Continuity of Care Quality Improvement Project
GMS Quality Improvement Framework 2026/27 – Year 2 Specification

Aim

The overarching aim of the 3–5-year continuity of care quality improvement project is to strengthen quality assurance processes in general practice by embedding relational continuity as a recognised marker of high-quality care.

Specific Objectives

These specific objectives set out the overarching aims of the 3–5-year continuity of care quality improvement project:

- Improve Clinical Outcomes: Demonstrate measurable improvement in patient and carer experience, uptake of preventive interventions, and reduction in preventable morbidity and mortality by enhancing relational continuity of care, with a focus on value-based healthcare approaches.
- Address Health Inequalities: Continue to prioritise relational continuity for vulnerable populations, including those with complex needs, to reduce disparities in healthcare access and outcomes.
- Enhance Practice Operations: Embed relationship-based care into practice processes by adapting appointment and triage systems, extending consultations for complex cases, and utilising IT infrastructure and the new measurement toolkit to support continuity.
- Support Strategic Alignment and Evaluation: Encourage GP practices, clusters, and health boards to measure and report continuity of care as a key enabler of Welsh Government strategies such as Prudent Healthcare, Value-Based Healthcare, and NHS Sustainability.

Year 2 Aim

For Year 2, the specific aim is to support all participating practices to complete the full six-step continuity of care QI cycle, as set out in the RCGP Continuity of Care Toolkit, moving from preparation and baseline measurement through to planning, implementation, evaluation. Practices will be expected to embed successful changes where appropriate, or where evaluation shows limited or no improvement, return to planning or adapt their approach before continuing the cycle, demonstrating progress and improvement over time.

There will be a national evaluation of this QI project, which will include various activities across the five years of the project. Year 2 requirements are designed to support a Wales-wide evaluation of continuity of care improvement and the embedding of learning, enabling both practice-level and national insights into what works (or not). Specifically for Year 2, practices will be expected to:

- Use the newly provided digital continuity measurement tool from the University of Bristol to ensure robust and consistent data collection and analysis. https://www.bristol.ac.uk/continuity-calculator
- Demonstrate completion of each stage of the improvement cycle, producing baseline and follow-up continuity data, implementing and evaluating tested changes, and based on evaluation findings, either embedding successful approaches or adapting and restarting the cycle where improvement has not yet been achieved.
- In future years, the expectation is that practices will show continuous quality improvements from year to year.

Background

Continuity of care in primary care is defined as the ongoing relationship between a patient and their GP, extending beyond specific episodes of illness. This relationship is distinct from coordination of care, though improved coordination often follows from strong continuity. Evidence demonstrates that increased GP continuity is associated with reduced appointment demand, improved patient outcomes, and greater efficiency. The project continues to focus on the patient-GP relationship within individual practices, recognising the complex interplay between finite resources and patient needs.

The evidence base for continuity of care is robust, showing benefits including: better patient satisfaction, increased trust between patients and GPs, improved adherence to medical advice and medication, greater uptake of preventive medicine, higher quality of GP

care, reduced complaints and litigation, lower rates of emergency department attendance and hospital admission, lower overall health system costs, and reduced mortality.

The Evidence Base

The evidence base underpinning the importance and value of continuity of care between a patient and their GP is substantial. A summary of the benefits and links to the evidence base can be found in the Year 1 Service Specification.

Areas for Quality Improvement Project Activity

Practices that have high rates of continuity of care have systems that seek to maintain continuity of care for their whole population. This maximises the benefits to their patients and to their own practices. However, as a practice you may feel that establishing continuity of care for your whole population is unachievable for you, so you may wish to focus on individuals who benefit most from relational continuity of care, for example:

- Individuals with significant mental health challenges
    - Approximately 1 in 4 adults in Wales experience mental health challenges annually
- Vulnerable people – people who experience multiple, severe and overlapping disadvantage, often finding it difficult to access healthcare despite experiencing extremely poor physical and mental health in comparison to the general population. This can include people experiencing homelessness, in contact with the criminal justice system, asylum seekers and refugees, Gypsies, Roma and Travellers
- Older adults with frailty
    - Wales has a higher proportion of older adults compared to other UK nations, with 21.3% of the population aged 65 or older (compared to 18.6% in England)
- Patients with complex long-term conditions or multiple morbidities
    - An estimated 33% of Welsh adults live with at least one long-term condition, and 12% have multiple chronic conditions
- Populations living in socio-economically deprived areas
    - Wales experiences significant socio-economic disparity
    - These communities face higher rates of chronic illness, lower life expectancy and significantly lower healthy life expectancy

This approach to prioritising continuity for those with the greatest needs has been described as ‘proportionate continuity’. Burden of disease projections in Wales show that

all of this is projected to grow over the next 20 years; finding effective ways to support these groups of patients is key to long term NHS sustainability. By focusing on these demographic characteristics, the QI project will ensure that practices are clear what actions are needed to ensure relational continuity reaches those with the most to gain, addressing their unique healthcare needs while promoting equity and sustainability in general practice.

