeps people out of hospital.[15] The presence of greater numbers of GPs per head of population is associated with lower all-cause mortality (especially cancer and heart disease). The supply of GPs appears to have more influence on lower standardised hospital mortality than the ratio of specialists in a hospital.[16]

International studies have shown that, where primary care is strongest, hospital activity is reduced and the supply of GPs in a region is associated with fewer hospital admissions. In our NHS 95 % of all healthcare contacts occur in primary care. On an average day GPs provide over one million consultations.

A whole year's care by a GP costs about one tenth of a day in hospital. A face-to-face consultation with a GP costs about the same as a telephone consultation with an anonymous adviser through NHS Direct.

Research has further identified the positive effects of strong primary care systems through international comparison and analysis.[11] Even American policy-makers and researchers are now recognising the power of continuity of care in the concept of 'medical home',[17] especially for helping patients with co-morbidity.[18] This comes after years of focus on single-condition case management – and emphasis on technological intervention within strictly controlled care pathways, rather than a generalist, integrated or holistic approach.

Relationship continuity makes primary care so effective

There is a lot of evidence that a good relationship with a freely chosen primary care doctor, preferably over several years, is associated with better, more appropriate care,

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better health and much lower healthcare costs.[11] These advantages come from the trust that builds up through relationship continuity.

Trust means that when a patient asks a doctor if an X-ray or a referral or scan is needed and the doctor says it isn't, that the doctor is believed. Keeping people away from secondary care is generally good for them – unless it is really necessary – and that is the most difficult judgement any of us have to make.

David Haslam, *Malta Medical Journal*, 2008[||]

Research evidence demonstrates that continuity of care is associated with increased trust and security in the doctor–patient relationship. This supports 'wait and see' management of self-limiting conditions; that is, it reduces unnecessary and possibly harmful medical intervention.[19,20,21]

Policy-makers can capitalise on the trusting relationship between primary care staff and patients to manage risk and resources effectively with little delay when new priorities arise. In the 2009 swine flu outbreak, different countries made different arrangements for managing the outbreak. In Wales, arrangements for preventing and treating swine flu were channelled though the GPs, unlike in England where different and new arrangements were made in each locality to allow patients to access antiviral medication.

We only treated patients in the high risk groups with antivirals (rather than just anyone with symptoms) and they spoke to, or were seen by, their own GP or local out-of-hours doctor first.

Speaking to a known and trusted doctor enabled us to explain the rationale for treatment and reassure most that it was a self limiting illness and should be treated symptomatically like any other 'flu bug'. Confining treatment to at-risk groups only, I feel, also enabled us to contain expectation and not undermine the policy of not prescribing for self limiting illness.

Welsh GP

Continuity of care and better outcomes

Research also tells us that relationship continuity (the doctor and patient knowing each other well) is also associated with better:

- recognition of health conditions including diabetes[22–24]
- medicines usage and adherence[25–27]
- uptake of screening programmes and of immunisations[28]

|| www.um.edu.mt/umms/mmj/index.php?id=22

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- and with cost savings in investigation, prescribing, hospital referral and admissions,[20,29–31] use of A&E,[32,33] and overall cost of health care.[11]

There is much research evidence about the effectiveness of continuity of care in long-term conditions. In diabetes in particular, Naithani *et al*. demonstrated that explanations over time from the same clinician improve patients' understanding of the disease and its management.[34] A doctor or nurse who knows the patient can give personally tailored advice. This is more powerful in supporting the patient to manage his or her own condition effectively and with confidence.

Patients who experience discontinuity are more likely to discontinue treatment by not turning up for appointments or by taking their medication less assiduously.[35]

Continuity of care contributes to patient safety in other ways. It reduces conflicts of responsibility by encouraging a doctor's commitment to the patient as the care co-ordinator – a sense that 'the buck stops here'. Much of the personal care focus in general practice today is based on principles of person-centred care and a holistic approach. This has been described by McWhinney, an international authority on general practice.[36] He stresses that the key is responsibility, not personal availability at all times. It is on this body of theory that young GPs' training is based.[37]

When people are in trouble

One of the challenges in general practice is to help people with medically unexplained symptoms. It is not always possible (or appropriate) to reach a diagnosis for many people who present with a unique collection of symptoms, and most of these resolve spontaneously. A less experienced doctor and worried patient may press for unnecessary and unhelpful investigation. Managing unexplained symptoms requires a good relationship between doctor and patient, involving a sympathetic enquiry into the psychological background. The patient will usually respond well to emotional support.[38] Research has shown that patients with unexplained symptoms are no more likely than those with medically explained symptoms to seek explanation, reassurance or interventions such as investigations, drug treatment or referral, but they are much more likely to seek emotional support from their clinician.[39] They will seek one they know and trust.

A good therapeutic relationship can also be of inestimable value for patients for whom things do not go well – for example in terminal illness or where treatment is unsuccessful.

Julie has had endometriosis for over fifteen years, which has drastically affected her life. Despite many medical and surgical treatments, she still lives with almost constant pain.

'I found myself moving from Southampton to Belfast, living with family. My new GP was sympathetic, and after some further trips to hospital … we established a regime of pain control to follow at home.'

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Her GP comments:

Those who are privileged to provide continuity of care (still, I feel, the bedrock of general practice despite modern working practices) will appreciate the difficulty in motivating a patient in difficult times. As in many such cases, I have felt a degree of hopelessness at my inability to change Julie's management for the better, but you can still provide support by simply being a listening ear.

