Frailty Directed Enhanced Service (DES) and Continuity of Care webinar

23 and 29 September 2026

Question and answer session responses

The question-and-answer session generated a high level of engagement, with many questions submitted by attendees. Responses provided during the live session can be accessed in the recording, while key themes emerging from the discussion are captured below.

Clinicians from the general practice multidisciplinary team

Question	Response
Please share the way to calculate continuity for non-GP clinicians.	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland** For the patient group count the number of direct consultations with the clinician(s) of interest and divide by the total number of direct consultations that the patients had. Express this as a percentage.
We are a large practice but more ANP/ACP heavy with only 2 GPs and we tend to pick up majority of the caseload with GPs covering duty/complex cases. Will the SLICC be able to review continuity with ANP/ACP rather than GP consults?	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland** The dashboard only includes doctor consultations but are looking at including other clinician groups in the future.
Does the panel have any thoughts for continuity in small rural practices with small numbers of clinicians with often only one GP in the building on any day? Happy to hear thoughts on tricky coal face issues.	**Dr Paul Baughan, General Practitioner Dollar Health Centre and Clinical Lead for General Practice, Healthcare Improvement Scotland**

	Every practice will need to think about its own circumstances and design an approach that works for its workforce and population. In a small rural practice where there may only be one GP in on a Monday and a different GP in on a Tuesday, continuity is still possible. One practical approach is to encourage planned follow-up with the clinician who already knows the patient, even if that means waiting a few days for an appointment on the day they are next in the practice. For many ongoing or complex issues, especially for people living with frailty, seeing the clinician who knows the person may be more valuable than simply seeing the next available clinician. Of course, that won't always be possible or appropriate, particularly when there is an urgent problem. That's where informational continuity becomes really important. Good records, clear documentation of baseline function, care plans and anticipatory care planning can help ensure that when a different clinician does see the patient, they are building on previous consultations rather than starting again from scratch. **Dr Carey Lunan, Senior Medical Advisor on Health Inequalities / GP Chair of Scottish Deep End Project / Honorary Senior Clinical Lecturer Edinburgh University** Continuity is likely to be very high in these circumstances! The challenge is often with bigger practice teams, but there are still ways that this can be done well, such as buddy systems and microteams.
We are a large practice but more ANP/ACP heavy with only 2 GPs and we tend to pick up majority of the caseload with GPs covering duty/complex cases. Will the SLICC be able to review continuity with ANP/ACP rather than GP consults?	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland** The provided tool doesn't currently support that, but we are reviewing the possibility of this. The alternative is to manually calculate as defined in the FAQs.
I am a SAS Grade doctor (originally GP trained) providing episodic continuity of care for frail elderly people within an MOE MDT Medical Day Hospital (unique to Scotland). How can Community Geriatricians best help going forwards? The traditional quarterly talking shops involving discussion of "difficult cases" doesn't seem to work well and these events are time consuming for everyone to attend. How Community Geriatricians are able to help in the future will have implications for job planning and organisation of services for MOE hospital departments. What is it that GPs are looking for in way of support (if in fact any) in managing frail elderly patients, is it simply advice, or increased access to direct patient assessment by MOE? Would virtual Day Hospital clinics help, for instance?	**Dr Paul Baughan, General Practitioner Dollar Health Centre and Clinical Lead for General Practice, Healthcare Improvement Scotland** The answer is unlikely to be the same for every practice or locality. Rather than designing support around a predetermined model, there may be value in community geriatricians having conversations with individual practices, groups of practices or clusters to understand what would be most helpful locally. For some, that may be timely specialist advice and guidance; for others it may be easier access to direct assessment, joint reviews of selected patients, support with comprehensive geriatric assessment, or virtual clinics. I suspect the greatest value will come from flexible partnership working rather than traditional large case-discussion meetings.

	Dr Carey Lunan, Senior Medical Advisor on Health Inequalities / GP Chair of Scottish Deep End Project / Honorary Senior Clinical Lecturer Edinburgh University Thanks for this question, it is probably out-with the scope of the Frailty DES, but this would be a useful topic to raise through the Board interface groups, when they are up and running. Ease of access to specialist clinical decision support is highly valued by GPs and general practice teams.
Does SLICC include telephone consultations, or does it have to be face to face?	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland** Yes, it includes all direct consultations i.e. face-face, home visits, telephone consultations, video consultations and e-consultations.

