

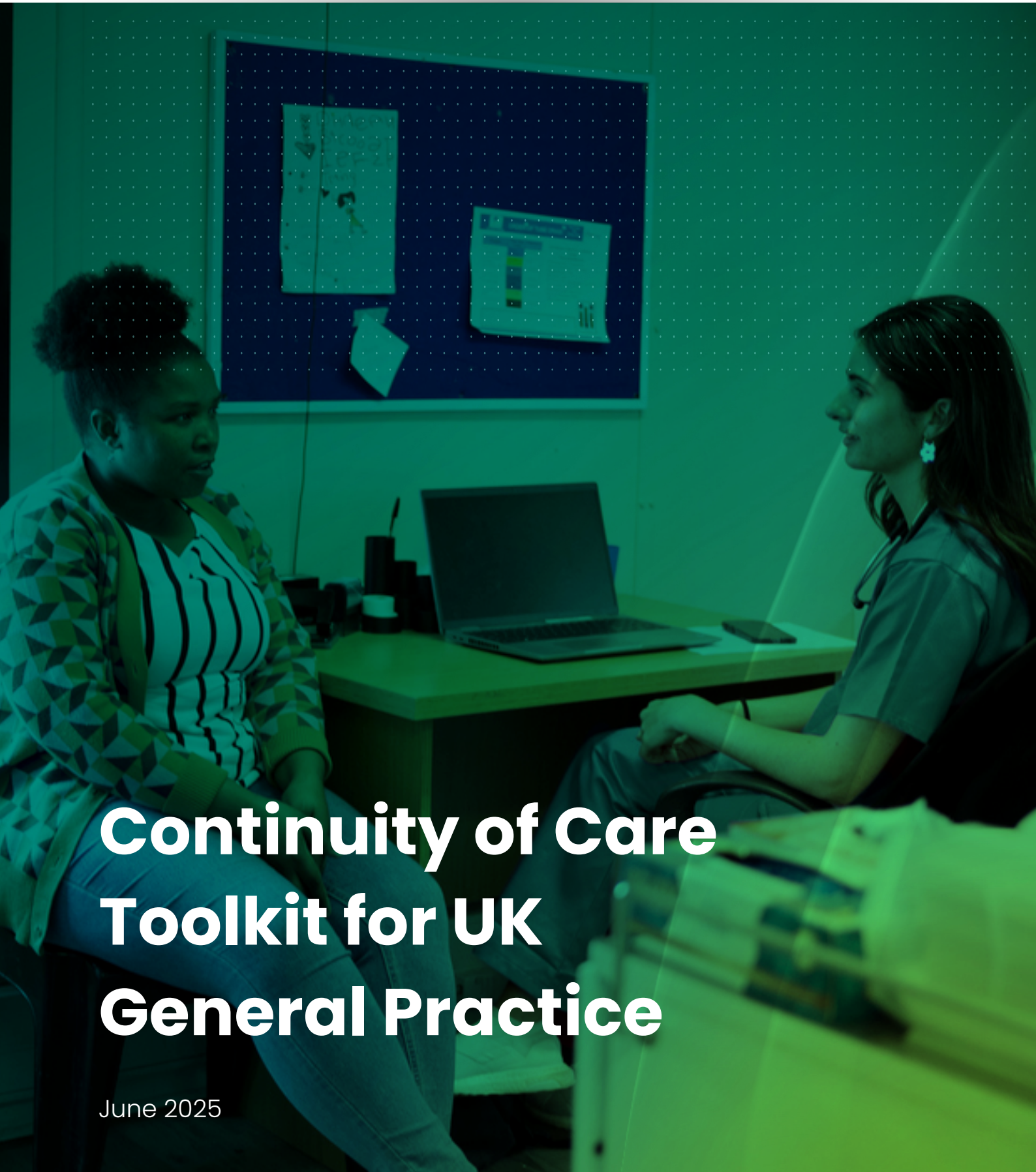


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Continuity of Care Toolkit for UK General Practice

June 2025

Contents

What This Toolkit Is

01

Why Continuity of Care Matters

02

What Is Continuity of Care?

03

How to Start Improving Continuity

04

Identify Who Benefits Most

05

Measuring Continuity

06

Understand what is “good”

07

Quick Wins to Improve Continuity

08

Practical Implementation Tips

09

Align With 2025–26 PCN DES

10

Better Access, Not Just More Access

11

Get Started Today

12

Using EMIS to Support Continuity of Care

13

Communicating with Patients

14

Continuity of Care Plan Template

15

01. What this Toolkit Is

It includes practical steps for identifying continuity needs, engaging patients, redesigning workflows, and embedding digital tools – as well as real case study insights from GP teams already making it work.

This toolkit helps GP practices and PCNs enhance continuity of care for patients who benefit most. It combines real-world strategies, planning tools, patient communication resources, and EMIS system tips to support safe, measurable, and sustainable improvements in relational care.