Julie Harvey and Ian Warwick, *British Medical Journal*, 26 June 2010 **

When relationship continuity works well …

Marion used to like to see her GP, Dr Colin, regularly – she often came on a weekly basis for a chat and a bit of advice. One day she didn't come. Alarm bells rang, so Dr Colin went round the next morning and found Marion collapsed in bed, seriously ill with pneumonia. An ambulance was called, she was admitted to hospital, successfully treated and eventually resumed her visits, although she changed them to Tuesday as Dr Colin's surgery hours had altered.

… and it is just as important for nurses:

I know all 130 of our patients on warfarin, which greatly helps with patients taking their medication regularly, turning up for checks and knowing how to adjust their dose. The continuity means that patients have confidence that the person making the decisions knows them well. All discharges of patients on warfarin are referred to me so there is minimal opportunity for people slipping through the net. We also have a really good relationship with the local hospital anticoagulation department to ensure a safe transfer from hospital to general practice. Patients like the personal service and feel cared for.

Nurse practitioner who runs an anticoagulant monitoring service for patients of a large practice

Patients appreciate relationship continuity

Surveys of patients' experience and research tell us that patients value continuity of care. They are more likely to be satisfied with an encounter with their 'usual', i.e. their chosen, doctor than with one they feel they know less well – no matter how good that GP's technical skills. Researchers have shown that positive patient outcomes such as enablement (feeling able to cope with their condition after a consultation) are closely linked to relationship continuity.[40] In Scotland the government is recommending an evidence-based index as a measure for doctors to use in their appraisals and

** www.bmj.com/content/340/bmj.c2661.full

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revalidation.[41] The CARE index[42] is a measure based on pattern feedback that assesses the quality of the interaction between GP and patient in a consultation. Higher scores are associated with 'knowing the doctor well' and with better outcomes, such as a sense of enablement and improved wellbeing.

Mainous and Gill's 1998 study is one of the few to have compared the relationship with a single family physician with the care from a group practice.[43] They found the benefits of continuity came more from the single personal relationship than from loyalty to a practice or team.

It is important to note that patients can find too much choice confusing but want to exercise choice over their individual personal clinician.[44] They need information from the practice on which to base this choice. They will often also ask family and friends for recommendations and the opportunity to experience care from a number of different doctors before making their choice. Having made that choice, to be prevented from seeing that doctor can be frustrating.

My GP retired a couple of years ago. I had a good relationship with him but never considered it anything special, although once or twice he made comments about 'knowing me well', which surprised me. When it came to 'choosing' a new one in the same practice, I could not believe how apprehensive I was. Should I opt for one of the experienced older partners? But then he might retire just when I was really old and in most need of him. Should I choose one of the younger GPs? But then they might move or work part time. So should I choose the newest and youngest, a newly qualified doctor? He'd hopefully be around long enough to see me out but does he have the experience?

Since then, I must have had at least a dozen GP appointments. I have always asked for my 'chosen' GP. Only three times have I actually seen that doctor; once because I could wait for four days and the other because 'my' GP was actually the duty doctor.

Member of the RCGP Patient Partnership Group

Continuity of care is not for every patient all of the time. The National GP Patient Survey (GPPS) asks respondents if they have a doctor they prefer to see, before asking how often they have managed to see him or her. The GPPS results indicate that the proportion of patients holding this preference can vary between practices and may be less prevalent in urban areas. However, it should be remembered that the response rates to the GPPS are very low in some parts of the UK and the results may be unrepresentative.

What can go wrong with relationship continuity?

There are many anecdotes and some research evidence that significant diagnoses may be delayed by familiarity, or that a doctor may rely on his or her assumed knowledge of the patient through familiarity, to delay focusing on vague symptoms. In contrast,

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a doctor who has not seen the patient before will investigate earlier to make up for his or her lack of knowledge of the patient. It is sometimes the case that a serious diagnosis only comes to light when there is a discontinuity in care, as when a patient has to see a different doctor in an emergency.[45]

One of the challenges of general practice, where important conditions occur relatively infrequently, is to remain alert to the possibility of the unusual and significant. It is the nature of general practice that it has to deal with early presentations and undifferentiated presentations of illness. It is part of the GP's armoury of skills that tells him or her when to take action. On balance the good of general practice, described above, outweighs this potential weakness. This is provided that patients are able to return when they want to discuss their concerns again, that doctors remain aware of possible diagnostic traps in the early stages of investigation,[38] and that doctors review and share the learning from such cases.

If a patient loses faith in his or her usual doctor, the patient should, of course, have the opportunity either to mend that relationship or to see someone else.

When I was 35 I attended my local surgery three times over a period of about four months, feeling lethargy and with swollen glands in my throat and neck. As I had young children at that time, the first two doctors told me I might have mumps and then mumps that I was taking time to get over. (I was at the time pretty sure that I had never had them as a child.) On my third diagnosis of possible mumps I responded in disbelief with 'You cannot be serious'. He considered for a while then said it might be glandular fever, but then I was really too old to have contracted it!

Anyway, the test results came back positive, and, given that my six-6-year-old had been very whingey for quite a while, I asked about whether he could have it too. I was then told he was too young to get glandular fever. I persisted a little and the GP agreed for me to take him for a test – that was positive too!

Member of the RCGP Patient Partnership Group

There may also be a problem when many doctors are involved. Those without a continuing relationship with a patient may assume that the usual doctor knows about, and will deal with, aspects of long-term care, when in fact no one takes responsibility for action until it becomes urgent. This has been called the Collusion of Anonymity[46,47] and it still causes deaths.

I work in a small practice (less than 4000 patients) as a salaried doctor with three partners, two of whom are part time. Continuity can be a problem, but we try to get round this by making good notes with clear expectations, showing our thoughts on what to do next.

