Improving Continuity of Care

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'If a patient goes on a diagnostic journey, having continuity of care is taking no detours.'

1. Background

Continuity of care was once a paradigm of general practice, eroded through lack of prioritisation and overwhelming patient demand. Despite this, its benefits are eminent, well-proven and largely acknowledged by clinician and patient alike. **A survey answered by 43 of our most frequent attenders scored continuity of care as 4.67 out of 5 for importance (93.4%).**

Modern primary care struggles inexorably against a current of expectations from increasingly complex patient needs, floundering secondary care wait times and a diminishing budget. It has adapted by conglomerating into bigger Primary Care Networks with more community care being provided by clinicians with more specialist knowledge. Triage processes enable higher levels of same-day patient access alongside additional primary care roles to facilitate unprecedented levels of appointments being delivered.

The above changes, although made out of necessity, make continuity of care as we previously experienced it, an impossibility. Our task now is to harness its known benefits and integrate them into contemporary general practice.

2. Benefits

There have been many studies highlighting the positive outcomes from continuity of care.

Patients:

- More satisfied
- More likely to follow advice and engage in preventive medicine
- Less likely to attend A&E
- More likely to live longer, and have more cost-effective healthcare with fewer hospital admissions.
- Stronger doctor-patient relationship. (1)

Clinicians:

- Reduced risk of significant harm
- Increased job satisfaction.
- Improved ability to recognise and manage long-term conditions
- Better management of complex problems through accumulated knowledge
- Decreased costs from avoidable prescriptions and tests. (1)

The Word Cloud *(Figure 2)* was generated by our Frequent Attender Patient Questionnaire, capturing their perceptions of the benefits of continuity of care.

Figure 2

3. The Current Situation

Continuity of care is not easy to achieve.

At our practice we do not utilise patient lists, although everyone is arbitrarily assigned to a General Practitioner (GP). The exception to this is for palliative care when patients are meaningfully allocated a clinician to lead their care.

We have a central triage list that doctors work from, a system that enables a level of fluidity, smooth functioning and skill assignment greatly appreciated by the team. It does, however, mean the system is not set up to naturally promote continuity of care , further exacerbating an already difficult accomplishment. The above Fishbone Diagram *(Figure 1)* highlights the multitude of *'system'* or *'person'* centred problems that may be encountered.

The Usual Provider of Care (UPC) Index provides a tangible assessment of continuity of care. It is simply the percentage of appointments undertaken with a patient's 'usual' clinician, (the one they have seen most often). The Royal College of General Practitioners suggest that a **low UPC index is under 39%, medium between 40-69% and high above 70%**.

The baseline data collected from our practice gave us an **average UPC index of 42%** for patients above 9 consultations a year (the amount deemed sufficient to properly assess continuity). Practice GPs reflected unfavourably towards our current provision of continuity of care on the questionnaire posed to them at the outset of the project. *(Figure 3)*

In contrast, for our **palliative patients our average UPC index was 65%**, just shy of a 'high' level.

A patient survey of our frequent attenders revealed only 33% acknowledged they had a 'usual' GP who they consult with, of the remaining patients, 100% stated they would rather have had a 'usual' GP.

4. Change

To expand on the success demonstrated by our palliative patients we recognised a further cohort of patients who would benefit from improved continuity of care. Frequent attenders to the surgery are a group of patients who are likely to have significant biopsychosocial complexity alongside representing a disproportionately high level of workload (**40% of our annual consultations are with the top 10% of frequent attenders**). They are therefore optimally positioned to gain from the benefits of continuity of care as listed previously.

Our MOST frequent attenders comprised 133 patients who undertook more than 20 consultations with a GP (excluding additional roles and trainees) within a 12 month period. **Their average UPC index was 42%**. This cohort was assigned to the GP they had seen most regularly, with adjustments made to balance numbers according to sessions worked.

An alert was added for our care navigators to assign them to their allocated clinician or suggest a move to a day when they were available if the issue was non-urgent.

Care navigators were also encouraged to discuss with patients on booking about whether they had a 'usual GP', or had spoken to someone about this issue previously and whether they would rather wait to speak to them again. According to our patient survey **76% of patients were happy to wait up to 1-2 weeks to consult with someone they had spoken with previously**.

Clinicians were encouraged to suggest and book their own follow up for ongoing issues rather than allowing patients to self-book and invariably return to the central triage list in an unallocated appointment slot.

Stakeholders were engaged in the project with a practice-wide education session highlighting a case review where lack of continuity of care had likely influenced a patient's unfavourable outcome alongside the multitude of benefits from improving continuity of care.

