

Research paper

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Continuity of care and the patient experience



An Inquiry into the Quality of General Practice in England

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Executive summary

This report was commissioned for an inquiry into the quality of general practice in England commissioned by The King's Fund. Its aims are to:

- define continuity of care and assess its importance as a dimension of quality
- explore patients' and clinicians' perspectives
- define good practice in relation to continuity of care
- assess whether and how continuity might be measured in general practice.

Methods and definitions

This report distinguishes between two types of continuity of care:

- **relationship continuity** – a continuous therapeutic relationship with a clinician
- **management continuity** – continuity and consistency of clinical management, including providing and sharing information and care planning, and any necessary co-ordination of care required by the patient.

Each type makes an important contribution to a patient's experience of how care is connected over time. The report brings together the research literature on continuity of care and information gathered from practice visits and interviews carried out in 2009.

The importance of continuity of care and the role of general practice

Continuity of care – in the sense of a patient repeatedly consulting the same doctor and forming a therapeutic relationship – has been described as an essential feature of general practice in England. Generally, relationship continuity is highly valued by patients and clinicians, and the balance of evidence suggests that it leads to more satisfied patients and staff, reduced costs and better health outcomes. There are some risks and disadvantages associated with continuity of care, and these need to be understood and mitigated. The way in which primary care services were traditionally organised generated good levels of relationship continuity, and GPs did not need to promote this aspect of care. However, recent developments – in particular, the increasing specialisation and fragmentation of primary care services, changing professional work patterns and the emphasis on rapid access – have raised concerns that relationship continuity with a GP is becoming more difficult to achieve. In this context, professional leaders must recognise that relationship continuity can no longer be taken for granted, and that GPs must play a more active role in making it possible.

Management continuity is relevant whenever a patient is receiving care from more than one clinician or provider. It concerns the processes involved in co-ordinating, integrating and personalising care in order to deliver a high-quality service. The GP's clinical responsibility as coordinator of care for patients includes helping patients to understand and plan their treatment,

navigate unfamiliar services successfully and remain engaged with their care. Good relationship continuity can contribute substantially to achieving this. As primary care teams expand, clinicians other than GPs (such as practice nurses or community matrons) are increasingly taking similar roles in co-ordinating care, and this input is highly valued by their patients. Management continuity also has an organisational dimension, in ensuring that the practice team and the systems supporting it work effectively and efficiently, and that the practice is well connected with other professionals and organisations.

Despite professional recognition of the importance of continuity of care, there is little practical guidance for GPs on building and sustaining good relationships with patients, and neither relationship continuity nor management continuity are monitored or incentivised in the same way as other aspects of good practice such as access or prescribing.

Patients' experiences of continuity

Continuity of care becomes increasingly important for patients as they age, develop multiple morbidities and complex problems, or become socially or psychologically vulnerable. However, generalisations can be misleading, since relationship continuity has been shown to be valued by patients in many different circumstances. It is now recognised that patients play a substantial part in securing continuity, which requires good social and negotiating skills – especially when access is difficult.

For example, patients are often faced with making a choice between rapid access to care and seeing their clinician of choice. Under these circumstances, people with less confidence, less education and poor language skills may need support and encouragement from clinicians and reception staff to achieve continuity. Good relationships cannot be prescribed, but they can be encouraged by sufficient opportunity to see the same clinician.

Clinicians' and practice team perspectives on continuity

The GP practices we visited advocated the importance of continuity of care, and encouraged patients to establish a relationship with one GP, but did not expect exclusive continuity, recognising that patients make relationships with other clinicians and do not always prioritise seeing a particular GP. They considered access arrangements – particularly what happens at the front desk – to be crucial to securing relationship continuity, but highlighted the quality of consultations (including sufficient time to deal with a patient's problems) as a way of cementing 'committed' relationships.

Management continuity was also important to the practices. They emphasised sharing information, good communication within the practice team and establishing systems that supported effective patient management. Their attempts to coordinate care with professionals outside the practice were sometimes a source of frustration.

There were contrasting approaches to promoting continuity, ranging from the paternal (where practices directed patients) to the transparent and enabling (where practices gave patients maximum information to inform their choices). However, it was notable that none of the practices had any means of monitoring levels of continuity, either from practice information systems

or patient-reported experiences, and there was no easy way of assessing whether continuity was improving or declining.

Defining good practice

Good practice in relation to continuity of care can be encapsulated in the following ways.

Relationship continuity

Relationship continuity involves patients being encouraged (but not compelled) to establish a therapeutic relationship with one or more particular professionals in the practice team.

Practice culture and organisation should support patients and professionals to maintain these relationships, and adjust them in order to reflect changes in the patient's preferences, needs or social circumstances.

This is enabled by practices being explicit about the importance of continuity and how it is achieved, which means:

- providing information for patients about the clinicians in the practice and their availability for face-to-face consultation, telephone, or email contact; publicising the practice's policy on continuity of care; and guidance on how to maintain continuity with GPs and other clinicians
- patients, clinicians and reception staff knowing who is the patient's usual or preferred GP
- ensuring sufficient time in the consultation for interaction that will promote formation of a relationship
- access arrangements that allow patients to exercise choice about who to consult, speed of access, and method of access (including phone, face-to-face consultation, or perhaps email)
- sufficient capacity for same-day and advance appointments
- helpful front-desk staff who are well trained to offer options that promote continuity, as well as achieving timeliness of consultation
- the usual GP being responsible for medication reviews and for discussion of test results
- working arrangements for clinical staff that include part-time, junior and temporary clinicians in ways that maximise rather than disrupt continuity
- providing additional help for patients who may experience access difficulties – for example, because of language or learning difficulties, cultural differences, physical disability, mental health problems or social isolation.

Management continuity

Management continuity involves patients being involved in treatment decisions and planning their own care, including referrals, and being helped to navigate services and systems outside the practice.

The GP takes responsibility for ensuring that patients with long-term

conditions, multiple morbidity or complex problems receive comprehensive, personalised, holistic and co-ordinated care. The GP may take the lead co-ordinating role, or may collaborate with colleagues in the practice team or from other services who act as care manager or co-ordinator. There are clear lines of accountability and leadership. Co-ordinated care includes offering interpersonal continuity, so that patients know which professional is responsible for co-ordinating their care and how to contact them, and GPs know which patients they are responsible for.

The GP and practice team also help patients to reconnect with services or systems when they experience discontinuities or fragmentation of care.

Management continuity is enabled by:

- full use of practice information systems and electronic communication
- timely availability of relevant clinical information – particularly from hospitals
- personal contact between providers, including regular meetings and informal discussion
- established routines for handovers and exchange of information
- proactive follow-up of patients after significant life events or health events.

Monitoring continuity of care

Practice teams monitor continuity of care through audit of aspects of access, co-ordination, communication and patient experience, including identifying and analysing significant events that may indicate specific problems, and seek to make improvements.

This is enabled by:

- patient input into developing practice policy on continuity and producing patient information
- involving the whole team – particularly front desk staff – in improving continuity
- identifying a practice lead for continuity, to champion this aspect of quality among competing priorities
- support and guidance on improving continuity from primary care organisations, professional bodies and regulators.

Measuring continuity of care

In order to monitor and improve quality of care on any dimension, it is important to measure it. However, this remains challenging for both main types of continuity. The simplest proxy for relationship continuity is how often a patient sees the same clinician. However, even this apparently straightforward objective metric presents difficulties of data collection, and raises questions of interpretation and hence utility in practice. Practices' ability to monitor the interplay between access and continuity is seriously limited by the inability of current practice-information systems to provide robust routine data on patients' patterns of contact with professionals. Measures of patient experience offer a more direct route to assessing patients'

perceptions both of continuity and the quality of the GP–patient relationship. Developing general metrics for co-ordination of care may prove even more challenging. Continuity and co-ordination across organisational and professional boundaries is of prime importance in achieving good outcomes for patients with long-term conditions, and one way forward may be to develop specific assessments linked to patient experiences of care.

Recommendations

To support continuity of care in English general practice, we recommend:

- building on these suggestions about good practice by conducting a wider review of current promising methods of assessing and promoting continuity in practice and developing a toolkit for practices
- ensuring better understanding of the importance of continuity and the need to prioritise or incentivise it alongside other developments in health care
- investigating ways of measuring continuity of care that can be used in service settings for improving quality
- studying the effects – including costs and benefits – of discontinuities of clinician in today’s general practice.

1 Introduction

Continuity of care – often thought of as ‘seeing a doctor you know and trust’ – has been consistently identified as a defining feature, and an assumed strength of general practice, around the world. It is inextricably connected with patient and doctor building a relationship of trust and the GP accepting overall responsibility for co-ordinating care, including helping patients navigate increasingly complex health care systems. Good and lasting therapeutic relationships flourish in a culture that values interpersonal care and within organisations that offer sufficient opportunity to see the same clinician.

Traditionally, the NHS provided a high level of continuity of care in general practice. However, social and organisational changes, and the thrust of health policy over the past two decades, have altered substantially the delivery of GP services (see Appendix 2). Concern has been expressed that too often, successive developments in primary care (however well intentioned) have had the perverse result of making it more difficult for patients to see their chosen clinician. This has been most obvious with the recent drive for fast access. If continuity of care is to remain an inherent element of general practice, then more explicit and concerted effort by patients and clinicians may be needed to build and sustain its various aspects. For this reason, it is topical and timely to examine the quality of continuity of care in English general practice.

Aims

The brief for this project outlined a broad examination of continuity of care in general practice, with a particular emphasis on understanding ‘good continuity’ from the patient’s point of view, considering the different types of continuity distinguished by researchers and their relationship to other aspects of quality in primary care, and assessing the state of the art of measuring continuity of care. The aims of this paper are therefore to:

- define continuity of care
- explore patients’ perspectives on continuity of care
- explore clinicians’ and practice team perspectives and current practice in relation to continuity
- consider the interweaving of continuity and access in primary care and illuminate continuity as the temporal dimension of the therapeutic relationship
- provide an overview of how continuity has been operationalised and measured, and the utility of the measures for assessing quality and improving it
- summarise the issues involved in understanding and measuring continuity in general practice

Methods

We employed a variety of methods to gather the material on which this report is based. We sought published research and other relevant documents,

following up leads from key sources; checked websites for information on surveys and up-to-date findings; and used personal contact through various networks to alert us to material we may otherwise have missed. In addition, we interviewed selected informants in general practice to provide an understanding of professionals' perspectives on continuity of care.

There is a substantial literature on continuity in primary care, much of which has been reviewed (from 2000 onwards) as part of the major programme of research on continuity commissioned by the Service Delivery and Organisation programme of the National Institute for Health Research (National Institute for Health Research 2010), referred to herein as 'the SDO continuity programme'. This programme generated research reports, journal papers and syntheses that made an important contribution to understanding continuity of care in the context of the NHS. We took this body of work as a starting point, and looked at more recent literature for papers that updated or extended the material.

We did not carry out systematic searches or attempt a comprehensive literature review but followed leads on issues of interest, including measures of continuity. The focus of our efforts was to find evidence and analysis concerning general practice in England or the United Kingdom. However, salient international research has also been included. Reports of qualitative and quantitative studies were included where they were relevant to the aims of this paper, and our assessments of the quality of the research. We relied on the research literature for our account of patients' perspectives on continuity of care because the timescale and resources for producing a report precluded carrying out original research with the necessary ethical approval.

We explored the question of how GPs and practice teams currently viewed continuity of care, through interviews, which were carried out in six practices in London and Hampshire during July and August 2009. We did not aim to find representative practices, nor to produce generalisable findings: essentially the six practices, and our respondents, were a convenience sample for gathering examples of how continuity is currently understood and managed. This was judged to be the best use of limited resources to fulfil the brief of describing 'high quality' in relation to continuity of care.

We selected two areas with different socio-demographic characteristics, and initially contacted key individuals in local networks who put us in touch with practices or GPs they thought would be interested in helping us. From among those who responded positively and rapidly, we selected practices of different size. We interviewed two of the GPs because they held positions in local organisations that gave them a broader perspective on primary care developments. A list of the practices and respondents can be found in Appendix 1.

Drawing on the literature review, we developed a topic guide for the qualitative interviews in order to elicit respondents' understanding of continuity, its importance and influence in everyday practice, how continuity was established and maintained, and views about measuring continuity. The interviews were exploratory and conversational in style, and allowed respondents to introduce topics and make connections that they considered salient. All the interviews were audiotaped (with participants' consent) and transcribed. This process was augmented by interviewers' observations, as well as by information gleaned from practice websites and patient booklets. We read and discussed the material, identified key issues and selected illustrative quotes for the report.

The method of selecting the sample of practices and individuals is likely to have created a bias towards those with an interest in quality of care in general, and continuity of care in particular. The attitudes and policies of these practices towards continuity cannot represent the whole spectrum of practices in England, so the findings have been supplemented and contextualised with material from other practice websites, research reports and policy documents.

We discussed preliminary research findings and ideas with the inquiry panel on several occasions, and at a wider seminar in February 2010. This provided useful feedback and guidance. A number of reviewers read an earlier version of this report and made constructive comments and suggestions that have helped to enrich and improve it.

Definitions: relationship and management continuity

The term 'continuity of care' has been understood in various different ways. For more than 30 years, substantial research attention has been given to clarifying what is meant by continuity of care and establishing consensus on concepts and definitions (Starfield 1980). Early in the last decade, research programmes on both sides of the Atlantic framed continuity from the patient's point of view as the experience of a co-ordinated and smooth progression of care (Freeman *et al* 2001, Reid *et al* 2002), and this approach went on to inform subsequent investigation.

