Considering Continuity of Care Webinar Questions and Answers

This webinar was part of Healthcare Improvement Scotland's (HIS) work on the Primary Care Phased Investment Programme (PCPIP) on 25 February 2025 via MS Teams. The topics for our programme of learning events are based on themes collated from PCPIP participants at earlier events, workshops, webinars and professional networks.

This document provides answers from the webinar speakers to questions posed by webinar participants that were not addressed during the live Question and Answer session.

Please also note that we can only answer questions directly relating to HIS' role in PCPIP. This means that we are not able to answer questions about Scottish Government policy, resourcing or finance.

Pre-submitted questions

(Q) Frequent attenders use considerable resource within all our systems and are a group of patients that would certainly benefit from continuity of care. Some papers published from England/ further afield have shown that a multidisciplinary approach can be key. Are there any known examples of established MDT (or pilot ones) specifically for this patient group in Scotland?"

Carey Lunan: *"Having worked as a clinician in NHS Lothian for many years, I am aware of the work of the Patient-experience Anticipatory Care Planning Team (PACT) team in managing frequent attendance/high intensity usage within ED. It is an MDT model, with a focus on informational continuity, managerial continuity and relational care."* Healthcare Improvement Scotland produced a report on this which is available on the HIS webpages.

(Q) Continuity of care can only become reality with increased GP WTE numbers - this needs direct investment in Global Sum - how can this group influence that?

As part of the PCPIP evaluation work, the delivery of care within 4 demonstrator sites in Scotland will be explored. HIS are collecting and analysing qualitative and quantitative information to understand continuity of care. The findings of this analysis will be shared with stakeholders including Scottish Government with the purpose of informing future investment decisions.

Questions for the panel during the session

Unless otherwise indicated, the following answers are from Healthcare Improvement Scotland, with Dr Paul Baughan advising as the National Clinical Lead for the Primary Care Phased Investment Programme.

(Q) Is it dangerous to try and continue to separate presentation types and roles – urgent presentations can come from our most complex patients and also if time is not invested in our complex then we won't reduce urgent presentations? How do we support both using the expertise of all roles without splitting the individual presentations.

(A) Yes, this is a good point, as people with complex care needs can present urgently. Some practices have systems in place so that all the GPs offer some urgent slots on a daily basis, and the person 'navigating' or 'triaging' call requests will direct the person with the urgent problem to the GP who knows them best.

A quality improvement approach can support changes or improvements to continuity of care. Such an approach would start on a small scale, with one group of patients to test the process in your individual practice. Our Primary Care Improvement Collaborative can support primary care teams to test and implement improvements to their processes. Teams can contact his.pcpteam@nhs.scot to find out more about joining the collaborative.

(Q) Would aiming for relational continuity for everyone be better than a targeted approach of identifying priority patient groups for continuity as this process of identifying will take time, effort and I'm not sure the data is easily available for all cohorts (e.g. people living in poverty).

(A) Yes, this should be the aim, as the evidence shows that at a population level, people benefit from relational continuity of care. They are more likely to take on board proactive and preventative lifestyle recommendations and adhere to medication. However, if for any reason a practice struggles to provide good continuity of care for everyone then they should try to provide it for particular cohorts (people with multiple LTCs, frailty, palliative and end of life care etc.)

(Q) Following on from a comment […*earlier in the webinar…****] about the HIS evidence suggesting that people may prefer access to continuity, what (if any) is the evidence to support the hypothesis that improving continuity of care leads to an improvement in access?***

(A) There is evidence from the University of Cambridge that good continuity of care reduced the frequency that people attended their GP practice, therefore reducing demand and improving access. Having a 'regular doctor' can significantly reduce GP workload, study finds | University of Cambridge

Dr Carey Lunan added: "*this is the most useful and up-to-date paper, because the improvement in access is linked to the reduction in workload that comes with relational continuity of care, which frees up capacity in general practice."* This paper describes one of the largest studies of its kind, when researchers from the University of Cambridge and INSEAD analysed data from more than 10 million consultations in 381 English primary care practices over a period of 11 years.

(Q) It's a shame there isn't a practice manager on the panel as continuity of care can be very dependent on the practices appointment system and the role of the receptionist

(A) Yes - on reflection it would have been helpful to have a practice manager on the panel. We were fortunate that several practice managers took part in the webinar and contributed to the chat, enhancing the content for participants.

The PCPIP programme includes 4 part time practice manager representatives advising us about the practice manager role in an increasingly MDT environment. Our practice manager colleagues are actively exploring this, and we will share any generally applicable learning that emerges from this work.

(Q) If we don't get continuity back, is General Practice doomed?

(A) If we lose continuity of care, research strongly suggests that General Practice will be a less attractive place to work. Recruitment and retention issues would likely become more difficult than they are now.

(Q) ***How is continuity being looked at in the demonstrator sites, and how will lessons learnt from that be rolled out?***

(A) HIS is exploring the impact of MDT expansion on continuity of care through interviews with staff and patients in the four PCPIP demonstrator sites. HIS is collecting quantitative data through the UPC (usual provider of care) index. Note that Dr Kieran Sweeney gave more information about the UPC measure during the webinar which is included in the webinar recording and slides.

(Q) Why was relational continuity question taken out? [of the HACE survey]
(A) The Scottish Government Health and Care Experience Survey 2023/24 Technical Report outlines the rationale for survey questions.

Questions addressed to Dr Carey Lunan during the session

Dr Carey Lunan's responses (unless otherwise indicated) to the following questions:

(Q) Given the expansion/evolution of Primary Care Occupational Therapists in Scotland, is there scope for their clinical skill set to be tapped into/harnessed in order to support?
…and
(Q) What about the balance of relationship continuity and specialist care such as MSK within GP practice

(A) Although not explicitly put to the panel, these two questions were addressed in the discussion. We noted that condition-specific or episodic continuity was also important for developing trust, improving treatment adherence etc when someone else in the team had more expertise than the 'usual GP'.

Dr Paul Baughan, HIS National Clinical GP Lead, added: Allied Health Professionals can also help by encouraging patients to see their usual GP or GPN for any long-term health conditions and ensuring that any communication is addressed to the usual GP rather than any GP within the practice.

Question addressed to Dr Kieran Sweeney

Dr Kieran Sweeney's response to the following question:

(Q) Kieran mentioned Vision searches being worked on - is there any indication of timeline on when these will be available, please?

(A) *"We are actively working on a set of instructions for Vision practices. I am collaborating with a Vision practice who have already measured UPC in order to do this. I anticipate with a few weeks we will have something to share*."

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