AIMS:

1) Improve continuity of clinician interaction in our most frequent attenders to the surgery with a 10% increase in their UPC index by the end of the year.
2) Change practice mentality towards continuity of care with a proactivity towards booking follow up and maintaining consistency with complex patient care.

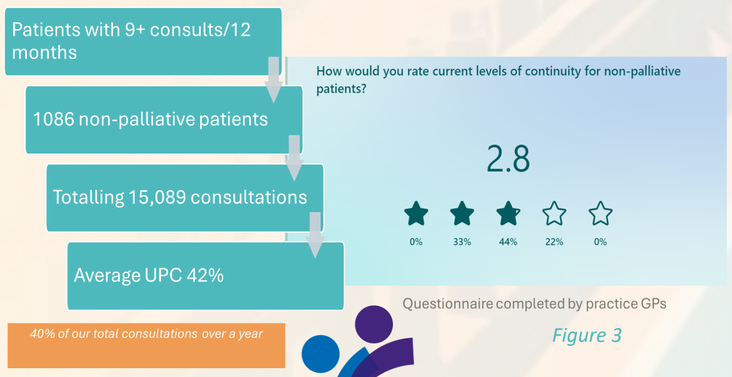

Figure 3

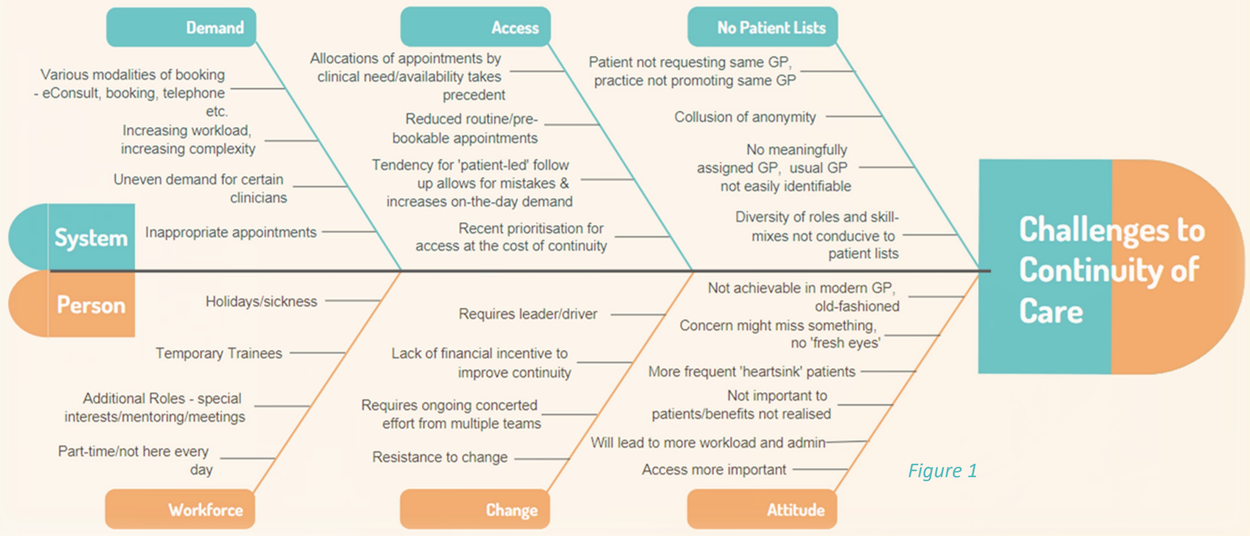

Figure 1

5. Outcome

Reassessment of the UPC index for our same cohort of most frequent attenders (20+ consultations/year) after a 9 month period following intervention revealed a **modest improvement in continuity**. The average UPC index for these 133 patients had risen from 42% in February to 45% in October. A step in the right direction although some way short of the aspired 10% improvement. The box and whisker diagram shows a similar improvement in all measured parameters. *(Figure 4)*

A second questionnaire sent out to the frequent attenders demonstrated there had been an **improvement in their perception of having a 'usual' GP** with 54% feeling they now did (previously 33%).

Balancing

Measurement of the total number of appointments held with this cohort of patients was also reviewed. In February it averaged 13.5 consultations in 6 months whereas in October this had actually increased to 22.0 over 6 months.