It was initially suggested that to achieve 'experienced continuity' for any patient, the clinical care provider needed to offer services that demonstrate the following six characteristics:

- providing one or more named individual professionals with whom the service users can establish and maintain a consistent therapeutic relationship (often termed relationship, relational, personal or interpersonal continuity)
- ensuring that care is provided by as few professionals as possible, consistent with need and uninterrupted for as long as the service user requires it (longitudinal continuity)
- being flexible and adjust to the changes in a person's life over time in their own personal and social context (flexible continuity)
- offering effective communication
- being based on excellent information transfer following the service user (information continuity)
- demonstrating good communication between professionals working in statutory and non-statutory agencies, working in primary and secondary care, and with the service user and their informal care networks (cross-boundary and team continuity).

This schema was subsequently simplified into three types (Haggerty *et al* 2003, Freeman *et al* 2007):

- relationship continuity - longitudinal, personal, continuous, caring
- management continuity - cross boundary, team care, flexible seamless service
- informational continuity.

Studies of patients' experiences of diabetes care led Gulliford and colleagues (2006) to combine the last two of Haggerty's types and argue that the most relevant distinction for patients is between a 'continuous caring relationship' with a clinician and 'seamless care' (in other words, management continuity, which includes all aspects of integration, coordination and sharing information).

Management continuity ('seamless care') includes co-ordination, teamwork, good record systems and the timely communication of relevant information between and within care providers and with patients and carers. It is more than just information transfer, and includes negotiation of care plans and verbal and other cultural communication between teams and individuals. Some information – usually more personal and private – is shared between patient and clinician and not recorded. Such tacit information may thus be an element of both relationship and management continuity (Freeman *et al* 2007).

Relationship continuity is not necessarily restricted to a single clinician: patients may value and maintain therapeutic relationships with several clinicians, including doctors, nurses and other professionals. To make relationship continuity possible, patients need to be able to consult with the same clinician over a period of time. In the past, patients often stayed with the same family doctor for many years. Seeing the same person in this way is termed 'longitudinal continuity'. The distinction between longitudinal and relationship continuity is discussed further (see Longitudinal continuity, p [currently 36]), when we address the issue of measurement.

Some longitudinal continuity is necessary for relationships to flourish, but this is not in any way guaranteed, and Ridd *et al* (2009) emphasise that the quality of the contact is also crucial. Management continuity, on the other hand, always implies the involvement of more than one clinician or health care provider – even for a single problem.

Continuity of care was originally a professional and organisational construct, and professional insight was needed in order to identify it. Patients were seen as passive recipients of systems of service provision and organisation that either delivered continuity or did not. Discontinuity was generally regarded negatively, as a failure of the system to be remedied.

However, during the past decade researchers have moved to a model that privileges service users' perspectives on continuity, exploring their understandings, experiences and choices, and allowing the possibility that discontinuities may sometimes be viewed positively. Investigating the lived experience of patients has led to a more dynamic view of continuity, which encompasses complexity, discontinuity and change over time. One important aspect that has emerged – elucidated by Parker *et al* (2010) – has been an appreciation of service users' agency, choice and control over continuity, working in partnership with clinicians. Research in primary care, in particular, has illuminated how continuity of care is 'co-constructed' or 'co-produced' through interaction between patients and professionals, and is facilitated or obstructed by how services are organised and managed (Boulton *et al* 2006).

Continuity can be seen as both a process and an outcome. Baker *et al* (2006) argue that while the experience of continuity is an outcome for the patient, this is mediated by the processes of relationship and management continuity. These two categories are not discrete: there is inevitable overlap, both in the experience of patients and the perceptions of researchers. It has been suggested that management continuity should be distinguished from co-

ordination of care and the systems and processes that support it. However, we found this distinction difficult to sustain, and have used the terms interchangeably in this report. Considering these two types of continuity of care separately helps to clarify how high quality is understood and achieved, including the factors that support or obstruct it, and how it might be measured.

In this report we distinguish the two main types of continuity:

- **relationship continuity** a continuous caring relationship with a clinician
- **management continuity** continuity of clinical management, including providing and sharing information and care planning, and co-ordination of care.

2 Why is continuity an important dimension of quality of care?

Relationship continuity and management continuity are not equally valued. While there is general agreement that management continuity is highly desirable (save in exceptional circumstances) and should be maximised, relationship continuity is more controversial. It is perhaps best considered as an example of agency, where 'the value of continuity is to reduce agency loss by decreasing information asymmetry and increasing goal alignment' (Donaldson 2001, p 255). Seeing a known and trusted clinician should enhance communication about problems and sharing of the goals of care.

This section summarises evidence for the benefits and disadvantages of relationship and management continuity.

Relationship continuity

Relationship continuity is generally highly valued by patients and staff, and there is convincing evidence of its association with better health outcomes, although it has been linked with risks and potential harm as well as advantages and benefits. In addition, the costs associated with delivering relationship continuity may appear to be higher.

The advantages and benefits of relationship continuity have been shown to include:

- increased satisfaction, both for patients and staff, and enhanced loyalty (Becker *et al* 1974, Roberge *et al* 2001, Saultz and Albedaiwi 2004, Fairhurst and May 2006). Patients show how they value their chosen clinician by their willingness to wait and to pay more (Pandhi and Saultz 2006)
- reduced conflicts of responsibility for clinicians – particularly reducing the 'collusion of anonymity', where a succession of clinicians deal only with what is most immediately pressing (Balint 1957, Gray 1979)
- increased security and trust within the doctor–patient relationship (von Bültzingslöwen *et al* 2006). This increases willingness to accept medical advice and adherence to long-term preventive regimens such as statin medication (Brookhart *et al* 2007). It supports 'wait and see' management of non-specific symptoms that are often self limiting (Hjortdahl and Borchgrevink 1991), and may reduce undesirable medicalisation of symptoms
- improved problem recognition and quality of management – especially for diabetes (O'Connor *et al* 1998, Koopman *et al* 2003, Evans *et al* 2008)
- reduced costs: prescriptions, tests, A&E attendance, and hospital admissions (Wasson *et al* 1984, Hjortdahl and Borchgrevink 1991, Sweeney and Gray 1995, Mainous and Gill 1998). A recent Dutch study found that newly registered patients used more health care resources during their first year with a practice than in subsequent years (Jabaaij *et al* 2007).

Some risks and harms of relationship continuity have been suggested, including:

- 'loyal' patients tolerating inappropriate and detrimental waits for their chosen clinician, although this seems to be anecdotal, and we found little in the research literature to support this assertion
- delayed diagnosis A fresh start with a new clinician may open up new diagnostic perspectives. The example of the insidious onset of hypothyroidism is often quoted, but we have not found any evidence to verify this. However, one Australian paper reported that continuity of GP care could delay diagnosis of diabetes (Broom 2003)
- increased costs This is because flexibility of staff deployment is reduced. One of the main drivers for reducing longitudinal continuity in general practice has been the desire of a group of clinicians to share workload equally (Freeman 1985). However, discontinuity may also have costs. Patients reluctant to wait have to see the least sought-after clinicians, who may be new partners, trainees, locums, or just plain unpopular (Freeman 1989). Most GPs are familiar with the downside of locums: patients coming back to their usual doctor for a second opinion about the same problem, thus causing duplication and waste. This phenomenon is well known but not yet quantified by systematic study. Conversely, in a US setting some patients with long-term conditions expressed a willingness to pay more for continuity (Pereira and Pearson 2003)
- encouraging collusion An example might include sickness certification. Another risk is a reduced conformity to professional standards and guidelines (Hjortdahl and Borchgrevink 1991, Summerskill and Pope 2002).

These sometimes opposing factors may explain why there is equivocal evidence on the relationship between continuity and patient outcomes. In addition, Gulliford *et al* have pointed out that increasing longitudinal continuity may be a response to deterioration in health status (Gulliford *et al* 2006), and this may help to account for a lack of association between greater continuity and better outcomes in a number of studies. There have been very few randomised trials where allocation to a single clinician is the principal independent variable (Becker *et al* 1974, Wasson *et al* 1984), although these have unequivocally favoured seeing the same clinician.

In addition, it is easier for studies to measure longitudinal continuity (see Section 5) than to explore the nature and duration of relationships, even though the latter may be more important. Seeing the same doctor does not guarantee a good relationship. It may therefore be too restrictive of patients' choice to limit patients to a single doctor – for example, through the use of personal lists. Relationship continuity should be an available but not a compulsory option (Freeman and Hjortdahl 1997). The most common problem today is that it is not available (Windridge *et al* 2004).

Finally, directing attention to the patient–clinician dyad underestimates the scope of relationship continuity. Patients live in networks of family and friends who may have knowledge of, and perhaps some relationship with, a particular clinician (Gore and Ogden 1998). Conventional health services research does not usually trace these networks and wider relationships, which may reduce our awareness of the extent of the effects of continuity on outcomes.

The evidence cited above about cost-effectiveness is not comprehensive, and little of it is derived from English or even European data. There appears to be

no recent research into the costs of discontinuities in general practice in the United Kingdom.

Weighing up the evidence, the benefits of relationship continuity appear to be better supported by research than the risks – a conclusion also reached by Gray *et al* (2003).

Other arguments in favour of relationship continuity are framed in terms of its congruence with the values underpinning the NHS, the social processes involved in health care and the professional ethos of general practice (see Section 3). Offering patients the opportunity to maximise relationship continuity is an essential part of a health care system that values patients as individual people with their own particular contexts, stories and priorities. In general practice, relationship continuity is part of a philosophy that embraces personal knowledge and biography in preference to technological fixes (Beach *et al* 2005). This has many additional benefits that are hard to measure, but that motivate patients to seek help and professionals to respond (Greenhalgh and Heath 2010).

Management continuity

Management continuity is about crossing boundaries and bridging gaps in care systems that are increasingly complex and specialised. Good communication and co-ordination is needed, both within and between professionals, teams, care systems and institutions. All clinicians have an important role to play in maximising management continuity. However well designed the care system, gaps inevitably occur – and patients often need a clinician's help with crossing them (Cook 2000).

Appropriate information transfer – also known as informational continuity – is a key factor in management continuity, often justifying its description as a separate type. We see informational continuity as a tool for management continuity, rather than its essence. It is important that written information is supplemented by direct interpersonal or inter-team communication, either face to face or by electronic means. Information has to be interpreted and prioritised. A US review of communication and information transfer at hospital discharge found that deficits were common, and affected care quality in 25 per cent of follow-up visits (Kripalani *et al* 2007). A recent report from the Health Foundation concludes that 'poor communication, particularly during handover from one team to another, and during discharge from hospital, is the commonest cause of poor quality care' (Øvretveit 2009).

While management continuity is almost always an unmitigated 'good', there are occasional exceptions – mainly in the field of mental health. Mental health clinicians accord high priority to maintaining ongoing contact with patients suffering from chronic, often lifelong problems such as schizophrenia, bipolar disorder or recurrent depression (Crawford *et al* 2004). Such contact is a form of management continuity, and relationship continuity may be encouraged as a way of maximising engagement with the team for continuity of management.

But mental health problems are stigmatising, and patients may opt for disengagement (discontinuity) – particularly when they are in remission. This may delay diagnosis and treatment of relapse, and so can be a source of tension between clinicians and patients. In this context, management continuity can feel like compulsory surveillance (Freeman *et al* 2001).

3 The role of general practice in continuity of care

This section draws largely on how the GP's role has been described by professional bodies and commentators on general practice in the United Kingdom and internationally. It also discusses recent developments in policy and in the organisation and delivery of primary care that have implications for continuity of care.

Continuity of care appears as a central feature of most definitions of general practice and primary care. Relationship continuity is inextricably woven into the traditions and core values of general practice, and in the past was supported by the organisation of primary care in the United Kingdom (see Appendix 2). All clinicians form relationships with patients. In specialist practice the relationship is with a patient who has a certain disease, while in general practice relationships often begin before the illness is identified, and are not defined by it (McWhinney 2000). The GP's role as the main primary care provider, with a distinctive overview of a patient's health care, includes a responsibility to co-ordinate care from other providers, as Safran (2003, p 248) explains:

From the earliest definitions of the term primary care to the most recent, all have stressed that primary care is predicated on a sustained relationship between patients and the clinicians who care for them. Primary care differentiates itself from other areas of medicine by attending to the whole person, in the context of the patient's personal and medical history and life circumstances, rather than focusing on a particular disease, organ, or system. Finally, the primary care physician plays a distinctive role in integrating the care that patients receive from within and outside of the primary care setting.

Relationship continuity

Guidance from the Royal College of General Practitioners (RCGP) on good medical practice emphasises the importance of a continuing GP-patient relationship, and elaborates on the GP's contribution to an effective partnership with patients, based on openness, trust and good communication (RCGP 2008). However, it does not instruct the GP to take any specific action to promote continuity of care. Instead, it seems to make an implicit assumption that interpersonal continuity will occur, by default, as long as the GP offers reasonable availability and access, and communicates well with the patient.

This may be an unintended consequence of the RCGP using as a framework the General Medical Council's *Good Medical Practice* (2006), which interprets continuity as the delivery of services in a co-ordinated and timely manner by more than one health professional (management continuity), rather than focusing on the doctor-patient relationship sustained over time, which is how continuity is typically understood in primary care).