It's designed for use by:

Practice Managers



Digital and Transformation Leads



PCN Managers



Clinical Leads



PCNs aiming to meet
2025–26 DES requirements



02. Why Continuity of Care Matters

Perspective

Benefits of Continuity

Patients

- Don't repeat story
- Feel known & supported
- Fewer A&E attendances

Clinicians

- Better knowledge of patients
- Earlier diagnosis
- Reduced admin load

The NHS

- Reduce avoidable hospital use
- Improves system flow
- Improves care coordination

1 in 5 patients rarely or never sees their preferred GP.



Declining continuity risks fragmented care and rising costs.

03. What Is Continuity of Care?

Defined as:

"An ongoing relationship with a clinician or team, and coordinated care that flows smoothly across services."
RCGP (2016), Hill & Freeman (2011)

Types of continuity:

01 Relational: Seeing the same GP or team

02 Informational: Accurate records and shared knowledge

03 Management: Joined-up care plans

04 Episodic: Consistency during short-term care



04. How to Start Improving Continuity

Step-by-step process based on the Plan, Do, Study, Act (PDSA) cycle:

Start Out

- Explore what continuity means in your practice
- Build shared understanding and enthusiasm

Define & Scope

- Identify your aim: e.g. "Improve continuity for high-risk patients"
- Gather staff/patient feedback and choose where to focus

Measure & Understand

- Use tools (e.g. EMIS searches, continuity indices)
- Track current continuity levels
- Set baselines

Design & Plan

- Identify changes needed: roles, systems, appointments
- Develop workflows

Implement

- Launch with a small cohort
- Monitor early outcomes

Handover & Sustain

- Share results and embed changes in systems and culture
- Re-measure and adapt

05. Identify Who Benefits Most

Likely to Benefit	May Not Need It
Frail or elderly patients	Young & healthy adults
Multiple long-term conditions	Patients preferring flexibility
Mental health concerns	One-off or acute needs
Recent complex diagnoses	Episodic or urgent-only attenders

Use digital risk stratification and your clinical judgement.

06. Measuring Continuity

Use simple tools to assess current performance and track progress.

Recommended Tools:

- [Usual GP Tool](#) (OneCare, EMIS) - [Guidance, EMIS Searches](#)
- UPC Score (Usual Provider of Care)
- COCi (Continuity of Care Index)
- SLICC (St Leonard's Index – for named GP practices)

Recommended Start

UPC Only: Begin with the gold standard for baseline measurement and research comparison

Named GP Practices

UPC = SLICC: Combine research standard with named GP performance monitoring

Advanced Analysis

UPC + COCi: Research standard plus detailed team-based care analysis

UPC = Gold Standard for benchmarking.

Use dashboards to visualise how often patients see their usual GP.

07. Understand what is “good”

While focusing on your own progress is important, learning from others can reveal new improvement opportunities. Reach out to other practices working on similar continuity improvements to share experiences and insights.

This approach helps you:

- Benchmark your current position
- Discover untapped potential for growth
- Build a supportive network of peers on similar journeys

UPC Classification Levels

- **Low:** 0.39 or less
- **Medium:** 0.4–0.69
- **High:** 0.7 or more

Important Note on Data Comparison

When comparing your practice’s data with others, remember that numbers alone don’t tell the whole story. Focus on how you present your results to inspire positive change. Highlight improvements that directly benefit your patients and team, rather than just pursuing better statistics.

08. Quick Wins to Improve Continuity

Action	Impact	Set Up Time	Risk
Assign named GP to high-risk patients	High	<1 week	Low
Offer “wait for usual GP” choice in triage	Moderate	<1 week	Low
Create micro-teams (“Dr A + Nurse B + Admin”)	High	2–4 weeks	Medium
Use digital booking with GP preference	Moderate	1–2 weeks	Low
Encourage continuity in patient comms	Moderate	Immediate	Low

09. Practical Implementation Tips

1: Practice organisation:

- Named GP systems or buddy systems
- Continuity champions
- Clinician-protected time

2: Technology:

- EMIS/SystemOne continuity dashboards
- Booking preferences & alerts
- Online consults with usual GP routing

3: Patient engagement:

- Explain the benefits
- Promote “see your usual GP” messages
- Use friendly language like: “Your GP knows you best — book with them if you can.”

4: Staff Development:

- Train teams in continuity value
- Support relational continuity (e.g. longitudinal care)

5: Feedback and Improvement:

- Add continuity questions to FFT
- Use patient groups to co-design systems



10. Align With 2025 – 2026 PCN DES

- Risk-stratify patients who would benefit from continuity
- Assign named GPs based on clinical need
- Use digital tools to identify and track patients
- Provide online access that supports continuity
- Include structured data from all modes of access (phone, online, walk-in)

11. Better Access, Not Just More Access!

It's not either/or. With the right tools and workflows, digital access can enhance continuity – not undermine it.

Good practice examples:

- Use AI tools to prioritise continuity during triage
- Display continuity info in digital booking
- Combine demand dashboards with continuity metrics

12. Get Started Today

1. Pick a patient group (e.g. top 5% complex patients)
2. Measure current continuity – this [Continuity of Care Assessment Framework](#) may help
3. Agree aim (e.g. 20% increase in patients seeing usual GP)
4. Choose quick wins
5. Monitor and share results

“Continuity isn’t a luxury – it’s a clinical safety and relationship tool. Start small, learn fast, grow impact.”