Continuity

Question	Response
How do we measure/indicators that there is good/bad continuity?	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland** Continuity of score measures are used and give a proportion/percentage of consultations that are with usual or most seen doctor. There isn't an agreed "good/bad continuity" score. Improvement over time is the aim with patients seeing the same clinician as often as possible/desirable.
Our biggest issue which works against continuity is the lack of room space. We have a system which has identified the immediate need based on the 90th centile and excess appts above this are classed as routine but we have at least 4 GPs per day working from an office with no clinical space. Only these GPs do HV. This means that some GPs are not available for FTF and some not for HV any given day, with part-time working this is compounded. Any suggestions in this circumstance?	**Dr Carey Lunan, Senior Medical Advisor on Health Inequalities / GP Chair of Scottish Deep End Project / Honorary Senior Clinical Lecturer Edinburgh University** We recognise the challenges of LTFT GP working and limited room capacity. Relational continuity will not be possible for every patient, for every encounter, but ideally, we prioritise it for those who are known to benefit from it the most, as much as possible, and create systems that make that feasible within the circumstances for the practice (e.g. buddy systems, microteams, use of telephone appts in addition to in-person appts)
Will it class a triage information gathering call as a consultation when they are then seen by a different clinician the same day about the same problem?	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland**

	Consultations recorded as “triage” will not be considered as direct activity so will not influence the continuity of care score. For example, if a duty doctor triages a patient to their usual or most seen doctor, only direct contact will count.
How do we use SLICC to show continuity delivered by a buddy system (a patient whose continuity is shared between 2 GPs for example)?	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland** You can use the dashboard, but it won’t be as accurate as if you calculate the score manually. This is defined in another answer.
How to manage expectations vs continuity? Most patients opt for the next available appt, even when known well to other GP who may have an available slot even later that day despite admin trying to encourage them to see the same doctor again.	**Dr Paul Baughan, General Practitioner Dollar Health Centre and Clinical Lead for General Practice, Healthcare Improvement Scotland** Yes, a very real challenge and tension in modern general practice. Continuity is most valuable when there is complexity, uncertainty or a need to understand change over time, but patients will not always choose continuity. I think the aim is not to achieve 100% continuity for every patient, but to make continuity available, explain its value, and prioritise it for those who are most likely to benefit. When a patient wants to see a different clinician because they feel their problem hasn't been resolved, that's understandable and continuity should never become a barrier to a second opinion. Equally, seeing multiple clinicians can sometimes fragment care and make it harder to build a shared understanding of what's going on. Access and continuity are both important. Sometimes the best option is the next available appointment, and sometimes the best option is seeing the clinician who already knows the patient and their story. **Dr Carey Lunan, Senior Medical Advisor on Health Inequalities / GP Chair of Scottish Deep End Project / Honorary Senior Clinical Lecturer Edinburgh University** The RCGP toolkit contains patient resources that explain the importance of relational continuity of care, and when patients understand this more, they often feel more prepared to wait to see their usual doctor if the issue if not urgent. This can help patients and practice teams, as it can prevent unnecessary re-presentations and reduce workload. But culture change for practices, and for patients, does take time.
We encourage individual clinicians to take responsibility for patients during a period of ill health - personal responsibility for results, no docman marked "to make an appointment" - we pick up the phone. Is this continuity going to be reflected? Can it be captured?	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland** It will be positively reflected in the score if the doctor that is seeing that patient is the doctor that the patient has seen most in the past 2 years (for mSLICC) or they are the patient’s assigned clinician in the GPIT system (for SLICC)
Patients wish to see different clinicians for some if not all aspects of health care. How does this affect the continuity scoring?	**Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland** This will likely reduce continuity overall. However, the expectation is that patients have the opportunity to see a named doctor. If they choose to see someone else that’s OK, in

	general continuity will be better than a system where there is no attempt to direct patients to a named doctor.
I am a physio specialising in community dementia care and often have episodic continuity with my patients over several years. Is there any way I can help support this work- particularly for patients who are not well known to their GP surgeries or nursing services?	**Dr Carey Lunan, Senior Medical Advisor on Health Inequalities / GP Chair of Scottish Deep End Project / Honorary Senior Clinical Lecturer Edinburgh University** In these circumstances, informational continuity is also important; sharing the person-specific information that you have with the patients registered general practice, built through episodic continuity, will help to improve their care. **Dr Paul Baughan, General Practitioner Dollar Health Centre and Clinical Lead for General Practice, Healthcare Improvement Scotland** I think the episodic continuity that physiotherapists provide is incredibly valuable and can make a real difference. Alongside that relational 'episodic' continuity, a shared clinical record is important in providing 'informational' continuity. It allows observations and concerns from physiotherapy to be visible to GPs, nurses and other members of the MDT, helping everyone build a more complete picture of the person and their needs over time.