Some commentators have argued that GPs should be more active in creating and sustaining interpersonal continuity, by considering how all aspects of organisation and delivery of care can help to achieve continuity – including clarifying the expectations, values and responsibilities inherent in the GP-patient partnership (Safran 2003, Haggerty 2009). Professional initiatives to influence the development of general practice in the United Kingdom

recognise that interpersonal continuity can no longer be taken for granted, and address directly the need to preserve what is considered an essential element of general practice (RCGP 2007, Gillies *et al* 2009).

Management and information continuity

The RCGP does offer explicit and extensive guidance on the GP's role in maintaining information and management continuity, considering record-keeping, working in teams, sharing information with colleagues, and referring patients (RCGP 2008). In terms of information continuity, the RCGP's 'exemplary GP':

- keeps accurate, contemporaneous records sufficient for another clinician to effectively take over care of the patient
- can demonstrate an effective system for transferring and acting on information from other doctors about patients
- gives patients the information they need about their problem and treatment options, in a way they can understand
- involves patients in decisions about their care.

The RCGP guidance also addresses working in teams within the practice and working collaboratively with other professionals and agencies. It highlights the GP's leadership responsibilities in the primary care team – particularly in terms of acting as an advocate for patients and co-ordinating care (RCGP 2008, p 36). In the context of delegating care to another member of the practice team, it states that the GP's role is 'to ensure that the person to whom you are delegating has the ability and qualifications to provide the care required, and part of your leadership role is to ensure that patients do not fall through the net of care with nobody taking responsibility' (RCGP 2008, p 37).

Finally, its discussion of collaboration with other health care professionals (including out-of-hours services), social services and voluntary agencies emphasises the GP's continuing clinical responsibility for the patient, and the need to maintain contact with colleagues and ensure that information transfer is timely and effective (RCGP 2008, p 37).

Implications of recent developments in general practice

In recent years general practice has undergone significant changes, some of which reflect wider social and organisational trends and others that are the consequence of central policy initiatives. Many of these changes have had implications for patients and clinicians establishing and maintaining continuity of care.

Relevant social change includes the increasing mobility of the population and health service staff alike and the widespread trend towards more part-time working, associated with more women being economically active. GPs are now less likely to be full-time clinicians and also less likely to stay in the same practice for many years. These factors clearly limit the opportunities for patients and doctors to get to know each other over extended periods of time.

Even more influential have been the policy developments resulting in changes in the delivery of primary care and general practice. Trends in GP service provision that were apparent more than 20 years ago have shaped

current practice and its potential to ensure that patients can see their preferred doctor.

- Group practices have continued to grow, and include a wider range of professionals – notably nursing staff, who are increasingly doing clinical work traditionally carried out by GPs. Increased practice size may result in some benefits, in terms of organisation and range of clinical services, but larger practices may not offer the same levels of personal care and continuity as smaller practices.
- The characteristics of the GP workforce have altered substantially, as have GPs' expectations of a working life. GPs no longer offer their patients 24-hour care and many have commitments outside the practice, including PCT management or leadership of Local Enhanced Services. More GPs now work part time and on a salaried basis. Changes in practice remuneration associated with the 2004 contract appear to have discouraged practices from taking on permanent staff, resulting in increasing numbers of salaried (often part-time) clinicians, who may not stay in the practice for more than six-to-twelve months.
- By the turn of the century, Government concern about access led to targets for practices to prioritise speedy access to doctors (Department of Health 2000), for summary see Gerard *et al* 2008. Some practices initially responded by allowing patients to book appointments only up to two days ahead, thus preventing people securing non-urgent appointments with their usual doctor. For further discussion of the relationship between access and continuity as they impact on patients and professionals, see Access and continuity (pp 23–4) and Management continuity (pp 24–6).
- The 2004 new GP contract marked the end of 'personal registration' with a particular GP: patients are now registered with the practice as a whole. While the concept of 'my doctor' may live on, there is no longer any formal basis for it.
- The ending of GP 24-hour responsibility for patient care and the transfer of out-of-hours care provision to primary care trusts has proved more expensive than anticipated, and has been linked to some high-profile cases of unsafe and discontinuous care. Professional concern with this state of affairs has recently been articulated by Campbell and Clay (2010), following earlier work assessing patient expectation and satisfaction (Campbell J *et al* 2009).
- Introduction of the Quality and Outcomes Framework (QOF) in 2004 has been associated with improved performance in achieving the selected clinical targets, though perhaps not greatly accelerating existing trends (Campbell SM *et al* 2009). Concerns remain about the potential for unintended consequences – notably, disadvantaging aspects of care that are not measured or rewarded (Raleigh and Foot 2010, Heath *et al* 2009). Even for patient groups included in the targets, exception reporting may divert attention from the care of individuals with the most challenging and complex needs.
- Policies designed to increase patient choice are promoting alternatives to general practice-based primary care, in a variety of new facilities with 'unfettered access', offering extended opening hours, a wide range of services on one site, and the obligation to take unregistered

patients. Locating several providers in one place should improve management continuity – especially between primary care and specialist services – but as Imison *et al* (2008) have cautioned, this alone is insufficient to overcome existing barriers and develop better ways of co-ordinating care. Centralising some services also raises the issue of maintaining links with other primary care services in the locality, while open access for patients brings with it the risk of disrupted continuity of care for those registered with practices outside the new facilities.

- Other proposed changes have obvious implications for continuity of care, but the full effect will depend on how they are implemented. One example is removing practice boundaries, (which raises the possibility of patients living beyond a certain distance from the practice forgoing home visits by their GP). Another is the suggestion that GPs should concentrate their time and effort on patients with more complex needs – a corollary of which is that patients with minor illness will be asked to see other clinicians in the practice team, or to use telephone consultation.

Each of these developments has brought advantages for patients, but many have resulted in continuity of care becoming more difficult to achieve. In some cases, the impact on continuity was unintended. However, discussion of the most recent developments has brought renewed attention to the consequences for continuity of care. If seeing the same clinician cannot always be guaranteed, then consideration must be given to when, and for whom, GP continuity matters. In future patients and professionals may have to make more explicit judgements and trade-offs between access and continuity to secure appropriate care in particular circumstances.

In this situation it would seem incumbent on general practitioners to be more proactive in encouraging patients to achieve relationship continuity when they desire this. Not to do so is to send a different message – that relationship continuity is unimportant and can safely be left until last among conflicting priorities.

4 What does high-quality continuity of care look like in general practice?

This section considers patients' and providers' perspectives on continuity of care. First, it explores patients' perspectives, drawing on the research literature. Then it presents the findings of research in GP practices in London and Hampshire, to illustrate the views of clinicians and practice teams, and to consider what they are currently doing to achieve continuity. This information is supplemented and contextualised by material from other sources where relevant. The section concludes with a summary of good quality in relationship and management continuity.

Patients' perspectives

There is now a substantial body of research literature that explores patients' views, preferences and experiences of primary care. In general, studies in primary care have focused on the type of continuity most evidently associated with general practice: a continuing relationship with a GP. Patients' views about co-ordination of care, including information continuity, do not emerge so clearly.

Consistently seeing a known and trusted GP is often the most effective way of securing good information and management continuity in primary care, so it is perhaps not surprising that the interpersonal aspect of continuity dominates patients' narratives (Cowie *et al* 2009). Where several clinicians or agencies provide care, good management continuity is often taken for granted and seems invisible to the patient, only becoming apparent (in the form of gaps and deficiencies in services) when it fails.

Research often includes patients and carers, but it can be difficult to distinguish carers' views in the findings, and they are not separated in this analysis.

Relationship continuity

Empirical studies demonstrate that most patients recognise and value continuity in primary care, but vary in how much priority they give it, depending on their characteristics, circumstances and reason for consultation. Relationship continuity has been found to be of higher priority to patients with serious, impactful or chronic conditions (rather than acute, minor illnesses), by older people, and by those in poor health or who feel vulnerable (Nutting *et al* 2003). Cross-sectional surveys of consultation behaviour typically find that some patients say they simply want quick and convenient access to care, while the majority actively seek continuity and are prepared to wait to for an appointment with a clinician of their choice (Baker *et al* 2006).

However, the findings of a mixed-methods longitudinal study (Boulton *et al* 2006) demonstrated that patients did not always succeed in achieving the type of care they preferred and, even if they were successful, did not necessarily assess their experience as satisfactory. The study painted a complex picture of primary care consultation over time, showing that it is shaped by the patient's preferences, needs and behaviour, as well as interactions with clinicians and the practice organisation and culture. The

interplay of these influences produced a number of different patterns of consultation, but there was no simple relationship between the objective consultation pattern and a patient's subjective assessment of continuity of care or quality of relationship with their GP. Patients who saw several different clinicians over the study period may have done so by choice (for example, women who consulted a female doctor for contraception or gynaecological problems) or because they were unable to book convenient appointments with their usual doctor.

Not all patients who received care from a single GP (longitudinal continuity) considered that they had a good personal relationship with the doctor. This was confirmed by a study in a socially deprived community in Scotland, which found that seeing the same doctor over time was not in itself a guarantee of a patient assessing the relationship positively in terms of trust, feeling valued, being able to express concerns, and the doctor's understanding of their situation (Mercer *et al* 2007).

The SDO studies also show that a good relationship with one doctor can be sustained satisfactorily even when a patient sees other clinicians: 'where patient and doctor regard each other as "own" and see each other regularly, their personal relationship can withstand a good deal of selective and instrumental use of other services and practitioners' (Boulton *et al* 2006, p 754). Patients most frequently consulted GPs, but also saw other professionals including nurses, counsellors, physiotherapists, occupational therapists and podiatrists, although they rarely reported relationships of similar duration and depth with these clinicians to those formed with GPs. A few patients had formed a bond with a clinician other than the GP: the full research report quotes a woman who regularly saw a practice nurse and spoke more positively about her relationship with the nurse than with the GP (Baker *et al* 2006). Indeed, there is growing evidence that patients value the relationships they develop with case managers or community matrons who are demonstrably 'there when you need them' (Bowler 2009), creating a sense of safety and security (Wright *et al* 2007, Leighton *et al* 2008, Brown *et al* 2008, Sheaff *et al* 2009).

The patient's perspective of the doctor-patient relationship has been explored in a wide range of research. In a recent review of qualitative studies, Ridd *et al* (2009) distinguished both quantitative (the number of contacts with a particular clinician) and qualitative dimensions (consultation experiences). They identified four main elements that contribute to the depth of relationship: knowledge, trust, loyalty and regard. The quality of relationship seems to be consistently important for all patient groups.

This analysis is supported by a study of asylum seekers in Glasgow, where 'two related issues appeared to build (patients') confidence in their GP: seeing the same GP each time they attended the surgery, and feeling that they were respected during the consultation' (O'Donnell *et al* 2008 p e7). Communication is an important element of patients' assessment of the quality of a consultation. In a study of enablement after consultation, patients from minority ethnic groups reported much higher enablement scores when they were able to consult a GP speaking their first language (Freeman *et al* 2002).

Tarrant *et al* (2008) have shown that positive experiences of past interaction influence patients' assessments of trust in the GP. Perhaps less intuitively, so do expectations of receiving future care from that GP. Anticipation of

the future is a factor recognised by game theory as important in building a committed partnership, but this has rarely been explored in research into the doctor–patient relationship.

Access and continuity

Establishing and maintaining a relationship with a clinician depends on having ready access to them, and the issues of relationship continuity and access have been described as 'inextricably intertwined' (Guthrie and Wyke 2006). In the past decade, national policy initiatives to meet demand for 'urgent' primary care have generated debate that has polarised the two issues in primary care and presented them as incompatible ideals in a system that has not increased capacity to meet demand.

Research into patients' experiences of booking appointments has highlighted that patients are sometimes prepared to 'trade off' waiting to see a GP with whom they have a good relationship in favour of quick access to an unknown GP – often described as 'sacrificing' continuity (Guthrie and Wyke 2006, Boulton *et al* 2006, Cowie *et al* 2009).

'Discrete choice' experiments, which present hypothetical scenarios involving different dimensions of care, enable assessments to be made of the relative importance of access and continuity in a variety of circumstances (Rubin *et al* 2006, Turner *et al* 2007, Cheraghi-Sohi *et al* 2008, Gerard *et al* 2008). All these studies found that patients do not uncritically seek fast access, but have clear preferences about seeing a familiar clinician and giving this greater priority when the problem is ongoing and of high emotional impact. Recent work in Canada showed how patient perceptions of their doctor's knowledge of them decreased when the doctor had an access-orientated practice style (Haggerty *et al* 2008).

The SDO continuity programme concluded that most patients wanted both timely access to a GP and the opportunity to see a GP they knew and trusted, rather than one or the other (Baker *et al* 2006), supporting earlier findings from the National Centre for Primary Care Research and Development (Bower *et al* 2003). A more recent study of patients' experiences of emergency and urgent care found that even when urgency was paramount, patients were alert to the importance of continuity and its contribution to quality care:

In particular, people valued seeing their own GP whom they knew and trusted, and who knew about them and their medical history. They felt that their own GP could assess urgent acute episodes in the context of their medical history.

(O'Cathain *et al* 2008, p 22)

Patients have also remarked on the problem of accessing GPs via receptionists (Gallagher *et al* 2001).