We can run into problems, though. Cedric is a 68-year-old man with a history of prostate cancer who was being treated for hypertension, but did not regularly consult the same doctor. A delightful man, he prefers

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to discuss other interests we have in common, rather than dwell on his problems when he sees me, and this can be very distracting. His blood pressure treatment had been changed around when he came to see me with a swollen leg. I sent him to our excellent thrombosis nurse at the local hospital. The nurse excluded a blood clot in his leg, but did some other tests and found his kidney function had become a lot worse as a result of the medication change. The previous results in his notes were from 2007 and, since then, none of us had written down that we had asked him to have any blood tests. His kidney function did pick up when we reduced his new treatment, and I have now audited all our patients on this drug after discussing this as a significant event with my colleagues.

Rural GP

Lena was a 40-year-old woman with schizophrenia. Under the care of a consultant and with a mental health nurse to guide her, she obtained her usual medication from her GP practice. She took to seeing a part-time GP, Dr Green, whom she trusted. She was confident enough to attend these appointments without the support of the mental health nurse. She was usually well organised and managed to see Dr Green regularly and take her standard medication without prompting.

One day she arrived for an appointment a bit late, but Dr Green was duty doctor and running late because of many interruptions. Dr Green felt confident that Lena was being well looked after. He also thought that he knew her well enough to simply give her a new prescription without spending much time talking with her that day.

A week later Lena killed herself by jumping in front of a train. In reviewing the records for the Suicide Review, Dr Green realised that it had in fact been a year since he had previously seen Lena. In that time she had seen nine different doctors, presumably because she had started leaving her request for appointments until she needed her new prescription urgently. There had been no communication between the Mental Health Team and the practice in that time, and no one had recorded a general review of Lena's state of health. When the practice met to discuss the tragedy, they realised that all the doctors who had seen Lena were either locums who had not returned or doctors who believed she normally saw Dr Green, or the Mental Heath Team, and that all was well.

The balance

The balance of evidence between the positive and possible negative effects of continuity is now clearly in favour of enhancing relationship continuity. GPs need to be on their guard that familiarity does not lead to assumptions that can undermine their vigilance for constellations of symptoms. These can signify that something is amiss or that

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something new is present, or that the deference engendered by the patients' trust deflects them from bringing vague, troubling symptoms to the doctor. The jewel in the crown of primary care is the trusting and mutually respectful relationship that allows the space for exploration of problems and the sharing of decision-making. It is this that improves patients' health outcomes and helps to protect the health service from inefficiency.

The importance of management continuity

Management continuity is more straightforward and is easier to recognise as important and useful. It concerns good communication between healthcare team members, or between providers, and supports the concept of the patient's care pathway through the system. It relies on good records and timely communication across organisational boundaries to the right person. It is threatened by multidisciplinary and part-time working. Patients really only notice it when it is lacking. It is therefore sometimes called 'seamless care'. It is supported by the commitment that comes from good relationship continuity. Indeed, relationship continuity often makes up for its weaknesses, bridging information and communication gaps through additional personal effort.

When Catherine was 93 years' old, still living at home in an isolated village, she developed a rare, painful and serious skin condition.

Her GP did not know much about it but thought she recognised the condition. She sent photographs of the rash with the referral letter and, on the strength of that, Catherine was seen urgently by a dermatologist.

The dermatologist telephoned the GP to discuss the case and Catherine's management so that she could be cared for at home. He discussed the treatment, dosage regimes and other safeguards. He arranged for his specialist nurse to meet the district nurse to show her how to treat and dress the blisters.

Local Enhanced Services have been offered by our members as a policy that encourages relationship continuity. Anticoagulant monitoring in the community provided by practices for their own patients is one of these (see above). But when this service is provided by another GP practice or hospital, things can go very wrong.

Arnold is an 89-year-old man who has heart disease and lives alone. Blood tests for his warfarin monitoring are taken by the district nurse. The blood would be sent to the local laboratory and the results phoned through to the practice. Then the practice nurse would phone Arnold to tell him how much warfarin to take.

One day the sample was late arriving in the lab, so was not analysed before the surgery closed. The result was not ready until 2 a.m. the next morning. This was very high, indicating that the patient should not take any warfarin until another test could be taken. The laboratory therefore phoned through to the Out-of-Hours (OOH) service. The OOH doctor then

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called Arnold's home at 2 a.m. with the results. Because he was fast asleep and without his hearing aids, he perceived that a strange man was calling him, purporting to be a doctor and trying to get all the details of his address. When the doctor asked if he was bleeding and if he was okay, he was confused and terrified. The doctor appeared not to have considered the risk that he might have fallen while getting out of bed in the dark, or have been very frightened by the telephone call.

His GP comments 'He had already taken his warfarin and the call made no difference at all to his care. The result could have been phoned to the surgery first thing in the morning, so that familiar staff could call him and sort out his dosage and check on his condition.'

As GPs are encouraged to collaborate to widen the scope of the investigations, care and treatment offered in the community, they are grouping together in federations. This is a model the RCGP supports as a way of improving primary care services to patients. It keeps their relationships with their GPs strong and retains familiarity. It could sustain and protect smaller practices. Within federations the GP's role as co-ordinator of care and guide becomes even more important.

Things often go badly wrong for patients when they are in transition between different parts of the health service. In such a case the doctor, acting as the patient's agent, will go out of his or her way to fill the gaps. Patients themselves and their relatives may have to put in enormous effort and persistence to overcome deficiencies in care at the interface, and these can be exceptionally distressing.

Annie is 88 years' old and has senile dementia. She is cared for at home by her slightly younger sister, Sarah. She is becoming increasingly frail and the GP has recently arranged for her to have day care four days a week at a special centre run by social services.