13. Using EMIS to Support Continuity of Care

EMIS provides a powerful suite of tools that can help practices embed and track continuity. These features align well with PCN DES goals and can be implemented incrementally:

Key EMIS Features for Continuity

Function	How It Helps
Usual GP Field	Assign and manage continuity cohorts – essential for reporting and alerts
Continuity SNOMED Code	Use 980781000006105 or EMIS code EMISCCO16 to flag continuity focus
Protocols	Trigger alerts or pop-ups on record load to promote continuity
Appointment Filters	Enable searches and booking by micro-team or named GP
Care Plan Alerts	Notify teams of agreed GP-patient arrangements (useful for frequent attenders)
Online Booking Controls	Restrict slots to 'Usual GP only' or offer alternatives when not available
EMIS Prompts	Guide reception teams to offer continuity-consistent decisions

EMIS Workflow: Measuring “Who Did the Patient See?”

1. **Select Consultations:** Choose a time period and list of users (clinicians).
2. **Run Report:** Use “Fill Patient Details” option.
3. **Export to Excel:** Download consultation logs.
4. **Clean Data:** Use Find & Replace to clean empty fields.
5. **Filter & Sort:** Organise by clinician, patient, and date.
6. **Analyse:** Compare actual GP seen with the usual GP assignment



Best Practice Tips

- Clear communication within GP-nurse-admin triads
- Continuity notes shared across the team
- Standardised handovers during transitions
- Assign 1–2 continuity leads (e.g. Practice Manager + Reception Lead)
- Prioritise high-impact groups: frailty, mental health, palliative
- Date all alerts to track recent GP changes
- Educate receptionists on using “own GP” flags when booking
- Review EMIS continuity reports quarterly to identify patterns

14. Communicating with Patients

Use official RCGP patient flyer

- Reinforces benefits: trust, safety, less repetition
- Encourages patients to wait for their usual GP
- Easy to understand and designed for patients
 - ◇ RCGP (V2.1 2022) Continuity Leaflet – [‘Build Trust with Your Doctor’](#)



Use your ‘Continuity of Care’ explainer video in:

- Waiting room screens
- Online consultation welcome messages
- Website homepage or ‘Meet the Team’ page
- Practice newsletter

Tip:

Keep captions on, and summarise the key message at the end of the [video](#).

**‘Your doctor knows you best.
Ask to see them again.’**



Theme	Example Post
Trust & familiarity	"Seeing the same GP helps us know you better – and you won't need to repeat your story."
Willingness to wait	"Happy to wait a little longer for your usual GP? Let us know. We'll try our best!"
Memory & care coordination	"Your GP remembers your health journey. That makes every visit count."
Digital + continuity	"When you book online, look for your usual GP – or tell us if you'd like to."
Targeted invites	"If you live with a long-term condition, continuity of care really matters. Ask about your named GP."
Meet the team	"Continuity works best with trusted teams. Meet your micro-team at our practice"

- Use Facebook, Instagram, X (Twitter), and waiting room screen images.
- Suggested campaign: **#ContinuityCounts** – weekly focus on one theme

15. Continuity of Care Plan Template

How to Use the Template

Using this template can help align your work with PCN DES expectations and support long-term improvements in relational care.

Based on case study insights from six different GP practices featured on the RCGP eLearning site, this section outlines practical lessons and proven strategies for implementing continuity of care in real-world primary care settings. These lessons reflect patterns of success from varied practice environments.

Template Link: [Click Here](#)

GP Scheduling & Workload:

- Encourage GPs to work across 4 days/week, or pair two GPs to share a patient list
- Monitor list sizes weekly to maintain fairness and prevent overload
- Introduce daily continuity slots (morning and afternoon) for each GP

Patient Education:

- Introduce continuity from registration with named GP explanation
- Use letters, posters, and leaflets to explain the value of continuity
- Reinforce messaging at every patient contact point

Clinical System Adjustments:

- Code patients for continuity and assign in EMIS/SystemOne
- Use pop-up alerts for continuity reminders
- Ensure the 'Usual GP' field reflects actual lead GP assignment

Measurement and Monitoring:

- Track metrics like UPC (Usual Provider of Care)
- Benchmark against local practices
- Monitor external influences like staff leave or ARRS role impact

Start Small and Scale:

- Begin with a manageable group (e.g., top 30 high-need patients)
- Get systems right before scaling up
- Build internal credibility through early wins

System Integration:

- Use timed slot releases (e.g. 48 hours before)
- Route communications and prescriptions via lead GP
- Ensure documentation goes to the correct GP

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JUNE 2025

Need support?



We've helped our clients manage transitions through our Digital & Transformation Managed Service (DTMS). Whether just starting out, or refining the current approach, we can provide tailored support to help embed new processes effectively and sustainably.

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