Most studies of continuity have focused on patient-initiated consultations and choice of clinician, but research into patients' experiences of care opens up a broader view of the interplay between access and continuity, revealing that GP- or practice-initiated contact, although relatively infrequent, may be an important way in which continuity is reinforced. A synthesis of the SDO continuity studies found that patients with long-term conditions identified the ability to rely on the GP or practice team to initiate contact when necessary –

for example, for regular monitoring – as being central to their understanding of continuity (Parker *et al* 2010).

Similarly, an action research study that sought the views of patients with cancer found that they appreciated their GP or another member of the primary care team making contact with them at times when they felt particularly vulnerable – for example, on discharge from hospital or completion of treatment. This was seen as signalling the GP's commitment and personal responsibility for them, and the practice's willingness to provide continuing support. The practices involved subsequently improved their services by providing more of this type of proactive care (Kendall *et al* 2006, Murray *et al* 2008).

Management continuity

Research in primary care offers only fleeting glimpses of patients' perceptions of management continuity or issues around co-ordination of care. These come mainly from interviews with patients receiving specialist care, who looked for communication, planning and co-ordination between primary and secondary care.

Transitions between care settings and services are significant points at which patients are particularly vulnerable to loss of continuity. Patients expected GPs to know about their hospital treatment, and to have the results of investigations. Since good management continuity concerns the smooth working of processes between professionals and agencies that are generally invisible to the patient, it is inherently difficult for them to assess the work involved in achieving it. This often becomes apparent only when co-ordination breaks down and impacts negatively on the patient's experience of care (Preston *et al* 1999, Cowie *et al* 2009).

Aspects of management continuity come into much sharper focus in studies on the experiences of patients with long-term conditions or multimorbidities, who typically receive care from various clinicians and services, often in different settings at different stages in their illness trajectory. A study of patients with respiratory illness found that:

Patients were very aware of the increasing number of professionals, specifically the various nurse roles and specialist services and expressed confusion with their navigation through the disease experience. Those who did not have access to a central figure, (such as a community matron or respiratory nurse) often mentioned their need for a professional who could 'tie things together' especially as the traditional role of the family doctor was perceived as waning. This was particularly evident when patients perceived they were being passed between providers who were not communicating with each other, and when their co-morbidity necessitated attendance at a succession of specialist clinics.

(Pinnock *et al* 2008, p 208)

In the SDO continuity programme, patients identified timely availability of information, and effective planning and communication, as key components of co-ordination of care. However, their circumstances, illness and needs for care determined when and how these aspects of co-ordination became salient. Stroke patients' confidence about discharge from hospital was helped by a tangible sense of 'being handed over' from one team of professionals to another (Hill *et al* 2008). For patients with cancer, out-of-hours care was a

concern: they wanted clinical information to be shared, preferably in a proper handover process (King *et al* 2006). In contrast, patients with diabetes appreciated services being flexible enough to respond to their changing needs over time – particularly in the event of unanticipated changes in circumstances or an emergency (Naithani *et al* 2006).

A US study of elderly patients with multimorbidities found that this group viewed continuity as an essential element of good care that should ideally be provided through a single co-ordinator of care who could help prioritise competing demands (Bayliss *et al* 2008). A recent review of research into continuity of care across all domains concluded that having one principal provider with a holistic view of the patient is central to patients' experiences of good management continuity and provides a sense of security and confidence about the future (Haggerty *et al* 2009).

These studies indicate that for some patients, continuity means more than simply connected health care and smooth transitions: it encompasses having confidence that providers will respond appropriately if the need arises. Patients with long-term conditions may also perceive management continuity as including how well medical treatment is integrated with other aspects of their lives, families and carers (Haggerty, personal communication 2010, citing King *et al* 2008).

Information continuity

Patients are aware of the importance of information in continuity of care, and expect clinicians to have medical records available in the consultation (Baker *et al* 2006). It is frequently reported in the literature that patients dislike having to repeat their story to different clinicians, and this is one reason given for preferring to see a familiar doctor. In this way relationship and information continuity in primary care are perceived as being closely linked.

Patients also look to clinicians for information about their illness and treatment, and are critical of being given conflicting or inconsistent information (Preston *et al* 1999). Studying the experiences of patients with type 2 diabetes led Gulliford *et al* (2007, p 2) to highlight the informational aspects of continuity in their definition of a 'continuous caring relationship with a usual professional':

Patients value being able to build a relationship with a usual professional (generally a doctor or nurse) who not only knows their medical history and treatment plans without being reminded, but also treats them as a person who may well have other needs and anxieties. They are prepared to listen to the patient and to explain medical procedures and tests clearly, which help develop a trusting relationship where the patient participates in their treatment plans.

The overall findings of the SDO continuity programme indicated that patients in all the studies valued clinicians who were prepared to give time to discussing their condition and treatment – helping them to understand and make decisions, rather than simply providing timely information (Parker *et al* 2010). This corresponds closely with the findings of research into aspects of the consultation that patients identify as important to them (Mercer *et al* 2007).

Perspectives of clinicians and practice teams

In the interviews with GPs and other members of practice teams, all respondents said that they and their practices believed that continuity of care was important, and that they sought to promote it in the way care was organised in the practice. They did this in various ways. We asked for examples of how practice teams built and maintained continuity, and any problems that they had experienced. The following account illuminates aspects of good practice, using illustrations from these practices and occasionally from other sources.

Relationship continuity

All the respondents said that their practice encouraged patients to establish a relationship with one GP, but did not expect exclusive relationship continuity. None had personal lists, and they viewed these as too restrictive of patient choice. They accepted that continuity was not always a priority for patients:

There are two populations we look after as GPs: one is those who want and value continuity and there are those who haven't met you before, they've got an acute problem, a chest infection, and they don't really care which doctor they see, what they want is someone who can see them in a timely fashion, can communicate well, is friendly, and will treat them, that's the end of it.

(GP, Hampshire, practice Y)

Respondents took it for granted that a patient could maintain relationships with several members of the practice team, and with other practitioners working in the community – for example, if they needed regular nursing treatment or monitoring – although they generally assumed that the relationship with the GP would be the most fundamental and enduring. They considered it entirely acceptable, and often unavoidable, for a patient to see someone other than their usual GP for example if they had an urgent problem; needed specialised care from another member of the team; wanted to discuss a problem they found embarrassing; or chose to consult a GP of the same gender

Respondents also accepted that availability of appointments and staff could interfere with patients' attempts to see the same clinician. Despite this, they perceived patients' consultation patterns as strategies and choices. For example, respondents referred to patients who had 'a preferred doctor and first reserve', who had 'tried out' various GPs before 'settling' with one, or who after a while with one doctor, moved to a different GP.

Guthrie and Wyke (2006) found that GPs made assumptions about patients' preferences from consultation patterns but rarely enquired about the reasons for breaks in continuity, or discussed with patients their choice of who to consult. These conversations tend to take place with receptionists when patients are negotiating appointments, and doctors would not necessarily be aware of them. Receptionists that we interviewed prided themselves on getting to know their patients' allegiances and preferences and 'doing their best' to meet them.

While our respondents emphasised patient choice in finding a suitable GP, most also believed they had a role in promoting continuity as part of good care – even if patients themselves did not appreciate its importance

– as highlighted by Sweeney and Gray (1995). Salisbury (personal communication 2010) explains:

The relationship is not all on the patient's side: it also depends on the doctor. I am sure I am a better doctor for some of the vulnerable patients I deal with because I've got to know them and care about them, and I go the extra mile for them – even if they don't care about me at all or which doctor they see!

Clinician respondents said they were most likely to act if there was a high degree of discontinuity that was considered inappropriate or potentially disadvantageous to the patient, and it was only then that GPs were likely to raise the issue of continuity with a patient. Several GPs indicated that if a problem arose they would take the opportunity during a consultation to feed back to people in order to modify their help-seeking behaviour, to help them use the service more appropriately:

We encourage patients to see their regular doctor, and when they don't – when we find we're the fifth doctor in as many weeks or months being consulted about the same sort of problem – then we try and address that with the patient, and say 'Why don't you see the doctor that you trust the most? Because it's much better that you get a coherent approach to this.

(GP, inner London, practice A)

This problem was perceived to be rare in the Hampshire practices, but the inner London practices, which had socially and ethnically diverse patient populations and higher turnover rates, described the need to actively 'keep an eye' on consultation patterns. Practice B occasionally reviewed the 'frequent fliers' at the open surgery, and practice A discussed at team meetings patients considered to have 'chaotic' consultation patterns. We were not able to assess the effectiveness of these actions.

Most respondents said they would advise patients to see the same clinician for an episode of illness, and practices had various arrangements to secure continuity for follow-up appointments, including:

- receptionists asking patients requesting appointments whether they had consulted about the problem before
- GPs advising patients to come back to see them, and in some cases booking follow-up appointments during a consultation
- allowing a patient to book a follow-up appointment immediately after consultation only if this was sanctioned by the GP (although the practice had primarily introduced this policy to limit patient-initiated unnecessary follow-up appointments, rather than to secure continuity).

Respondents thought that follow-up by the same clinician was important in wound management and treatment of skin conditions, which require close monitoring of healing and are difficult to document satisfactorily in records. However, encouraging continuity within an acute-care episode may have negative consequences for longer-term relationships with a preferred GP, since consulting for a new problem (possibly requiring urgent access) has been shown to be associated with failing to obtain interpersonal continuity (Baker *et al* 2007). Some GPs talked about the judgement needed to balance the benefits of following through a particular episode of treatment with the need to maintain longer-term continuity for the patient, bearing in mind patient choice and the requirements of professional etiquette.

Patients with long-term conditions were mentioned frequently as a group who particularly valued relationship continuity, and with whom clinicians also thought it beneficial to maintain a high degree of personal continuity – although not necessarily or exclusively with the GP. One GP felt that successful management of long-term conditions was built on taking the 'long view' and working in partnership with patient:

For something like hypertension, continuity is absolutely key: you've got to see the same person, they've got to work with you – they've got to want to do it.

(GP, inner London, practice D)

In a study comparing the views of patients and their doctors, hypertension was one of the few problems for which GPs gave higher priority to longitudinal continuity than patients did (Kearley *et al* 2001). Perhaps patients see this as a mere blood pressure check, while doctors see it as a potential therapeutic negotiation that is best not undertaken between strangers.

Despite respondents holding strong views about the value of continuity for patients and doctors, and expressing a preference for patients to establish a relationship with a usual GP, none of the practices in our sample included any statement about continuity in their practice literature or on websites. This appears to be the norm, but a search on the internet found that some other practices do spell out for patients their values and expectations concerning continuity of care (see the box, overleaf).

Practice managers and receptionists had a slightly different take on continuity from that of clinicians, emphasising patients' relationship with the practice as a whole, including the staff, environment and organisational culture. They felt they had a part to play in achieving that continuity, by making the practice feel approachable and familiar, so that patients knew what to expect and had a sense of 'belonging to the practice'. A practice manager spoke about continuity as being:

... built up over time – you've been coming for minor things over the years, and when something big happens or something important then it's there when it really matters. But I think it's not just a relationship with the doctor or nurse: it's the whole practice that you're familiar with. It's the whole service from your practice, and how you feel about that – whether you feel that you're going to a practice that you know you're welcomed in.

(Practice manager, inner London, practice A)

Overall, there was a sense that continuity could be encouraged and facilitated, but should not be imposed. One GP (from practice A) summed up this view:

It does depend a little bit on the patient pushing at the right door. We try and help them know where those open doors are.

Examples of GP surgeries setting out expectations for continuity of care

Example 1: The Exchange Surgery, London SW16

Our approach to your health care

We work to promote the benefits of continuity of care, and to ensure that your doctor knows you as an individual.

There are benefits to you in being able to see the same GP for your appointments and to know that they are aware of you and your family's situation.

For this reason we encourage that your whole household is registered with us to allow us to co-ordinate your care where this is beneficial.

If you have ongoing health needs and wish to have continuity of care with one GP please request appointments with the GP of your choice and, excluding emergencies, we will endeavour to book you with the same GP.

All of our GPs are permanent and work with our practice doing regular surgeries. We try our utmost to cover annual leave internally so that you will be seen, wherever possible, by a permanent doctor. Where this not possible we try to use the same locum GPs to ensure our service is to the same high standard at all times.

Source: www.theexchangesurgery.com

Example 2: Manor House Surgery, Glossop and Hadfield, SK13

Continuity of care

You have the choice to see any of our doctors or nurses. However, we value continuity of care. This means dealing with, either seeing or by telephone, the same doctor or nurse for the same episode of illness. We know this leads to better care and it also helps the doctor or nurse to look after your needs appropriately. Therefore we encourage you to see the same person throughout a particular episode of care whenever possible.

Source: www.manorhousesurgery.co.uk

Access and continuity

Respondents saw access arrangements as key to securing relationship continuity for patients, and some GPs expressed concern that emphasis in national policy on speed of access and offering extended hours had effectively restricted choices for some patients and made continuity more complicated to achieve. The practices had various urgent care arrangements, including open surgeries, designated same-day urgent appointments and use of a triage team, all of which offered the patient limited or no choice of clinician.

The importance of the front desk

Respondents acknowledged that 'what happens at reception determines whether you get continuity or not', although each practice had distinctly different policies and procedures for booking appointments that gave patients either more or less choice, and allowed receptionists and clinicians different degrees of involvement and discretion in negotiating speed and type of care.