Dashboard

Question	Response **All responses by Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland**
Who should I contact if I have issues accessing or using the dashboard?	Please contact NSS.GPactivity@nhs.scot in the event that the dashboard isn't populating with the practice data. Link to dashboard - In-hours Dashboard.
When does dashboard go live?	It is currently live for all practices in Scotland.
How do you access the dashboard? Is it something that needs to be loaded onto the Vision system? Is it accessed through patient notes in Vision or separately through online portal?	It is downloaded and installed from the Albasoft website.
Does the dashboard work with Vision?	Yes, it works with both EMIS and Vision.
Does the dashboard pull the information from Vision or must it be filled up manually?	It pulls the information from the GPIT system. For the measure to be accurate, practices should be recording their encounter type accurately e.g. face-to-face, telephone consultations etc.

Where does the CoC dashboard get its data i.e. does it use entries into a patient's notes? EMIS/vision (will pick up data entries and special requests) or does it use appointments booked in the diary?	It uses encounter data which comes from the entry each time a patient is seen. Not from appointment book. More info generally about the dashboard here GP In Hours Activity.
The dashboard mentions Assigned Clinician in the GP IT system. Our allocation of patients to GPs at the point of registering with our practice is completely random and bears no relevance to who that patient ends up seeing...so they might have great continuity but never actually see their registered GP. Do we really have to change their registered GP to reflect continuity?	It isn't the registered GP that should be changed, it's the "usual GP" in EMIS. SLICC uses this field to calculate the score so if this isn't the doctor they see most often, the score will be lower than usual. The usual GP should ideally be changed to allow for practices to direct patients to the correct clinician when patients try to book appointments.
Can you give a bit more detail about the precise way to access the correct dashboard. I am looking Tableau /Primary care dashboards/ General Practice Encounters/ GP Continuity of Care and after selecting my practice, I am not seeing the options to select mSLICC or any information about assigned/ most seen clinicians?	You may be trying to access a different dashboard. The dashboard can be downloaded via this link In-hours Dashboard or the link if you go to the albasoft website. The option for the enhanced service SLICC/mSLICC will only appear after you enter the 8O23 code for patients and give the dashboard 24 hours to pick up this information.
What happens to your numbers on the dashboard if some of the original 10 die during the DES period?	The DES payments are not in any way linked to the 'numbers' or scores, the intention with the DES is to raise awareness of the dashboard and confidence in using it. If someone on the list dies, having been prioritised for relational continuity of care, that is a good human outcome.
Does the dashboard pick up the data on only the 10 patients we select or all patients with frailty coded?	It depends in which way you mean. The DES filter at top right will show continuity score for the 10 patients included in the DES. If left at practice level it will show the whole practice continuity scores. It doesn't show continuity scores for all patients with frailty, only those included. If you want to expand on this, we can pick up here NSS.GPactivity@nhs.scot.
Can the dashboard help identify frequent attenders? It might then allow us to choose some of these who are also frail and focus on these patients to improve continuity?	You can use the frequent attender filter in the dashboard along with frailty to identify those that consult more often. Each patient in the DES doesn't have to consult each month for a score to be generated for those that do.

Coding

Question	Response All responses by Dr Keith Moffat, Primary Care Informatics Lead and Medical Advisor – PSD Scotland
Are the 10 patients for DES identified on the dashboard by using the 2jd codes? If so, can we code more patients than 10 then how do we get the data out for those 10?	The patients for the DES are identified for the measure with the Provision of continuing care 8O23. Any patient you code with this will show in the DES continuity filter in the dashboard.
Can you provide a list of codes that should be used to Code Direct contact correctly?	The measure uses the consultation type which is recorded when you record a consultation. You don't code these.