Sarah called her GP because Annie became agitated and restless, and more than usually aggressive towards Sarah. She was up all night hallucinating. The GP examined Annie and could find no physical illness. Realising that Sarah could not cope alone with Annie, he tried to arrange respite care. The care home said that no bed was available for at least a week. The GP gave Annie some sedation. On Saturday night Annie fell and Sarah could not get her back on her feet. In desperation she phoned the out-of-hours service. She spoke to a doctor, who sent an ambulance.

In the local A&E Annie had several tests and was kept under observation for four hours. Then the casualty consultant told Sarah that he could find no physical cause for Annie's agitation and that she was fit to be discharged home immediately. By this time Annie was actually asleep in the assessment ward. Sarah remonstrated with the consultant that she was exhausted and famished, having neither eaten nor slept for three days. She said she could not manage Annie at home on her own. She said she would return when she had had a rest and asked that Annie should be kept in hospital for a few days until respite care could be arranged. She asked that the hospital help to do this.

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The consultant replied that it was not the hospital's job and that it was Sarah's responsibility to care for Annie.

Feeling distraught with guilt, Sarah went home, leaving Annie in the hospital and went to bed. At 2 p.m. that afternoon Annie arrived home by ambulance. No follow-up support had been arranged.

Three days later, with the help of her daughter, Sarah got Annie into a care home where she visited her daily until her death two years later.

Whilst it is often, as in these examples, human commitment and common sense that makes the difference between success and disaster, there are now modern technological solutions that can enhance communication within and between clinical teams such as digital records, including images such as X-rays and scans, provided that requirements for information security and confidentiality are met. These can support the safe transition of patient care across boundaries. Telemedicine can allow consultations to occur over great distances and information can be safely transferred rapidly using the internet.

Where a central or shared record has many users, particular care must be taken with the human element of data entry and organisation to ensure the accuracy, integrity and completeness of the record. Patients themselves could contribute to this by having access to their digital records.

The single electronic patient record has been an aspiration for the NHS for at least a decade now. It offers exceptional potential for enabling all relevant clinical information to be available to practitioners in any care setting, particularly in emergencies. But while there is clearly scope for much enhanced electronic record linkage, there is no evidence that such 'information continuity' can substitute for relationship continuity. In everyday practice the reverse is true, with relationship continuity having to fill the cracks of missing information.[1]

Conclusion

Whilst management continuity is essential for a trouble-free patient journey through health care, it is often the commitment that comes from relationship continuity that smoothes the way. It could be the other way around. As lives get busier and more fragmented, management continuity should help to ensure the building of the trust and ease of access on which good therapeutic relationships depend. Thought and experience in practice must underpin new systems set up to ensure management continuity in our increasingly complex health and social care system.

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3 Why is relationship continuity hard to maintain today?

Continuity of care is under threat from both demographic changes, changes in society, funding arrangements and the increasing complexity of health care.

Demographic change

Over the last 40 years, populations have become more mobile. Annual turnover in practice lists of over 25% is now commonplace in some parts of the UK and GPs are themselves more mobile, changing where they work several times in their career. More recently the introduction of a salaried service for GPs where the length of contract may be shorter than the time doctors stay in partnership, and the lesser commitment to the practice, also means that many GPs move practice more often. More GPs now work as peripatetic locums or assistants, sometimes in more than one practice at once.

More people own cars and more commute long distances to work. All these changes have weakened the likelihood of patients and GPs remaining in contact over many years.

Increased ease of travel has allowed GP practices to cover larger areas. In addition there has been both professional and fiscal encouragement since the 1960s for doctors to work together in increasingly large groups. Practice list sizes have therefore increased, making it difficult for patients to work with and become familiar with only one or two doctors and one practice nurse.

In urban settings there has always been wide variation in affluence and multi-ethnicity. With increased mobility this mix is becoming more widespread. If people lack the language or social skills to negotiate increasingly complex practice arrangements, it can be very difficult for them to arrange to see the doctor of their choice rather than the first available. The disadvantaged members of society, often the most vulnerable, may be the least likely to be able to benefit from a continuous relationship with a GP.[48]

As life expectancy has increased, people are living longer with increasing numbers of different long-term health conditions (co-morbidity) and have more complex health needs. Although GPs are expert generalists, other services even in primary care have become more specialised. This makes it difficult for one individual doctor to provide for all of one individual's healthcare needs as he or she gets older and sicker.

Changes in society and practice

With all the extra activities GPs are encouraged to take on in addition to direct patient care, their working day has become more intense. Surgeries that run for more than three or four hours without a break are now commonplace. This leaves doctors with little energy or appetite for providing round-the-clock care. GPs initially coped by

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sharing nights on call with neighbouring practices and in the 1990s began to set up co-operatives, usually provided by local doctors working on a shift system. Since the 2004 contract GPs are not now available 24 hours, seven days a week on a personal basis – with very rare exceptions.

More women have entered medicine and particularly are attracted towards careers in general practice. More women than men work part time or may be away for extended periods such as maternity leave.

In addition there has been more emphasis over the last ten years on 'portfolio' careers and GPs are no exception. Their generalist skills and attributes of adaptability fit them to fill a variety of roles. GPs may work in more than one speciality, may do research, teaching or be involved in management or regulation, thus reducing their time actually working in clinical practice with their own patients.

Professional changes

Other healthcare professionals are extending their roles and skills in primary care. Nurses, nurse practitioners, healthcare assistants and counsellors now work as part of the practice team. They may work in the wider community and have much less regular contact with single practices – for example district nurses, health visitors, midwives, physiotherapists, dieticians, and social workers. All these professions have become increasingly specialised and independent. So, for example, a GP may need to relate to nurses working in paediatrics, palliative care, chronic disease, diabetes, respiratory and cardiac nursing. A patient suffering from more than one chronic condition may have to relate to several specialist nurses working in the community. Community pharmacists are also extending their skills, and recent contractual changes, aimed at increasing choice and flexibility for patients such as checking long-term medication and providing cardiovascular checks, have tended to fragment the care traditionally obtained through or from the GP.