It was not always easy to understand the procedures involved, what alternatives were available to patients and how decisions were arrived at. (This would require detailed observation – see, for example, Gallagher *et al* 2001.) Some practices made arrangements explicit, and allowed patients to choose from the options available. A GP described his practice (A)'s approach to continuity as 'We try not to be too directional'. Other practices required receptionists to elicit information from patients about their problem and did more to guide patients towards what was considered the most appropriate care option.

Practices varied in the extent to which they provided information that could help patients choose who to consult or to return to a particular clinician – for example, providing information about practice staff, displaying staff photographs, producing cards with contact details for clinicians to give to patients, publicising lists of the usual days each clinician was in the surgery, and giving notice of planned leave dates.

The receptionists interviewed valued being able to help patients, and liked to have a variety of access options to resolve negotiations about appointments – for example, offering telephone consultation appointments as an alternative to face-to-face consultation, and appointments with either a nurse or a doctor. Receptionists understood that the distinction they were required to make between 'urgent' and 'routine' requests did not necessarily align with patients' agendas: patients may reassess their urgent need for an appointment within 48 hours if their preferred GP was not available.

Respondents recognised that establishing and maintaining continuity could be challenging for some people. They identified less well-educated and less articulate patients, including recent immigrants who did not understand the NHS or for whom language was a barrier, as being likely to have difficulties. These may be the very patients most needing to see the same clinician (O'Donnell *et al* 2008).

They also highlighted children as being at risk of discontinuity if urgent care arrangements had little flexibility. One GP (practice Y) said that he always tried to fit in children, because he thought continuity was important for them, but whether patients knew this and how it was negotiated at reception was not clear. Survey evidence confirms that children have least relationship continuity, mainly because their problems (such as febrile illness) are seen as urgent and essentially short term (Freeman and Richards 1990). Relationship continuity is relevant for their parents as well (Howie and Bigg 1980).

All the practices flagged the notes of patients with special access requirements to ensure that receptionists made appropriate arrangements – for example, for patients requiring longer appointments.

Practices varied in the extent to which access problems were seen as front-desk issues or for the whole team to resolve (Haggerty 2009). GPs in two practices were critical of their receptionists for not showing the required

initiative to help patients achieve satisfactory access and continuity. Both commented that training appeared not to change attitudes, but recent recruitment of younger, more customer service-oriented staff had improved the service.

Telephone and email consultations

All the practices offered telephone consultation with GPs and nurses, typically booking time slots at the end of a consulting session. Practices are increasingly using telephone consultation, although there is little UK research or guidance on how best to incorporate it into a practice's repertoire of access options (Toon 2002, Liddell *et al* 2008).

Nationally, about 12 per cent of all GP consultations in 2008/9 took place on the telephone (Hippisley-Cox and Vinogradova 2009). Telephone access can enhance access to clinicians, and may help maintain continuity by offering patients an alternative if no convenient appointments are available. However, it was not clear to what extent the practices were using telephone consultation simply as a means of managing demand without regard to continuity (particularly for urgent care) or more purposefully, in ways that maintained continuity – for example, for follow up, or as an alternative to seeing the usual GP in person, as advocated by McKinstry *et al* (2009).

GPs in practices B and Y talked about their use of email consultation. The GP in practice Y allowed a few known and trusted patients to contact him directly by email. He saw this as efficient and supporting continuity. This approach is typical of email use as described in Car and Sheikh's review (2004). In contrast, practice B publicised 'email appointments' on the website, although this was at the discretion of the GPs. The GP interviewed was extending his use of email, and said that a growing number of patients were asking if they could contact him in this way:

I have no qualms about being more accessible, because it leads to efficiency gains elsewhere... and the patient does better with it... People like things to be speedy and efficient. There's an increasing range of communication styles... they don't always like formality from us – a lot of people are comfortable being more informal.

(GP, inner London, practice B)

While email consultation in the context of an existing GP–patient relationship has mostly been small-scale to date, a study of teenagers' use of a health advice website showed how email may also be used for establishing initial contact, enabling teenagers to start a relationship and build trust that would eventually encourage face-to-face consultation. The authors conclude that 'email communication is ideal for short questions, brief updates and follow ups and as a first point of contact' (Harvey *et al* 2008, p 304).

Building a therapeutic relationship

Implicit in clinicians' understanding of continuity of care was the assumption that continuity and the therapeutic relationship were mutually reinforcing, as argued by Ridd *et al* (2009). Clearly, access arrangements that enable patients to return to the same clinician are necessary for the patient to establish a therapeutic relationship with a particular GP – but clinicians also recognised that the quality of individual consultations and the relationship,

once established, could themselves cement and sustain continuity. In some interviews, we explored how 'committed' relationships became established, and whether more could be done to help patients and GPs form effective therapeutic relationships.

Time in the consultation

Respondents identified trust as the key ingredient of a good GP–patient relationship. The relationship was described by a GP in practice A as being constructed out of the 'small bricks of consultations with the same GP over time, to form a long-term narrative' leading to mutual understanding that fostered trust.

Some respondents felt that the current organisation of consultations supported formation of relationships well enough, giving sufficient flexibility to extend consultation time if required and to offer longer appointments if necessary. A GP in practice B said he 'engineered things to fit', keeping 'a couple of appointments free to soak up any extra time I need. I don't clock watch: if someone's talking, then that's fine. If I'm running late I can defer some of it, in a way that's sensitive (to the patient)...'. However, others were more critical of the ten-minute consultation, which they felt gave too little time to build relationships. A GP in practice X questioned why the ten minute consultation was so entrenched when so much else had changed in primary care:

Self-limiting illnesses have gone to more appropriate members of the team and we've been left with more complex problems, polypharmacy, multiple diseases, psychological problems and far more investigations, all of which we have to deal with... in a 10-minute slot.

These observations echo the findings of research by Lester *et al* (2009), in which GP principals reported a shift in the balance of their workload towards non-routine problems, including an increase in patients who had complex problems or who were difficult to manage. The GP in practice D had altered the structure of his surgeries in response to this, and now offered 15-minute slots, with longer surgeries to accommodate the same number of appointments as his partners. This suited him, and he felt it was appropriate for his patients:

I tend to see a lot of the more complex cardiovascular disease patients because that's what I'm interested in, and they're quite time consuming.

Practice-initiated contact

The topic of GP- or practice-initiated contact with patients (such as phone calls and visits) did not come up in the interviews until the interviewer asked about it directly, although for patients this practice is an important indication that their GP has a continuing commitment to them. Our impression was that it took place relatively infrequently. Most GPs and nurses remarked on how much patients appreciated a telephone call or visit, and recognised that it was a powerful means of reinforcing relationship continuity. One GP regretted that he now made fewer unrequested telephone calls or visits – for example, after discharge from hospital, or in the context of major life events such as bereavement or births:

People really appreciate it. It doesn't take much to phone someone. We couldn't visit all these people, but [to] actually phone and say 'I see you've

had your operation – is there anything we can do?’, it doesn’t take a second. I don’t do it because I put it to the end of the day and I don’t do it then. I think that would be an enormous step in building that relationship again... I feel very uncomfortable about that issue. I know it’s an area we could easily do better with and improve continuity of care.

(GP, Hampshire, practice X)

Initiating contact by making a phone call to see how patients are doing, or a judicious offer of support at times of difficulty, may be of practical value to the patient – but perhaps most importantly it demonstrates that the GP cares and has a continuing commitment to the implicit contract with the patient (Jacobson *et al* 2009, Haggerty *et al* 2003).

Management and information continuity

Much discussion about continuity in primary care focuses on the patient–GP relationship and interaction during consultations. Management continuity, or co-ordination of care, is accepted as a distinct dimension of continuity, but it has not received as much research attention as relationship continuity.

Our respondents saw co-ordinating care as part of a GP’s clinical responsibility: ensuring that the patient receives necessary care from other professionals and services, and that these services are co-ordinated effectively for the patient’s benefit. In this way, management continuity can be greatly facilitated by maintaining a personal relationship with a GP, although they recognised that the GP was not always the main or most appropriate co-ordinator of care, and that roles such as community matron or case manager, involving overseeing and co-ordinating care for specific groups of patients, were generally welcomed. However, there was a strong feeling that GPs often had to assume this role and were the ‘backstop’ if co-ordination broke down:

Where we are the main co-ordinator, and when everyone else fails, it all comes back to us. We’re the sticking plaster for a lot of these things.

(GP, Hampshire, practice Y)

Respondents also said that the time they spent on co-ordinating care was increasing, linking this to developments in the NHS, including the shift from hospital to primary care and the fact that more serious and complex conditions are now managed in general practice; a changing health workforce (more part-time jobs, rapid turnover of staff and specialisation); more inter-professional working; changing patterns of service provision.

Some of the necessary care co-ordination for a patient takes place during the consultation – for example, providing information, ensuring that patients understand their condition and treatment, and planning care, but much of the essential activity happens ‘behind the scenes’ in the practice. In the interviews, we asked respondents to reflect on what they did to support management continuity.

Co-ordination of care was typically described with a strong emphasis on sharing information and communication within the practice team – for example, ‘circumventing breaks in continuity by communicating effectively’ and ‘holding things together, having an overview, making sure that people involved know what they’re doing and keeping the notes updated’. Respondents considered the issue of how well practice teams work together

to co-ordinate things as being central to their ability to deliver high-quality care, and a GP with a Local Medical Committee role (practice Y) went further to assert that: 'Good GPs who work in (organisationally) dysfunctional practices can appear to be bad GPs'.

Managing information

One practice manager described GP information systems as:

... one place in which many kinds of information came together, sometimes over many years, to provide a very big picture of the patient... it's a huge advantage in terms of managing the whole.

(Practice manager, inner London, practice A)

GPs emphasised the administrative time that was required to ensure that records were accurate, complete and up to date and that information flowing within, into and out of the practice was acted on appropriately:

There's an awful lot of continuity associated with the referral process. Every day you probably spend up to about half an hour looking at blood test results and following up. There's all the practice notes from other members of the health care team about individuals and what you're going to do with them. There's all the home blood pressure results that come back and have to be actioned.

Then there's all the unseen stuff, like every patient's medicines have to be reviewed once a year, so we have to go to their records to see what's happening... reports to the Department of Work and Pensions [about] whether people are fit to work, fit to travel, sickness claims – all things separate from the face-to-face contact. It's difficult to quantify because it fluctuates and it always takes second place to face-to-face contact, so it tends to back up.

(GP, Hampshire, practice X)

To help part-time GPs manage information continuity, practice Y had set up an informal buddying arrangement between pairs of clinicians, for example, to enable test results to be reviewed and acted on rapidly, although this arrangement did not involve providing cover for direct patient care.

One GP described the co-ordination required for patients with long-term conditions:

We put in a fair amount of legwork behind the scenes making sure everyone with the chronic diseases that are in the QOF is getting the appropriate elements of their care.

(GP, inner London, practice B)

This GP had a special interest in information technology, and thought that current practice information systems and electronic links to other parts of the NHS (where these existed or were used) did not always support good co-ordination of care. He wanted to see:

... systems in place that make continuity happen, so it's not just down to memory... a lot of the GP software systems aren't good at providing continuity, in terms of making sure things happen when they should happen in the patient's personal management plan. We certainly find ourselves having to augment that in places so we're not reliant on admin

staff having to trundle through sheets and sheets of paper.

(GP, inner London, practice B)

From our observations, practices varied in how extensively and effectively they used IT systems and electronic communication to support managing information, but we were unable to explore this further.

Communication

Clinicians typically expressed a preference for personal contact as a way of sharing information, and valued the opportunities it offers for nuanced communication. All practices held regular practice meetings of various types, from an informal debrief after morning surgery, or opportunities to chat over coffee, to more formal whole-team meetings, and maintaining effective communication within the practice was perceived as something that needed to be constantly worked at. At practice X, respondents talked about using multiple methods of communication within the team – for example, reinforcing informal conversation by sending an electronic practice note, to ensure that the need for action was flagged.

Practice teams also met regularly with a wide range of other professionals working in the community, although they did not assess all attempts at communicating and co-ordinating outside the practice as successful. Getting to know the person, being located in the same building, and establishing appropriate frequency of meetings were all thought to help. A practice manager described relations with the community nursing team as follows:

They 'live' in our practice, so to speak, and communication's very easy. We know what's going on, they come to regular meetings with us, talk about patients... palliative care meetings, which patients are on the palliative care register, which should be, what stage they're at, involving the nurses – so that all goes on. That's all about continuity. We're trying to get to the point where we haven't got four or five people going into see the patient... it's better for one to co-ordinate it.

(Practice manager, Hampshire, practice Y)

Practice A placed particular emphasis on clarifying medical responsibility for patients with severe problems or terminal illness, nominating one doctor as the lead and another, who knew about the patient, to cover if necessary. These doctors could be selected by the patient. If the lead doctor was on going on leave, a formal handover would take place.

Reflections on current practice

Our respondents were enthusiastic advocates for the importance of continuity of care, and were doing their best to promote continuity in the way that care was organised and delivered in their practices. Some also saw themselves as resisting the erosion of continuity of care. But the overriding impression was of diversity of approach to achieving satisfactory relationship and management continuity. Attitudes to fostering continuity ranged from the paternal, where practices directed patients, to the transparent and enabling, where practices gave patients maximum information on which to base their choices.