I have tried to enter the codes suggested into patient notes (Vision) but they do not seem to be accepted - can you clarify how to do this?	If you can email the mailbox, we'll look at what the specific issue is - NSS.GPactivity@nhs.scot
What if IT provision is changed from EMIS to Vision mid-data capture?	During migrations some historic consultations may go from direct to indirect so you may see small shifts in overall practice SLICC and mSLICC levels, as well as the patients who are appearing in the usual provider of care (UPC) table.
If mSLICC is measured on consults in past month, will this tool allow measurement if patient has not been seen in this timeframe? (Some frail patient will be seen a number of times if unwell but may not be seen >1/month if stable). Also, given proportion of frail patient who are on palliative care list/nursing home register, there is a good chance that one of the 10 patients may not still be alive at end of 6-month mark- what happens in this case?	You will still see a percentage of mSLICC as long as some of the patients you have selected have a consultation in that month. If no one has, you'd see 0 for that month.
Does mSLICC calculate the 'most seen GP' from consults in the last month, or from consults over a longer period? In the dashboard, is the 'Assigned Clinician the 'Registered GP' or the 'Usual GP' (both of which are recorded separately in Vision)?	The Assigned Clinician is used for the SLICC calculation. The assigned clinician is the usual GP not registered GP. The 'most seen clinician' is calculated from the past 2 years.
Are we likely to demonstrate a change in the mSLICC score with only 10 frail patients if we have a relatively large cohort?	Yes, because the 'enhanced service mSLICC' and 'enhanced service SLICC' is the total number of consults with those 10 patients' calculated most seen GP divided by the total number of consults for those 10 patients. The denominator is therefore not your practice list size but the 10 included patients.
How do we access SLICC?	Click on the continuity tab in the dashboard and select SLICC in the drop-down filter to the upper right of the timeseries graph.

Identification

Question	Response
How should we select the cohort of 10 patients with frailty for the DES? Should we focus on patients with more severe frailty, those who attend frequently, or those whose care is currently fragmented?	Practices have flexibility in selecting their cohort of 10 patients. The greatest benefit is likely to be seen in people with more complex needs, more severe frailty, or those whose care is currently fragmented and who would benefit most from improved relational continuity. Practices may also find it helpful to use the dashboard's frailty and frequent attender filters to identify patients who consult regularly, as this can make changes in continuity easier to observe over time. However, there is no requirement to select patients with poor continuity, and each practice should choose a cohort that best reflects its local population and priorities.

Can we have a list of steps we need to take please? i.**e.** do we just have to identify patients, calculate Rockwood CFS, identify a "usual dr", give them the 8O23 CODE and then leave it to our practice manager/admin team to sort out the spreadsheet?	**Dr Paul Baughan, General Practitioner Dollar Health Centre and Clinical Lead for General Practice, Healthcare Improvement Scotland** Step 1-3: Identify and code people with frailty Step 4: Add 'usual Dr' and code 8O23 Step 5: Consider how your practice will provide more continuity for this cohort. Run dashboard twice – at start and end of DES
How do you identify which patient is linked to the patient key number?	The patient key is the unique patient identifier used within the GPIT system. In Vision, this corresponds to the patient's Vision identifier, which can be located using the patient search function (e.g. surname and date of birth). Entering the patient key into the GPIT system will display the relevant patient record. While the patient key is linked to the individual's CHI number within the system, it is the patient key that is used within the dashboard to identify patients.
Is it the SLICC that we run at beginning and again in 6m to see if continuity of care has improved?	It is the modified SLICC (mSLICC).

General

Question	Response
Is SLICC a standardised protocol? It appears only to look at the past calendar month. Only looking at one calendar month would seem to give small numbers, which obviously reduces any statistical significance of the result. Understand that some patients have multiple contacts, but in one month, for most patients, the numbers are still likely to be small.	The reason for one calendar month is that this allows practices to see month-to-month changes in continuity, so SLICC is designed for more operational use. As Paul mentioned in the webinar, choosing patients that are attending regularly is helpful. The dashboard can help with this as you can choose both frailty and frequent attender filters. For quality improvement projects statistical significance is less important. There are other tools used as a more longitudinal measure and are patient rather than practice level e.g. UPC index. This isn't good for showing changes over the short-term though. Focus on frailty | Right Decisions There is also the focus on frailty pocket guide that can support conversations on 1:1 and as part of MDT discussions around continuity of care.
Do we have to ask for consent to be in the cohort?	**Dr Carey Lunan, Senior Medical Advisor on Health Inequalities / GP Chair of Scottish Deep End Project / Honorary Senior Clinical Lecturer Edinburgh University** No consent is required; this is just part of providing good clinical care and is underpinned by a robust evidence base.
When do we complete DES reporting form?	By 30 April 2027.

Continuity of Care and Frailty Cluster Session - *Opportunities beyond the DES to improve Continuity of Care as a Cluster*

To register for one of the sessions, click on the links below:

- Tuesday, 27 October 2026, 13:00-13:45 or,
- Wednesday, 04 November 2026, 13:00-13:45

Session aims:

- Share experiences on initiating a quality improvement approach to the Frailty and Continuity of Care DES with clusters
  - Hear example(s) of how CQL(s) have approach this
  - Share approaches, successes, challenges and how they were/could be overcome
  - Generate change ideas that could be tested to improve frailty and continuity of care

Audience: CQLs and PQLs