Patients can now get more of their care and advice direct from these increasingly specialised and expert healthcare professionals. Some other health professionals, such as optometrists, can now make some referrals straight to specialist medical care without having to go through the patient's GP.

Policy and contractual changes

No doctor named on the medical card

The 2004 GMS contract removed the registration of patients with a named doctor, perhaps in recognition that there was more part-time working by GPs and that patients could and should be able to choose which doctor they saw in a practice. The GMS contract is now between the local Primary Care Trust (PCT) and the practice as a whole. Thus registration does not offer patients any kind of link with an individual doctor. Any subsequent choice the patient is able to make is seldom recorded. This sends a

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message that personal relationships are not valued. A possible solution is offered by one practice's story – see the end of section 6.

The side effects of the QoF

The GMS contract of 2004 introduced a pay-for-performance element, the Quality and Outcomes Framework (QoF) – which rewards practices for the quality of clinical care and organisational management. This increased the focus on chronic disease management in general practice, by incentivising the recording of various key health parameters and encouraging evidence-based treatment. Whilst this has improved health outcomes in some practices[12] by encouraging a more aggressive approach to the management of some health risks, some argue that this has been detrimental to holistic care.[49] GPs relied on their store of patient trust to persuade patients to attend extra health checks and this has frustrated some doctors (and patients), and threatens to damage the goodwill of some in the longer term.

The effect of promoting access

Perhaps the most important recent policy changes to undermine relationship continuity has been the requirement on practices to provide an appointment with any health professional on the day of request and a GP appointment within 48 hours, for all patients who want one. Practices also had to provide extended daytime opening hours beyond 8 a.m. to 6 p.m. and to return to the possibility of weekend opening. All this, combined with larger practice list size and more part-time working, means that GPs in larger practices increasingly work shift systems, often with several doctors having to share one consulting room. (The interaction between access and continuity is further discussed in section 4.)

Senior GPs spend less time with patients

Policy-makers are now very keen to involve GPs in the design and commissioning of secondary care services, taking over from the PCT. GPs are recognised as having the knowledge of their patients' needs, and an interest in the provision of high-quality care for their patients. They can argue effectively from a clinical perspective for improved quality and are often influential locally in bringing about change in health services. Although this work should be supported by adequate management structures and expertise, senior and experienced GPs are increasingly spending more time away from clinical work in strategic planning and monitoring services, working in partnership with NHS management and secondary care colleagues.

Larger practices

In recent years single-handed and small practices have come under increasing pressure from policy-makers. The funding structure of the 2004 contract made it difficult for small practices to maintain their income. This has also discouraged partnerships from

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taking on or replacing partners, resulting in an increased proportion of GPs working as salaried assistants. The insecurity of funding has discouraged practices from entering into long-term employment contracts with assistants, to avoid redundancy costs. The additional urgent access work inherent in the GP access policies has led practices to rely on extra or temporary doctors. These doctors only do one or two sessions a week to add extra capacity, making it less likely that a patient will be able to see a doctor more than once, or for more than a few months before the doctor moves on.

Multiple entry points to health care

For many years general practice was the gateway to health care in the NHS, with only A&E services and sexually transmitted disease clinics accessible to the public without a GP referral. As part of policy moves to increase the choice and convenience for patients in obtaining medical aid, successive governments have set up other sources of advice, such as NHS Direct, and other primary care outlets, such as walk-in centres, urgent-care centres and GP-led health centres and 'polysystems'. In addition, since 2004, when GPs could opt out of out-of-hours care and PCTs took over the responsibility for its provision, most out-of-hours care is provided by non-GP providers who employ mainly peripatetic GPs who may not know the local area. All this tends to fragment care and can provide the patient with confusing and conflicting advice. It also entails increasing challenges to make sure that the patient's clinical record is complete and comprehensive, and that there are no gaps in their care.

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4 Access and continuity

Access and continuity are inextricably linked. Experience with recent policy initiatives has shown that prioritising one can unbalance the relationship. Prioritising rapid access has been detrimental to the patient's ability to see the doctor of his or her choice and to relationship continuity.

Good access is vital in any primary care system. In the UK, this is the patient's route into health care; restricting it risks distress to the patient and may even cause harm. In the 1990s waiting times were often excessive and could reach two weeks or more for popular GPs, and in some practices for all GPs.

Accordingly the Department of Health (DH) launched a campaign to improve access times, based on the concept of 'Advanced Access' started in the USA.[50,51] While impressive improvements were sometimes seen, one essential factor specified by the US pioneers – adequate capacity – was often not available in UK primary care. This capacity also depended on individual practitioners being available to patients across the week. As we have seen with patterns of working in general practice, this is becoming harder to provide.

When the DH decided to incentivise both practices and PCT management to achieve '48 hour access' the target was often achieved – but at the cost of making advance booking more difficult, and in some practices impossible. The DH has subsequently insisted on the retention of advance booking with a named doctor, allowing patients the option of waiting to see the GP of their choice.

While there is good evidence that ideally patients would like both quick access and relationship continuity,[52] in practice many are willing to wait when they feel this is worthwhile. As well as qualitative studies,[53,54] a series of discrete-choice experiments show how patients prioritise quick access for short-term, low-impact problems but prefer to wait for a known and trusted doctor for more serious problems.[55–58] There is evidence of patients' frustration about GPs' availability. At a public consultation conducted in Liverpool, participants said that they would not mind travelling up to 30 minutes and seeing a GP other than their own if it meant longer GP opening hours. But they also said that health care should be personal, based on the needs of the individual and that they wanted to be treated as people.[59] Recent work in Canada has shown how patient perceptions of their doctor's knowledge of them decreased when the doctor had an 'access-oriented' practice style.[60]

I have been visiting this health centre for 30 years and I must say that this young doctor could show all the rest that I have seen in my time. Everybody I know in the local area says the same. You always get greeted with a lovely smile and she takes time to go over things. She puts you at ease and nothing

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is a problem to her. She puts a lot of time in at the medical centre; the only downside is that you have to wait longer to see her because she's that popular.