Personal lists and small teams

One suggested solution for enabling patients to see the same doctor has been for groups of GPs to run a personal list system, where patients normally only see one named doctor (see Gray 1979, Greenhalgh and Heath 2010). Before the 2004 GP contract changes, this was usually the doctor with whom they were registered. There is evidence that some patients may prefer this system (Freeman and Richards 1993, Baker and Streatfield 1995). However, it has the serious disadvantage of limiting informed choice (Freeman and Hjortdahl 1997) and can be difficult to deliver if many of the doctors work part time.

In a recent essay, Mainous and Salisbury (2009, p 57) ask 'Should we enforce continuity?' and argue that the content of the therapeutic relationship – especially trust – is 'the primary key to good outcomes'. They add that this is 'more likely if patients have chosen to see a particular physician' rather than being required to do so. Mainous and Salisbury supply no easy answers, but advocate that small 'teams within teams' having a maximum of three clinicians are formed within larger groups.

This suggestion is supported in the US setting by Rodriguez *et al* (2007), who found that 'when discontinuity with a primary care physician occurs, more favourable assessments of staff will result if patients are directed to a smaller number of clinicians, irrespective of whether these clinicians are formally team members or not.' Operating in extremely small clinical teams is an attractive suggestion in today's context, and more evidence about how they work in practice would be welcome.

The need to monitor continuity

It was notable that the practices we visited had little information available about their current levels of continuity, either from practice information systems or patient-reported experiences, and there was no easy way of assessing whether continuity was improving or declining. Practices did not monitor the level of continuity routinely or systematically in the same way they might monitor and manage access, prescribing rates or QOF indicators, and none made reference to any body of knowledge or source of expertise on how to foster continuity of care.

Inevitably, some issues and potential solutions are specific and local, but it is clear that the general principles of continuity have not been enunciated and disseminated – for example, on how a practice might assess its performance on continuity of care and reconcile relationship continuity with access priorities and targets. Nor are there generally agreed systems to optimise information and management continuity. If continuity is important then it needs to be accorded priority, and practices must be given advice on implementing procedures to support it.

Aspects of good practice: summary

Many patients and clinicians value establishing a continuing therapeutic relationship. This is co-constructed through the interaction of patients and clinicians in the context of the organisation and delivery of care in the GP practice and the wider health care system. Relationship continuity can no longer be taken for granted in general practice, and indeed is not always

essential, since capable patients can cope with a competent primary care team backed by good records (see Cowie *et al* 2009). But patients should have the option to establish a therapeutic relationship with one or more particular professionals in the practice team. Some breaks in continuity may be unavoidable, but good quality care is characterised by sufficient continuity to enable the GP–patient relationship to survive minor disruptions.

Practice culture and organisation should support patients and professionals to maintain continuing relationships, and to adjust them if necessary to reflect changes in the patient’s preferences, needs or social circumstances. We suggest that this is best enabled by being far more upfront both about the importance of continuity and the ways of helping ensure it (Gallagher *et al* 2001). This means:

- providing information for patients about the clinicians in the practice and their availability for face-to-face consultation, telephone and perhaps email contact; publicising the practice’s policy on continuity of care and offering guidance on how to maintain continuity with a GP or other clinician
- ensuring that patients, clinicians and reception staff all know who is the patient’s usual or preferred GP
- sufficient time in the consultation for interaction that will enable a relationship to form
- access arrangements that allow patients to exercise choice about who to consult, speed of access and method of access (for example, phone, face-to-face consultation and email)
- sufficient capacity for same-day and advance appointments
- helpful front-desk staff who are well trained to offer options that promote continuity, as well as achieving timeliness of consultation
- the usual GP being responsible for medication reviews and communicating test results
- working arrangements for clinical staff that include part-time, junior and temporary clinicians in ways that maximise rather than disrupt continuity
- identifying and providing additional help for patients who may experience access difficulties – for example, because of language or learning difficulties, cultural differences, physical disability, mental health problems or social isolation.

Patients look for a coherent experience of seamless care, which includes being given sufficient time to enable them to understand and manage their condition and plan their care. Patients other than experienced service users may find it difficult to assess the quality of co-ordination, although its absence can be starkly apparent as duplication, discontinuities or gaps in care. However, management and information continuity, or co-ordination of care, is accepted as an important part of the GP’s role and many patients look to their GP for explanation and guidance about specialist treatment.

One of the requirements of good management continuity is that the patient is involved in making treatment decisions and planning their own care, including referrals, and is helped to navigate services and systems outside the practice. If patients experience discontinuities or fragmentation of care (for example,

when crossing interfaces between services or organisations), it is the GP and practice team's role to help them reconnect with services or systems.

For patients with long-term conditions, multiple morbidities or complex problems, the GP takes responsibility for making sure that patients receive comprehensive, personalised, holistic and co-ordinated care. The GP may take the lead co-ordinating role, or may collaborate with colleagues in the practice or from other services who act as care managers or co-ordinators. Whatever the arrangements, care plans should be shared with the patient, and co-ordination responsibilities should be explicit, with clear lines of accountability. This includes offering relationship continuity to the extent that patients know which professional is responsible for co-ordinating their care and how to contact them, and GPs know which patients they are responsible for. Relationship continuity can itself encourage management continuity (Guthrie *et al* 2008).

Effective communication is required to support any necessary co-ordination of care between the following: the patient, informal care networks, the GP, the practice team, out-of-hours services and other professionals and services providing care. This is enabled by:

- good record-keeping
- full use of practice information systems to identify and monitor patients who need help with co-ordination
- good communication with other care organisations – in particular, with hospitals
- effective, timely electronic communication between professionals
- personal contact between providers, including regular meetings and informal discussion
- established routines for handovers (out-of-hours, holidays, sickness and with part-time professionals) and exchange of information
- proactive follow up of patients after significant life events or health events.

Currently, practices have little information about their performance in relation to continuity of care, and lack the means for routine continuity monitoring. We suggest that professional bodies should develop and test appropriate monitoring tools and encourage their use. A comprehensive assessment of continuity implies audit of aspects of access, co-ordination, communication and patient experience, including identifying and analysing significant events that may indicate specific problems, and initiatives to make improvements. This is enabled by:

- patient input into developing practice policy on continuity, and producing patient information
- involving the whole team, from front-desk staff to clinicians, in improving continuity
- identifying a practice lead for continuity, to champion this aspect of quality among competing priorities
- support and guidance on improving continuity from primary care organisations, professional bodies and regulators.

5 Assessing the quality of continuity of care

This section considers how continuity of care can be assessed and quantified. First it reviews concepts and measures used in research. It then goes on to look at instruments in current use, or with future potential, and finally provides some basic information about the current quality of continuity in general practice.

Relationship continuity

There is no generally accepted or widely used method of measuring relationship continuity in primary care. Much of the evidence about the current quality of continuity comes from research studies that conceptualise and assess continuity in a variety of ways.

Identifying the usual doctor

At the most basic level, it is not straightforward to identify which patients and GPs consider themselves to be part of a continuing therapeutic relationship. The introduction of the new GP contract in 2004 ended the tradition of GPs having a registered list of patients, and patients having a doctor named on their NHS card. Patients are now registered with a practice. Most multi-doctor practices allow patients to see any of the GPs, although some continue to operate a personal list system, in which patients are expected to see their own GP. Apart from formally linking patients with GPs by registration, no other organisational mechanism for encouraging continuity has been used in NHS general practice.

The most widely used GP electronic information system, EMIS, allows practices to register both a registered GP and a usual GP for each patient, but there is no simple or automatic method of updating the information. It is likely that practices use this function differently, and there is unlikely to be consistency in the quality and utility of information that might be generated from routine systems. Since many patients still use the concept of 'my doctor', one solution to this would be to develop ways of allowing patients to nominate their usual or preferred GP. This would offer a way of identifying a patient's 'own doctor' and could help clinicians and reception staff when prioritising appointments and consultations.

Another possibility would be to record the patient's preferred choice of clinician when booking an appointment, which would assist decisions about planning any necessary follow up. However it was elicited, information about patient preferences would be helpful for practices seeking to evaluate and improve the quality of continuity of care.

Longitudinal continuity

Measuring relationship continuity poses conceptual and practical difficulties. Some researchers have sought to resolve these difficulties by simplifying and objectifying relationship continuity as repeated consultation with the same clinician (longitudinal continuity) or seeking subjective measures of patient experience that encompass the quality of the relationship as well as consistency of contact. Clearly, a patient needs to see the same doctor on a

number of occasions to enable a therapeutic relationship to develop, but this does not necessarily ensure this, or correlate with subjective assessments of interpersonal continuity either by patient or by doctor (see Ridd *et al* 2009). These approaches have different strengths and weaknesses, and are discussed in turn.

Most recently, Salisbury *et al* (2009) have addressed what they call the 'minefield of conceptual and practical problems' faced by those seeking to measure continuity. They argue for theoretical clarity, and offer a framework that distinguishes longitudinal continuity from the quality of the therapeutic relationship and co-ordination of care, while recognising that the three concepts are linked and mutually reinforcing.

As a possible metric, longitudinal continuity is appealing because it is easy to understand, and the necessary data should be held in practice information systems. It would appear relatively straightforward to document a particular patient's consultation pattern over a given period of time, counting how many different clinicians the patient has seen, and from this derive objective measures of continuity.

Researchers have used this information to construct different continuity measures over many years, although there is evidence to suggest that at the organisational level they produce similar results (Salisbury *et al* 2009). The simplest index measures the proportion or percentage of all contacts that take place with the usual provider of care. This is the usual provider continuity (UPC) index (Steinwachs 1979). If a patient consulted every month for a year and saw the same clinician each time, their UPC would be 12/12 or 100 per cent. If they saw 12 different providers, the UPC would be 1/12 or 8 per cent. It would appear a simple matter to gather patient UPC indices routinely from computer records.

Unfortunately, as Salisbury *et al* describe (2009, p e139), 'major difficulties were encountered in measuring longitudinal continuity due to differences in how data are recorded in individual practices. Additionally, calculating continuity indices using routine records requires considerable resources and skills in data extraction and manipulation.'

So, it is challenging to operationalise this and other measures in the context of modern multi-disciplinary team-based primary health care, and requires value judgements about which recorded encounters should be included. Measures of longitudinal continuity can be altered significantly by decisions about which consultations (in terms of location, purpose and the health professional seen) to include in the denominator. It is a major drawback that practice systems cannot deliver the data necessary for one of the most widely used objective measures of interpersonal continuity (UPC). Its use is currently confined to the research domain.

In an evaluation of an intervention to improve access to general practice, Salisbury *et al* (2009) used an alternative measure of longitudinal continuity – the continuity of care (COC) index (Bice and Boxerman 1977). This is an individual measure similar in concept to UPC, and is attractive because it makes some allowance for how many different clinicians are consulted, as well as the usual (most frequent) one. The main disadvantage of the COC index noted by the researchers was that the scores do not have intuitive meaning, except the extremes of 0 (different clinicians seen on every occasion) and 1 (all care from the same clinician). Thus for routine purposes the UPC is likely to be the simplest to use and easiest to understand.

An even simpler approach is merely to record how many different doctors or clinicians, a patient encounters over a given time period. This is, of course, dependent on how many are available. In one practice comprising six regular GPs, some patients were recorded as seeing a different doctor for each of 12 consultations (Freeman and Richards 1990). The larger number was possible because of doctors in training and holiday locums. (The study did not include consultations with other clinicians, such as nurses.)

Early research by continuity enthusiasts showed that patients could receive up to 84 per cent of consultations from the same doctor, in the context of practices with personal lists (Gray 1979, Marsh and Kaim-Caudle 1976, p 50). Later studies of practices with more diversity of organisation found mean UPC scores ranging from 49–58 per cent in five shared list practices to 82–83 per cent in three personal list practices (Roland *et al* 1986, Freeman and Richards 1990). Personal lists are an effective way of delivering longitudinal continuity and enabling relationship continuity, but they are now uncommon and arguably are too restrictive of patient choice (Freeman and Hjortdahl 1997).

More recently, the evaluation by Salisbury *et al* (2009) found that 47 practices of varying size had an average 67 per cent UPC for consultations with GPs in the practice premises, with a range from 46–88 per cent (Salisbury *et al* 2007, pp 68–79). Continuity of care scores diminished slightly, but not significantly, in the practices that had introduced an intervention to improve access.

Patient experience of relationship continuity

Longitudinal continuity, as measured by UPC or otherwise is only a proxy for relationship continuity. The clinician that patients know, trust and prefer is not necessarily the one they have seen most over the index period of measurement (typically the previous 12 months), nor is seeing a particular doctor always a priority for patients. It may be more informative to ask them about their experiences and subjective assessments of relationship continuity.

Recent research has generally sought patients' rather than clinicians' views, and has used various qualitative methods, including interviews, focus groups, questionnaires and patient diaries. Some have linked this with data on consultation patterns. Most studies have been cross-sectional, exploring patients' experiences of continuity in relation to a particular episode of care, which has the advantage of taking into account the reason for consultation and the patient's preferences and expectations in that context. However, a disadvantage of considering only one episode is that an essential aspect of relationship continuity, its development over time, may be missed.

A simple proxy measure of relationship is to ask the patient (ideally before the consultation) how well they know the clinician they are about to see. This covers the dominant element of the depth of relationship of the four identified by Ridd *et al* (2009). For example, one study of consultation quality asked patients to rate their knowledge of the doctor about to be seen on a five-point scale ranging from 'not at all' to 'very well'. It then assessed the immediate outcome of consultations using the Patient Enablement Instrument (PEI) – a six-item questionnaire asking patients whether their ability to cope and care for themselves has changed after seeing the doctor (Howie *et al* 1999). Three items from the PEI are included in the General Practice Assessment Questionnaire (see Questionnaires in general use, p 42).

