Healthcare Improvement Scotland

Continuity of care webinar learning summary

Background

This learning summary was developed from the February 2025 HIS primary care webinar 'Considering Continuity of Care in Primary Care'. It formed part of a webinar series funded as part of the Primary Care Phased Investment Programme funded by Scottish Government.

About continuity of care

Continuity of care (CoC) in primary care includes three interdependent elements:

- **Informational continuity**: Focuses on high-quality information sharing and involves good record-keeping, accountability and effective communication of patient data across the care team.
- **Managerial continuity:** Focuses on coordinated care planning and shared accountability. This is especially vital for patients with complex needs involving multiple practitioners across care pathways.
- **Relational continuity:** Focuses on a long-term, trusting relationship between the patient and their GP or care team.

There are a series of benefits for providing good CoC, that includes increased adherence to medication, better uptake of preventative medicines, lower use of hospital out-patient departments, and lower mortality. It is of particular benefit to those patients living with multiple long-term conditions (multimorbidity), older people and those living with mental health conditions.

Opportunities to improve continuity of care

Offering CoC is a challenge in primary care, particularly given the rise in telephone triage, declining GP workforce and the rising numbers of patients registered with practices. While a rapidly growing multidisciplinary team (MDT) model within general practice has widened skills and experience, the system has also felt more fragmented. Some suggestions for areas to consider include:

- **Incorporating patient experience:** Provide open and regular communication with patients to ensure they understand their care pathway. For certain conditions, having timely access to the clinician who knows them best is more beneficial than having speed of access. Focus on groups who benefit most from CoC, including those with multimorbidity, older adults and people with mental health conditions.

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- **Improved measurement and monitoring:** Ensure there are robust measures for continuity and monitor this over time. Widely used methods to measure continuity such as UPC (Usual Provider of Care) and SLICC (St Leonard's Index of Continuity of Care) can be found in the British Journal General Practice article on measuring continuity of care.
- **Understanding the role of the wider MDT:** Delivering CoC is a whole-team effort. Everyone, from receptionists to clinicians, should understand their role in CoC and how it begins at first contact. Regular MDT meetings are essential to share challenges, information and support caseloads between all professionals who have a responsibility towards patients in the practice. Clinical MDT meetings, including practice and external clinical staff, allow discussion and sharing of information about individual patients.
- **Documentation and communication:** Regular communication improves information flow and signposting, both for patients seeking care but also for staff seeking information. It should also ensure that information can be accessed between meetings and documentation is easily accessible across the MDT.

Summary

The webinar panel highlighted that CoC remains a vital component of high-quality primary care, delivering benefits for both patients and healthcare professionals. By prioritising CoC for those who need it most, fostering team-based approaches, utilising continuity measurement tools, and engaging both staff and patients in the process, practices can make meaningful progress.

Resources

Deep End GP roundtable paper relational continuity of care for vulnerable populations

Royal College of General Practitioners Continuity of Care Toolkit

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