Patient Testimonial from 'Celebrating the Best of General Practice', RCGP Scotland, 2009

Practices have for many years had to manage the problem of the most popular doctors having insufficient capacity to see all those who want to see them, and this can be a reason for long waits. Other ways of consulting may help to allow more patients quicker access (see section 6 below).

Continuity is as much in the hands of the patient as the doctor. When a patient decides he or she wants to see a particular doctor, the patient often has to use sophisticated planning and negotiating skills to get what he or she wants. After the consultation, both doctor and patient need to want to meet again to continue the relationship. Doctors can then both encourage the patient to return and influence the booking of the next appointment, or alter their availability in particular cases.

Those preferring relationship continuity tend to be older and more ill. But a significant proportion of those most likely to benefit from seeing the same doctor are vulnerable in other ways (poorer education, language problems, disability, frailty due to old age or lacking social skills). The most deserving may thus find it difficult to get the continuity they want if success needs a forceful personality combined with excellent negotiating and communication skills. Research suggests that relationship continuity will benefit all patients (and the funding of the health system), however sporadic their healthcare needs. If relationship continuity were to be positively promoted by practices and easier for busy people to obtain, it could become even more popular. In a recent review of the GPPS, results in two contrasting areas of England for 2008–9 showed that, while overall the frequency of consulting a preferred doctor seems good, there were geographical variations and difficulties related to age and to ethnic group.[1]

A number of those commuting some distance have asked for registration with a second GP near their place of work. This has attractions and makes sense for short-term problems and some preventive care in people who are generally fit. However, there is a risk of confusion and divided responsibility. Incomplete information may cause, for example, risky medication interactions and needless duplication of tests. Should such patients suffer significant illness, they will need care from a strange GP at home, just when someone known and trusted would be most helpful. Therefore any workplace registration should be subsidiary to primary registration near home. Successful implementation will depend on better record-sharing than is currently possible and technological solutions for this should be sought.

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5 The consultation and continuity

We have shown that relationships are built through patient and doctor meeting repeatedly to consult. In the consultation the patient presents his or her story, tries to make sense of what is happening to him or her, and ideally is able to discuss and agree the best way to manage the situation. For several years GPs have found consultation times pressurised and patients have expressed dissatisfaction with the time available with their doctor in satisfaction surveys. In fact, statistics demonstrate that consultation times have been gradually increasing, and even before the GP contract the Audit Commission showed the median GP consultation length was 13 minutes.[61] This perception of insufficient time is not confined to the UK.[62] What can be responsible for it?

First there is more to do in a consultation. More patients have more than one health problem, which need to be considered together. GPs emphasise a holistic approach to care, exploring the significant interplay of biological, psychological and social factors in each patient. GPs now spend more time on chronic disease management, encouraged by the QoF. This may require complex adjustment of treatment and negotiation of lifestyle changes. Research shows that longer consultations are associated with better outcomes.

Where patients feel listened to, and have had their own views taken into account, they are more satisfied with the time they have had with the doctor.[63] Where there is a long-term relationship with the doctor there is more opportunity to increase the depth and effectiveness of the conversation with repeated meetings. Conversely, loss of this continuity negatively influences the patient's perception of and use of time through the inability to build on previous consultations.[62]

As my primary care doctor, she will listen to me, treat every symptom and always take me seriously (even though I have many illnesses). If I was seen by another GP I would have to start all over again, causing me more stress. The care I receive is second to none. I believe she goes that one step further to get to the bottom of things and, if she can't, she will find someone who will. She is not just a GP, she is a social worker, counsellor and answers all the needs of her patients. She is always at the end of the phone when you are in need.

Patient testimonial from 'Celebrating the Best of General Practice', RCGP Scotland, 2009

More time together means that there is time to listen to the patient; to arrive at a better understanding of the patient's concerns and come to a more accurate and thorough diagnosis; to focus more on the patient and less on the disease; and to have more time to work together to arrive at an acceptable treatment plan.[64] This is shared

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decision-making and is preferred by most patients and doctors. It has also been shown to be associated with improved outcomes for patients when they can make a better informed choice about treatment options. The paternalistic doctor-led problem-solving of 'Doctor knows best' is no longer acceptable in most situations.[65]

Finally, more complex consultations require more time to enter information accurately and more fully in the electronic clinical record. This is essential, not only as an *aide-mémoire* for the doctor (and for the patient) but also as a crucial underpinning for further care, when the patient sees different clinicians in the same practice.

GPs who run longer consultation times prescribe less and offer more advice on lifestyle and other health-promoting activities.[66] Longer consultations are clearly associated with better recognition and handling of psycho-social problems [67] and with better patient enablement.[40] One way of managing the ever increasing demands on the consultation time is to allow the relationship to become established through seeing the same practitioner so that better use is made of the time together.

Currently there is an incentive for GPs to allow ten minutes for most pre-booked consultations in the QoF. But for many consultations now ten minutes is not enough, even though GP teachers are constantly reviewing consultation techniques to make best use of the time available. However, the view of many commissioners of primary care is that the numbers of patients seen in one day is a better measure of productivity.

The evidence and the experience of both GPs and patients is that this approach is counter-productive and could risk missing key information, having too little thinking and negotiation time, and result in fatigue. Pushing up the numbers seen at the cost of the quality of the encounter could be a threat to both patient safety and cost-effectiveness. It is time to move away from this production line approach.