Another measure developed in Scotland is the CARE questionnaire – a process measure that assesses quality of interaction in the consultation, including empathy (Mercer *et al* 2004). Higher CARE scores predict better outcomes, such as symptom change and well-being, as well as higher PEI scores, and are enhanced where the patient knows the doctor well (Mercer and Howie 2006). CARE is now included as part of the Scottish Government's draft NHS quality strategy as the measure of choice for patient feedback in appraisal and revalidation (Scottish Government 2009).

One study that followed patients for a year and analysed preferences and patterns of service use described four different patterns of continuity of care experienced by patients. In three of these, patients achieved their preferences. However, one group of patients, who identified a clinician they considered their 'own' and wanted to consult, were generally not successful in doing so (Boulton *et al* 2006). These findings suggest that it would be useful to capture information on how frequently patients consult their preferred clinician (where they have a preference). This could be done by systematically recording patient preferences when appointments are requested, which would provide data for continuity metrics, and then allowing a practice to identify patients who were failing to achieve desired relationship continuity and intervene to remedy this.

Patient questionnaires currently used in general practice include items on success in consulting a preferred clinician (see Questionnaires in general use, below). This has the advantages of efficiency and anonymity, but the disadvantages of relying on recall over an undefined period of time and asking patients to generalise about an unspecified number of consultations. In addition, aggregate findings based on a small sample of patients may be difficult for practices to interpret, and are unlikely to be as useful for quality improvement as data collected concurrently about every consultation.

Questionnaires in general use

Two patient questionnaires in widespread use contain items relevant to relationship continuity: the General Practice Assessment Questionnaire (GPAQ – see National Primary Care Research and Development Centre 2010), which can be used within practices, and the GP Patient Survey (GPPS – see Ipsos MORI 2010b) – a continuous independent national survey of patients carried out by Ipsos MORI for the Department of Health.

GPAQ was developed by the National Primary Care Research and Development Centre in Manchester. It is a shorter form of an earlier questionnaire – the General Practice Assessment Survey (GPAS) – and until 2009 was used by practices to assess patient experience as part of the GP contract. There are two versions of GPAQ: one for use immediately after a consultation, which can be used to assess the quality of care provided by individual GPs, and another for posting out to registered patients which does not refer to specific consultations.

Much of the questionnaire focuses on issues of access, including timeliness of access to a preferred GP (Q4). One question (Q9) asks how often the patient sees their 'usual doctor' on a six-point scale, from 'always' to 'never'. Patients are also asked to rate this experience on a scale, from 'very poor' to 'excellent'. The same scale is used for questions about aspects of the consultation.

National benchmarks are provided based on data collected in 2005/06, and practices can compare their GPAQ results against these. For satisfaction with availability of a particular doctor (Q4), the national benchmark is 60 per cent (post consultation) and 58 per cent (postal). For satisfaction with continuity of care (Q9) the national benchmark is 69 per cent (post consultation) and 66 per cent (postal).

Practices were rewarded under the 'patient survey' element of QOF for giving GPAQ to a consecutive sample of at least 50 patients immediately after consultation and considering the results, including evidence of a practice meeting and written proposals for improvement. There was no check on action taken, and no requirement to address any issues in particular, so little is known about how practices used GPAQ results.

The GP Patient Survey (GPPS), on the other hand, is a national postal survey commissioned by the Department of Health. It has evolved incrementally. Originally intended to help monitor achievement of access targets and conducted annually, it is now more broadly based, and a random national sample is contacted quarterly. Results are publically available for individual GP practices and also grouped by primary care trust and strategic health authority. At the time of writing, the results of the first three quarters of 2009/10 were available (Ipsos MORI 2010a).

From the last complete year, 2008/09, the GPPS has included different questions relevant to relationship continuity. Section E asks whether the patient has a preferred doctor (Q15) and for an estimate of how often the patient sees that doctor (Q16). Unlike GPAQ, respondents are not asked to rate this, although the replies can be cross-tabulated with overall satisfaction. Section G assesses the quality of the most recent consultation, using different rating scales from GPAQ, and these assessments are not linked to the patient's 'usual doctor' (Ipsos MORI 2009).

Findings from the GP Patient Survey

Headline findings from the available three quarters of 2009/10 show little change from the 2008/09 survey, but fewer completed analyses are available at the time of writing. Thus most of the following findings are taken from 2008/09. In that year, 62 per cent of respondents reported a preference for a particular doctor. Fifty-seven per cent of those said that they always, or almost always, saw this doctor, and a further 20 per cent said they saw their preferred doctor 'a lot of the time'.

Analysing these results by locality shows that those most likely to express a preference for a particular doctor are likely to live outside urban and inner-city settings. The highest mean figure from single PCTs came from the Isle of Wight, and from Great Yarmouth and Waveney (72 per cent), while the lowest (51 per cent) came from Barking and Dagenham, and from Wolverhampton. There are similar results for patients reporting that they always, or almost always, saw their preferred GP: Dorset and Stockton on Tees have the highest rates (66 per cent) and Heart of Birmingham and Tower Hamlets PCTs the lowest (41 per cent).

Tables 1 and 2 provide a further breakdown of these findings for London and Hampshire, where the fieldwork for this report was carried out. Some of the difference between London and Hampshire is likely to be due to the age structure of the population. While overall the frequency of consulting

a preferred doctor seems good, there are geographical variations, and differences related to age and ethnic group. The tables also compare England as a whole with London and Hampshire, and the experiences of selected age and ethnic groups. Just over 2 per cent of respondents reported their ethnicity as Pakistani or Bangladeshi, which we have included, as these two ethnic groups reported the lowest success rates at seeing their preferred doctor.

Table 1 Is there a particular doctor you prefer to see at your GP surgery or health centre?(%)

	London SHA	Hants PCT	England	England			
				Age group		Ethnicity	
				18-44	65+	White British	Pakistan and Bangladesh
<i>Number of respondents</i>	379,735	37,102	2,163,456	652,702	600,973	1,669,369	28,895
mean response rate	30	45	38				
Yes	60	70	62	53	72	63	61
No	34	28	33	42	22	32	35
Only one doctor available	6	2	5	5	6	5	4

Source: Ipsos MORI (2009, Q15). Data from Pakistan and Bangladesh respondents from 2009/10.

Table 2 How often do you see the doctor you prefer to see?(%)

	London SHA	Hants PCT	England	England			
				Age group		Ethnicity	
				18-44	65+	White British	Pakistan and Bangladesh
<i>Number of respondents</i>	224,787	24,875	1,248,995	334,249	600,973	1,033,120	17,480
Always or almost always	51	62	57	41	70	59	32
A lot of the time	20	19	20	23	16	20	24
Some of the time	24	15	19	29	12	17	37
Never or almost never	5	3	4	7	2	4	6
Not tried at this GP surgery or health centre	1	0	0	1	0	0	1

Source: Ipsos MORI (2009, Q16). Data from Pakistan and Bangladesh respondents from 2009/10.

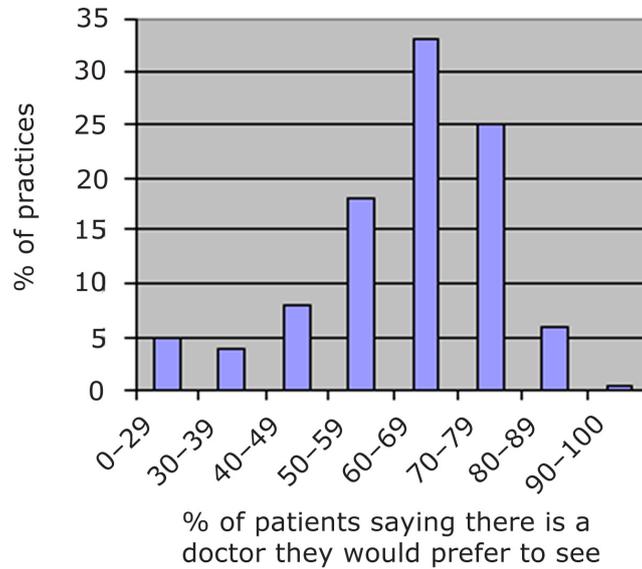
Taking the two questions together, less than one-third of London patients (31 per cent) both preferred to see a particular doctor and almost always managed to see them. In Hampshire the percentage was 43 per cent. Again, age and ethnic diversity may account for some of this difference. We do not know how people rate their experience of continuity with a preferred doctor compared to another GP, but these findings clearly indicate that there are variations in relationship continuity that may impact on other aspects of quality of care.

It is notable that while the Pakistani and Bangladeshi respondents were as likely as the national average to prefer a particular doctor, they were far less successful at realising their preference. How much of this is due to cultural factors and how much to other predictors of low achievement of choice, such as youth, deprivation, unemployment and other social disadvantage, appears worthy of further study.

The distribution of results for all practices in England is shown in the figures below. The majority of practices have between 60 and 89 per cent of patients saying they have a preference for a particular doctor, but the range is wide (Figure 1). Patients most likely to state a preference were women, older patients, those with a long-standing health condition and those registered with a large surgery (of more than 4,000 patients). There is more variation between practices in the proportion of patients saying they always, or almost

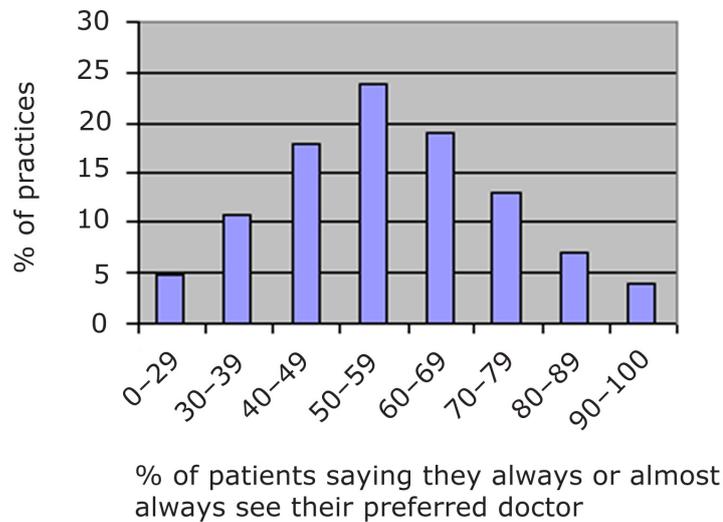
always, see their preferred doctor at the surgery (Figure 2). Older patients, those with a longstanding condition and those who were satisfied with the care they had received were more likely to say they saw their preferred doctor most of the time.

Figure 1 Distribution of English practices by proportion of patient preference for seeing a particular doctor



Source: Ipsos MORI (2009, Q15).

Figure 2 Distribution of English practices by proportion of patients able to see their preferred doctor



Source: Ipsos MORI (2009, Q16).

The GPPS also asks patients to state whether they had confidence and trust in the doctor they saw. Seventy-one per cent of patients said they 'definitely' had confidence and trust in the doctor they saw, while a further 24 per cent said 'to some extent'. These ratings vary with age, ethnicity and perceived state of health: older patients, white groups and those in good health are more likely to say they have confidence and trust in the doctor they have seen (Ipsos MORI 2009).

It is striking that the recent results from the GP Patient Survey support the findings of Baker *et al* in their 2006 SDO continuity study, carried out in Leicestershire and West London. Such triangulation increases confidence in patient-reported measures, but a note of caution is necessary because of the low mean response rates to GPPS, which were less than 25 per cent in some London PCTs.

Currently GPPS results are available at practice level but not for individual doctors, although data may be more useful and motivating for individuals. Howie *et al* (1999) showed that, using the Patient Enablement Index as the outcome measure, consistent results were obtained from only 50 responses per clinician. A useful aid to interpreting GPPS results is now available for practices (Carter *et al* 2009).

Trends in relationship continuity

The few available studies suggest fairly consistent levels of continuity over the past 25 years, based on measures of longitudinal care. Securing continuity has always been more of a problem for patients in larger practices (Freeman 1985, Howie *et al* 1999, Campbell SM *et al* 2001, Campbell JM *et al* 2001, Bower *et al* 2003).

A national sample of 42 practices has been regularly surveyed using GPAS for more than 10 years, and the findings suggest there has been a decline in continuity of care during this time. For the period 2003–7, patient assessments of access, co-ordination of care, nursing and overall satisfaction remained at a similar level, but there was a small but significant decline in patients' ratings of continuity of care and communication with doctors coincident with the introduction of the new GP contract in 2004 (Campbell SM *et al* 2009).

Management and information continuity

There is little consensus on how to assess aspects of co-ordination of care, although potential methods include measuring structures and processes of care, peer review, documenting provider perceptions, and patients reporting their experiences.

There is a large body of literature on general aspects of service co-ordination, co-operation and integrated care, which we have not addressed because of time constraints. Instruments based on interviews with providers to assess a practice's inter-organisational linkages and team effectiveness have been developed in other countries but not used in the United Kingdom, as far as we are aware (Amoroso *et al* 2007, Proudfoot *et al* 2009). Studies of patient experiences of co-ordination and management of care tend to be service or illness specific, and do not necessarily address issues of management continuity in general practice.