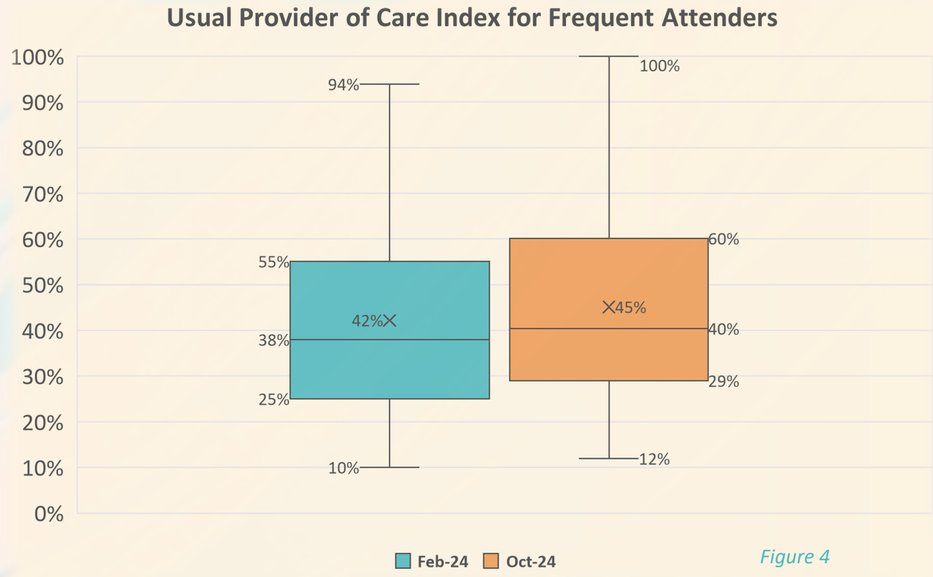

Figure 4

6. Reflections

Turns out continuity of care is not easy to achieve.

Even with a focussed cohort of patients it was difficult to make a significant change in their UPC index, albeit in a relatively short timescale. A number of the confounding factors featured in the Fishbone Diagram *(Figure 1)* were witnessed during this period. Patients, in reality, did not want to wait to speak to a designated clinician on a later day after the relief of getting through to book an appointment on that date.

Trainees had more availability, particularly for face to face appointments and therefore care navigators would book their slots rather than dredge through for the assigned clinician's next available one. For clinicians, it takes significant fortitude to book a 'complex' patient in with yourself when a trainee has a open slot, something even the most continuity-aware of us cannot indefinitely possess.

There were a few situations where there was a break-down in doctor-patient relationship necessitating a change in assigned GP.

Finally there were unavoidable events; sickness, holiday, urgent patient need, IT outages, training events, meetings, missed system alerts and rearranged appointments all which inevitably hindered progress with continuity.

The balancing measure demonstrated an increase in appointments held with this cohort of patients despite an improvement in their overall levels of continuity. This is incongruent to the existing data on the benefits of continuity of care. It perhaps demonstrates a period of 'off-loading' and planning whereby a patient and clinician set out a plan for managing complex multi-morbidity once continuity has been recognised. It may also simply represent the variation in patient condition and a increased period of 'unwellness'. The expectation would be as improved continuity of care continues this use of appointments gradually decreases as has been demonstrated previously.

I am hopeful that this process has changed the mentality towards continuity of care within the practice. Certainly there has been a notable increase in conversations and awareness about it since the beginning of this project. To that regard I feel the secondary aim of this project has been a success and the small improvement in UPC index seen will continue its trajectory in the upcoming months and years.

Continuity of care has been recently politicised and foreseeably may be more closely monitored alongside financial renumeration, it is likely this is going to be increasingly on the agenda for general practice.

Seemingly, as in real life, detours are inevitable, but we can still promote a forward momentum for our patients' diagnostic journeys.

Key Facts

- **Continuity of care has an array of benefits for clinicians and patients alike. It is becoming politically embroiled.**
- **It is measured with UPC index. A low UPC index is under 39%, medium between 40-69% and high above 70%.**
- **Our baseline average UPC for non-palliative patients was 42%**
- **Frequent attenders represent a disproportionately high level of workload (40% of our annual consultations are with the top 10% of frequent attenders).**
- **After assigning a cohort of frequently attending patients (>20 consults/year) to an assigned GP this UPC increased to 45%**
- **Patient recognition of having a 'usual' GP improved from a baseline of 33% to 54%.**

7. Next Steps

Continue to monitor our UPC indices for our frequent attenders at regular intervals. As patient contact ebbs and flows we should be re-running our searches for frequent attenders with an updated cohort reallocated to a GP.

Over time we may be able to expand this process to further patient groups most likely to benefit from improved continuity of care such as elderly, mental health, safeguarding and learning disability patients.

As a further project I intend to look into how we can optimise our MANAGEMENT of frequent attenders as the number of appointment slots being used by a small number of patients was startling...

References

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