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6 Helping patients to achieve effective therapeutic relationships

First, patients should be able exercise a choice of GP. 'Finding the right doctor for me' is crucial and can take time. But it should never be left to chance.[44] Patients often exercise their initial choice based on advice from friends and relatives, and on general preferences, such as gender, age or shared language.

Within the practice good information is key. Practices should offer such media as leaflets, websites and information boards in reception, allowing patients to identify and become familiar with who is available and how to contact them. Patients should be given the opportunity to 'shop around' and experience different doctors in the practice before making a decision. This decision should then be communicated to the receptionist and clinicians (usually by marking the clinical record).

Practices should allow flexibility for patients both to choose to change to another usual doctor, or to consult another on a particular occasion when the patient thinks it would be best for him or her. Indeed, some practices will flex the continuity model by asking patients to see another doctor with particular expertise such as gynaecology, family planning or minor surgery, when appropriate, rather than referring them outside the practice.

I spent many years without settling with one GP. All within one practice. But then a locum joined. I saw him by chance and clicked with him. He later became a permanent doctor in the practice and he's been my doctor ever since.

Member of RCGP Patient Partnership Group

Personal lists are advocated by some experts.[68] Whilst these can be a powerful tool, they can be too inflexible to take into account changes in patients' preferences, especially temporary ones. Patients must have the opportunity to make a well-informed choice and they should not be administered solely in the practice's interests by, for example, balancing the workload between very popular and less popular doctors. Relationship continuity should never be forced on patients.

Having small teams of doctors with similar attributes whose availability can be spread across the week may reduce the number of different doctors who a patient sees if a preferred doctor is not available.

Inner-city practice Croxon Street Surgery had a problem. When the newest partner asked to work part time following the birth of her first child, and three of the four other doctors needed to reduce their consulting hours for personal or professional reasons, only one doctor worked at the surgery

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every weekday. This combined with the needs of the local population and demands of the government's access targets to reduce continuity of care to a critical level. The partners realised that the lack of continuity was becoming a source of frustration for patients and a risk to their safety.

In order to improve things they formed together into teams of two GPs, taking on two part-time assistants to help them fill the gaps. After some thought and negotiation they proposed to their patients that teams should consist of two doctors who between them could cover the week and handle similar workloads. These doctors had similar styles but differing degrees of experience. Each team would handle its own emergencies every day and the administration for their patients. Work for patients who had not exercised a choice would be shared daily across the teams according to their capacity.

A three-month consultation with patients was carried out through the practice interactive newsletter, the website and in open meetings. Once the initial plan was settled, a publicity campaign was supported by special training for the receptionists and all clinical staff, leaflets posted to patients and handed out at reception, and a 'who's who' photo board in the reception area.

Patients were asked to exercise their choice of team based on what they knew of the doctors. This was a kind of 'discrete choice' in that if their preferred doctor was paired with one they did not like or knew less well, they had the option of choosing a different team. Patients were asked to settle their choice in three months. New patients were initially allocated to a team if they could not exercise an initial choice and were given six months to settle. Thereafter, requests to change were negotiated with the practice manager.

After one year 60% of the patients were settled and happy, the doctors and receptionists felt less stressed, were hitting their access targets and had achieved improved scores of patients' experience in patient surveys. At the end of the second year over 80% of the patients had settled with a preferred team.

The trust on which a successful therapeutic relationship is based needs time to develop. Rapport can be established immediately and the ability to encourage this is part of the skill set of a good clinician. Receptionists and the clinicians themselves can do much to encourage the relationship to grow by positively encouraging repeat and especially follow-up visits for a certain illness episode with the same doctor.

The use of modern technology can increase the opportunities to build the relationship through continued contact more flexibly. Not all meetings need to be face to face, and often trust can be consolidated through telephone contacts, especially if these are doctor initiated and if they increase the time available for consultation. GPs should make it clear when they are personally available by telephone for their usual patients, not solely when they are dealing with emergencies as the 'duty doctor'. When relationships are more firmly established email contact could be considered, provided that the inability of email to convey emotion is taken into account.

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7 Measuring and monitoring continuity

If continuity of care is to be rewarded and preserved it must be measured and monitored. Measuring continuity is not straightforward, but available methods can suggest where improvement is needed.

Relationship continuity

All practices now get regular reports from the GPPS.[69] Questions 15 and 16 give some feedback on patients' perceptions of relationship continuity, asking whether there is a particular GP they wish to see, and if so how much they achieved this. The GPPS also gives some assessment of how the patients perceived the quality of clinical encounters in the practice. Unfortunately the GPPS does not give results for individual doctors – limiting its usefulness. To get such feedback, practices need to administer questionnaires themselves; they can use both GPPS and the General Practice Assessment Questionnaire (GPAQ). Greenhalgh and Heath[8] recommend the Patient Perception of Physician Responsiveness Scale.[70] We have already highlighted the use of the CARE measure in Scotland.[41,42,71]

To achieve an effective therapeutic relationship, patients need to be able to see their preferred GP when they choose to. Their success can be indicated by the proportion of recent consultations achieved with their usual doctor (the Usual Provider Continuity index or UPC).[72] Although in theory easily obtained from computer record systems, these data are currently difficult to interpret.[73] This is a challenge to the design and use of practice electronic medical record systems, which needs to be addressed.

Management continuity

Here there are as yet no agreed overall measures for use in clinical practice. However, monitoring timely arrival of data from secondary care is relatively simple as a first step. It is also possible to appraise the relevance of information in referral letters. Other possibilities include audits related to medicines management in primary care, for example medicines reconciliation[§] audits to ensure that changes made in secondary care are recorded and followed up by the GP.