The exceptions are studies of the management of some long-term conditions,

such as diabetes and end-of-life care, in which primary care frequently plays a central role and the co-ordinating function of general practice comes into sharper focus. The reports commissioned by The King's Fund Inquiry (see www.kingsfund.org.uk/gpinquiry) on these topics explore aspects of co-ordination of care in more depth than we are able to here.

Researchers devising patient-centred measures of co-ordination of care have identified conceptual and practical difficulties – not least, that the complex issue of care co-ordination is under-theorised. Another problem is that any attempt to measure co-ordination must allow for the diverse and highly individualised health and social care needs of patient populations. It must also address individual differences in attitudes and skills, such as empowerment and self-management, which may contribute to actual co-ordination as well as to how patients evaluate their experiences (McGuinness and Sibthorpe 2003).

However, it is possible to obtain information about patients' experiences of care co-ordination in a structured way, by asking them to complete a 'career diary' (Baker *et al* 1999). For example, this approach has been used to assess the advantages of a GP co-ordinated integrated care package for patients with menorrhagia (Julian *et al* 2007). Recently, Haggerty and colleagues (2009) have reviewed patient-reported measures of management continuity and at the time of writing were field testing a rating scale for use in primary care (Haggerty, personal communication 2010).

Patient questionnaires

The two patient questionnaires currently in use in general practice include questions of relevance to management continuity. GPAQ includes items on involvement in decision-making and explanation of problems and treatment, asking patients to rate the quality of these. GPPS contains similar items, 'explaining tests and treatments' and 'involving you in decisions about your care'. GPPS also includes a section (J) on planning care, aimed at patients with a 'long-standing health problem, disability or infirmity', which asks about provision of information, involvement in management and written care plans.

The issues of measuring patient enablement and involving patients in care planning are being discussed more fully in other reports from The King's Fund Inquiry (see www.kingsfund.org.uk/gpinquiry).

Audit of systems and working practices

There is little routinely available data that allows assessment of the quality of practice systems, processes and working practices that underpin management continuity. Checks on record systems and the quality of records may take place during significant event audits and external investigations following complaints or in the context of evidence of poor service quality. Where there are agreed standards of care, external or internal audit of records can measure compliance with standards. The most common day-to-day management continuity problem facing GPs is the non-availability recent information about specialist tests and treatment. Simple audit against standards for timely receipt and completeness of in-patient discharge summaries would be a useful start in quality monitoring (Salisbury, personal communication 2010).

Documenting the quality of leadership and communication within the team,

and connections with external professionals and agencies, is likely to be more difficult. These aspects of quality are not immediately apparent, and require substantial skill and experience to assess. This is done on visits to practices by experienced external assessors – for example, to check eligibility for teaching, in a variety of ways, including by observing team meetings and rating aspects of the process. It is difficult to imagine that there would be any single indicator that would serve as satisfactory marker of quality for the complexities of team working in primary care.

Summary

To improve quality of care on any dimension it is important to measure it. However, this remains problematic for both the main types of continuity. The simplest proxy for relationship continuity is how often a patient sees the same clinician. However, even this apparently straightforward objective metric presents difficulties of data collection, and raises questions of interpretation, and hence utility in practice. One of the most serious limitations to gathering information relevant to the interplay of access and continuity is the inability of current practice information systems to provide robust routine data on patient choice and patterns of contact with professionals. Measures of patient experience offer a more direct route to assessing patients' perceptions of both continuity and the quality of the GP–patient relationship. The GPPS and GPAQ include promising items, but require more development if they are to yield specific and useful measures of relationship continuity.

Developing good metrics for co-ordination of care is even more challenging. The GPPS includes items relevant to management continuity that might be developed. Continuity and co-ordination across organisational and professional boundaries are of prime importance for patients with long-term conditions, and more specific assessment of quality of co-ordination is required for this group. In addition, good arguments can be made for including consideration of aspects of practice organisation and management that support effective information management and communication, as well as auditing simple cross-boundary communication, such as timely arrival of hospital letters and discharge summaries.

The practice's connectedness to, and ability to interact with and operate alongside, wider local networks of care and support for patients are also important factors, but routine measures of these dimensions will be tricky to construct.

6 Conclusions and recommendations

The balance of evidence is that relationship continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes, although there are some risks and disadvantages that need to be understood and mitigated. Management continuity is almost always desirable but, within the context of the increasing complexity of services, achieving it is challenging.

To enhance relationship continuity, patients need the opportunity to see the same clinician (longitudinal continuity), if they wish to do so. Longitudinal continuity is a pre-condition for ongoing therapeutic relationships, and should be encouraged, but it does not ensure success. Therefore we suggest that patients should not be compelled to see the same clinician in general practice: this should be a matter of choice. While younger or fitter patients generally have less need of relationship continuity, older or more vulnerable patients need it more. They should be helped to achieve it.

Patients seem to perceive relationship continuity as difficult to achieve; GPs perceive it as difficult to deliver. This is particularly a problem for large practices (which are becoming ever-more prevalent). Large practices appear to offer a lot of choice, but patients cannot necessarily see their chosen clinician within a reasonable time

In our practice visits we found a variety of strategies to encourage relationship continuity and a wide range of attitudes, ranging from paternalistic to those enabling patient choice. We were struck by the absence of agreed policies or any general body of expertise on how to encourage continuity. Specific guidance is also lacking from the Royal College of General Practitioners. Meanwhile, many developments in practice and national policy have had the unintended consequence of making relationship continuity more difficult to achieve.

To improve quality of care on any dimension, it is important to measure it. This remains challenging for both the main types of continuity. Even measuring how often a patient sees the same clinician presents difficulties of data collection, choice of metric and interpretation of findings. The inability of current practice information systems to provide robust routine data on patients' patterns of contact with professionals seriously limits practices' ability to monitor the interplay between access and continuity. Development is needed here.

Measures of patient experience offer a more direct route to assessing patients' perceptions both of continuity and of the quality of the GP-patient relationship. The GPPS and GPAQ include promising items. These require more development to yield specific and useful measures of relationship continuity.

Improving this aspect of the patient experience would be facilitated by primary care policies that recognise the contribution of continuity to quality of care in general practice, and by practices being incentivised and rewarded for achieving and maintaining this aspect of care. Initiatives on continuity should involve the whole practice team – particularly receptionists, who are key players in facilitating access and continuity but whose role has been little studied or developed.

There remain many unanswered questions. Better measurement is contingent on understanding the mechanisms of continuity and how it is enhanced and inhibited. Applied research could help clinicians and patients to maximise opportunities for establishing and cementing relationship continuity. There are gaps in our knowledge about how different types of continuity contribute to health outcomes, and about cost-effectiveness. The scarcity of longitudinal studies remains striking, but well-designed long-term studies are difficult and expensive. However, in the meantime, much can be learned relatively quickly through simple and cheap tools and techniques, such as patient experience surveys, patient diaries and significant event analysis in practices.

We recommend:

- bringing together current promising methods of assessing and promoting continuity in practice and developing some form of toolkit for practices
- ensuring a better understanding of the importance of continuity and the need to prioritise or incentivise it alongside other developments in health care
- investigating ways of measuring continuity of care that can be used in service settings to improve quality.
- studying the effects – including costs and benefits – of discontinuities of clinician in today's general practice.

Appendix 1: Table of practices and respondents

Practices and respondents			
Location	Clinical team	Organisation	Respondents
Inner London			
Practice A W2	5 GP partners 2 GP assistants 3 GP trainees 3 practice nurses	Appointment only	Practice manager 3 GP partners GP trainee Receptionist
Practice B SW1	3 GP partners Practice nurse	Open (walk-in) morning surgeries; afternoon/evening surgeries by appointment only	GP Receptionist
Practice C NW1	3 GP partners 3 other GPs Practice nurse	Appointment only	2 receptionists
Practice D SW4	3 GP partners 1 salaried GP p/t academic GP Practice nurse	Appointment only	GP (also recently a primary care trust professional executive committee chair)
Hampshire			
Practice X Small market town, population 13,000	5 GP partners 2 p/t GPs 2 GP trainees Nurse practitioner 5 practice nurses	Appointment only. Same-day appointments dealt with by triage team	Practice manager GP Nurse practitioner Practice nurse Reception manager Receptionist
Practice Y Small country town, population 23,000	10 GPs 3 practice nurses	Appointment only	Practice manager GP (also chief executive of the Local Medical Committee)

Appendix 2: Historical note on the evolution of English general practice and priority for continuity of care

At the start of the NHS, most practices were single handed. The traditional GP was rooted in his locality and 'lived over the shop', as exemplified by Dr Cameron and Dr Finlay – GPs in a fictional two-partner Scottish practice featured in a popular 1960s television soap opera. As doctors joined together in groups – initially of two or three, and later larger – patients were still registered with one named doctor. The GP was the gatekeeper to all secondary care, and provided comprehensive continuity. This was no golden age: the so-called Collings report (Collings 1950) testifies to isolation, poor facilities and often low clinical standards. But within the limited facilities available at the time, continuity – in all its types – was unquestioned.

As the poor relation of specialist hospital medicine, general practice was initially slow to develop. Then, in 1966, a substantial reform encouraged GPs to join together in groups to practise in purpose-built premises. Over the next two decades practices grew, taking on new staff to develop the primary care team, but patients would still consult with the same GP on almost every occasion, and teams remained small. The growing volume of paper patient records was contained in individual patient folders.

All three types of continuity of care remained at high levels. This was taken for granted, and was not a topic of public concern. At the same time, the academic leaders who began to describe the discipline and its scope specified personal and continuing care as a core attribute of the discipline (RCGP 1969, Leeuwenhorst working party 1974).

Higher standards of practice emerged, based on evidence from practice-based research. The scope for combining curing and caring with health prevention was explored (Stott and Davies 1979), and leading practices pushed for population-based preventive work (Hart 1988). But, with growth, professional effort started to be diverted from the patients to fellow professionals. GPs shared out the workload of patient care, and it became normal for practices to operate combined or shared lists where a patient could consult any GP without formality. This increased choice was desirable and popular, but it reduced individual GP accountability. The potential threat to traditional interpersonal continuity was highlighted by Pereira Gray (1979).

By the late 1980s, the NHS as a whole was changing more rapidly. It was hoped that encouraging more services to be delivered in primary care would save expenditure on the costly secondary sector, while at the same time the preventive work advocated by GP leaders should be available to all. A new GP contract in 1990 included 'health checks' and the first 'targets' for preventive services, backed by financial incentives. It was agreed with GPs' own negotiators that targets should apply to practices as a whole rather than to the lists of individual GPs. This led inexorably to the abandoning of personal GP registration in the 2004 contract. Patients are now registered with a practice rather than with a person.

Towards the end of the 20th century there was increased public concern about access and waiting times. Primary care trusts and individual practices were incentivised to meet a 48-hour access target. In other words, a patient

should be able to see a doctor (not a named doctor) with two working days. The perverse outcome was that many practices responded by preventing patients from booking more than 48 hours ahead, meaning that people seeking follow-up appointments for long-term problems could not secure an appointment with their usual doctor.

This caused distress (Windridge *et al* 2004). Even Prime Minister Tony Blair was forcibly made aware of the issue when he faced members of the public in the 2005 election campaign. As a result, the Department of Health started asking patients whether they were able to book in advance, and whether they preferred to see a particular doctor (National GP Patient Survey 2006–9). In 2006, the issue of relationship continuity was mentioned in a government White Paper for the first time (Department of Health 2006, p 73 para 3.60).

The biggest change in general practice came with the 2004 contract. The key feature was introduction of the Quality and Outcomes Framework (QOF). This was a radical, and largely evidence-based, move to improve the quality of both primary and secondary preventive primary care. It set a range of clinical targets linked to substantial financial incentives. Targets were also set for 'patient experience', but these were a small part of the total and were generally less rigorous. But one overall effect of QOF was a drive to increase care processes ('ticking boxes') – arguably, at the expense of responding to patients' stories (Greenhalgh and Heath 2010; see www.kingsfund.org.uk/gpinquiry).

Research is in progress to try and show whether emphasis on the measurable (QOF) is pushing aside quality in the immeasurable (interpersonal aspects of care). The whole process illustrates the clash of cultures between clinicians and politicians recently highlighted by Heath (2010).

Primary medical care is larger and more complex than ever before. It is still largely delivered by GP-led individual practices, but these have changed character. Within practices, changing work patterns are making it more difficult for patients to negotiate continuity. Recent policy developments have emphasised the importance of offering alternatives to traditional general practice-based primary care.

New facilities (initially called 'polyclinics', later 'GP-led health centres') are being set up, characterised by extended opening hours, obligation to take unregistered patients and offering a wide range of care facilities on one site. Lord Darzi has insisted that these facilities will deliver improved continuity of care (Department of Health 2008), but it is not clear what this means in practice. Co-location of facilities ought to improve management continuity, but other factors – such as operation of shifts in extended hours, lack of registration with individual clinicians, and the tendency to employ doctors at the start of their careers, possibly on short-term contracts – may make it difficult to establish an ongoing relationship with a doctor.

Now, in June 2010, it is clear that the NHS will be subject to severe cost containment even though the present government declares that it will not be 'cut'. It will be very interesting to see how much continuity of care – particularly relationship continuity – patients will experience under these pressures over the next few years. In this context, it is worth noting that the balance of evidence is that continuity reduces costs.

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