Existing procedures for practice assessment visits such as for QoF or clinical governance can also yield good assessments of management continuity both within the practice team and including the practice's handling of patient data from secondary and other care centres.

§ Medicines reconciliation is 'the process of identifying the most accurate list of a patient's current medicines – including the name, dosage, frequency, and route – and comparing them to the current list in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications, accurately communicated' (Institute of Healthcare Improvement [IHI]). This ensures that patients receive all intended medication and no unintended medications following a move from one care setting to another.

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Monitoring

Practices should be encouraged (and perhaps required)[74] to monitor their performance and report it to their patients. Pending the development of better tools, they already get GPPS feedback and they could be asked to act on this.

They are also required to demonstrate use of critical event analysis (CIA or SEA). The QoF and professional standards for appraisal could be modified to specify the inclusion of an assessment of continuity care factors on both causes and proposed remedies.

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8 Recommendations

Relationship continuity should be available to promote effective therapeutic relationships in primary care, but it should not be compulsory. Patients should be informed about the potential benefits and how to obtain it, and practices should be encouraged and supported to offer it. There are different but overlapping roles for the College, policy-makers, managers and commissioners, as well as for individual practices.

In continuing to promote continuity of care the RCGP will:

- explicitly prioritise it in education and training, from undergraduate education through to postgraduate training for GPs, and in continuing professional development
- include it in leadership training by maximising the conditions that foster it
- include attributes that promote therapeutic relationships such as personal availability and communication skills in professional standards for GP appraisal and revalidation
- promote the redesign of the GP digital record to make management continuity easier and the adaption of the clinical record, so that relationship continuity can be measured and monitored.

Policy-makers

1. Keep general practice familiar and local. By avoiding alienation it can deal with health inequalities effectively.
2. Support existing small practices and encourage them to avoid the problems of professional isolation through joining general practice federations.
3. Give patients opportunities to develop ongoing relationships with GPs they know and trust.
4. Prioritise continuity of care, capitalise on the trust it engenders to improve health outcomes and make best use of scarce resources for individuals and populations.
5. Subject new healthcare policies to an impact assessment for continuity of care.
6. Relationship continuity should be measured and rewarded. Current research knowledge and practical experience should be brought to bear on further work to devise workable process measures.

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7. GP time spent with patients should be safeguarded. External work such as commissioning should be allowed for in designing GP contracts whilst not distracting from the importance of direct patient care and should not be treated as a spare-time pursuit.
8. Increasing consultation length should be prioritised and incentivised. The pay structure and manpower implications of this should be reviewed and supported.
9. The structure of clinical record software used in primary care should be developed to make it easier to record relationship continuity and to promote ease of access to significant clinical information, in order to promote management continuity.
10. Employers should be encouraged to facilitate employees' visits to the doctor during reasonable working hours.

Healthcare managers and commissioners

11. Commission primary care in such a way as to encourage relationship continuity.
12. Listen to what patients say they want most.
13. Use existing levers to improve information quality across care boundaries, for example in referral letters and discharge summaries.
14. Commission medicines management to include drivers for continuity of care, for example through prescribing incentive schemes by rewarding adherence to medicines, medicines reconciliation, or medication review with the patient as part of holistic care.
15. GPs should lead the commissioning of out-of-hours care to ensure standards and continuity.
16. Avoid the fragmentation of care and over-complex co-ordination requirements. Take care when commissioning services such as local enhanced GP services, the procurement of services from multiple providers, and the agglomeration of primary care services.
17. Commission care pathways with attention to both management continuity and safety. Care should be taken to avoid opportunities for care fracture at the boundaries or frequent changes of providers and configurations.

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18 Make it possible for patients to develop a trusting relationship with at least one clinician over time.

19 Involve patients in plans for service changes and improving continuity. Listen to their views and ask for suggestions.

20 Give a clear statement of the importance of continuity of care to your practice ethos, for example in the practice leaflet and at registration.

21 Give patients clear information about how to get an appointment with their chosen doctor and when it is most important for their care that they do this.

22 Give clear information about how and when patients can contact their doctor in between face-to-face appointments.

23 Review the process for booking appointments to promote continuity.

24 Promote teamwork, internal communications and staff training. Larger practices could consider organising into smaller units providing closer team communication and extended availability across the week.

25 Appreciate, monitor and manage the potential pitfalls of very high continuity. These can include inflexibility for patients, collusion between clinician and patient in poor adherence to effective clinical management, delays in diagnosis of slow-onset conditions and loyal patients waiting too long to see their preferred doctor in acute situations.

26 Consider the length of consultation slots. Could these be extended beyond ten minutes? Could the practice offer patients a choice of consultation length?

27 Review staff capacity and employment policies. Balance outside commitments with direct patient care.

28 Measure and monitor continuity.

29 Give training and feedback to all staff about continuity.

30 Look for where things go wrong, Use critical event reviews to share learning and adjust policies and practice.

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9 In conclusion

What is powerful and what matters most in primary care is the quality and strength of the therapeutic relationship. Continuity of care is part of the process by which this can be obtained. Communication and consulting skills are also important. The quality of the therapeutic relationship is difficult to measure and therefore to commission. Facilitating it, by promoting time and opportunity for patients to choose their GP and for doctors and patients to work together in a consistent manner, should be the priority of policy-makers nationally and locally. GPs should be given the opportunity to do what they do best for their patients.

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Appendix *Definition of general practice*

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness.

They care for individuals in the context of their family, their community and their culture, always respecting the autonomy of their patients.

They recognise they will also have a professional responsibility to their community.

In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts.

General practitioners/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services.

They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.

SOURCE: WONCA Europe. *The European Definition of General Practice/Family Medicine* London: WONCA Europe, 2005.

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