Year 2 Project Requirements

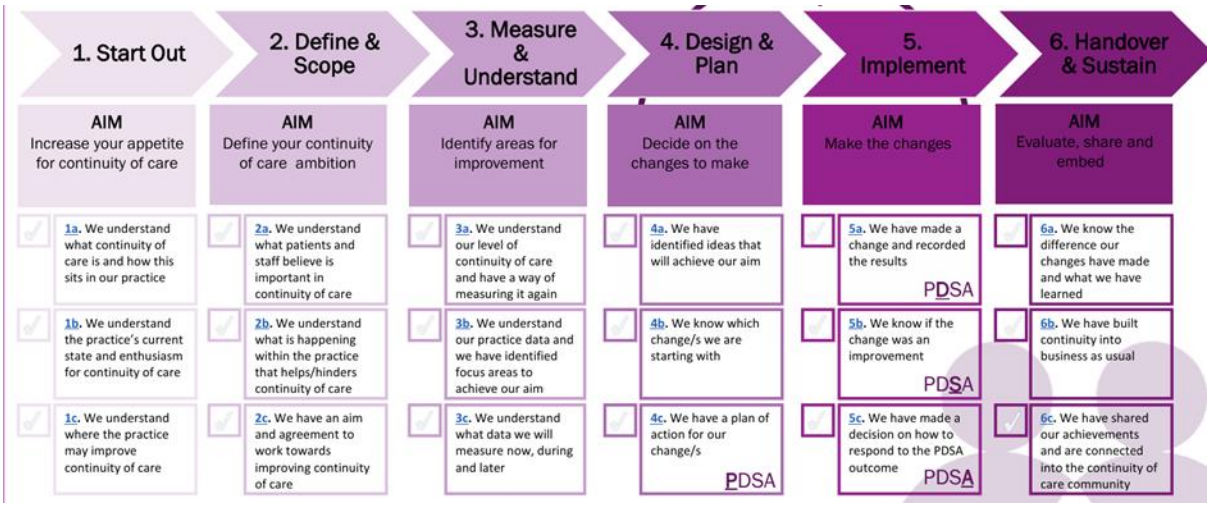
In Year 1 Practices were asked to complete steps 1 and 2 of the RCGP continuity of care toolkit. In Year 2, practices are required to complete one full cycle of continuity-of-care improvement As a minimum, this includes agreeing a plan, implementing it, and evaluating the results. In Year 3, based on the end of year evaluation, practices may embed successful changes, return to the planning stage, or adjust and continue monitoring, including where data do not show improvement.

Practice-Level Requirements

1. Complete the Full RCGP 6-Step Improvement Cycle:

- Step 1: Start Out – Revisit and reinforce understanding of continuity of care. Ensure all staff are engaged and understand the rationale and benefits.
- Step 2: Define & Scope – Gather updated feedback from staff and patients, review demographic and process data, and agree on a clear aim for continuity improvement.
- Step 3: Measure & Understand – Use the toolkit for measuring continuity of care to establish a robust baseline for future benchmarking.
- Step 4: Design & Plan – Generate and prioritise change ideas, develop a detailed action plan including timelines and responsibilities, and prepare for PDSA cycles.
- Step 5: Implement – Implement prioritised changes using PDSA cycles, collect and analyse data, and adapt as needed[1].
- Step 6: Handover & Sustain – Evaluate impact, embed successful changes into routine practice, develop a sustainability plan, and allow the sharing of learning at cluster and national levels.

[1] Progression from Step 5 to Step 6 is dependent on evaluation outcomes. As set out in the RCGP Continuity of Care Toolkit, practices may need to adapt, discontinue, or embed a change depending on its demonstrated impact. Where improvements are not evidenced, practices are expected to investigate why ,and may wish to select an alternative change idea and restart the cycle before moving to sustainability activities. This may mean returning to step 4. More details can be found in the RCGP toolkit.



2. Monitoring, Evaluation and Reporting:

- Quarterly measurement of continuity of care for the whole practice population (not just the target population) using the Bristol tool (https://www.bristol.ac.uk/continuity-calculator). Results of all four measures in the toolkit should be uploaded quarterly via PCIP.
- At least quarterly internal reviews of progress within each practice to monitor implementation of the continuity of care QI cycle.
- Quarterly collaborative/cluster discussions to review progress, share learning, and identify emerging challenges and successful approaches.
- Submission of a nationally agreed QI poster/report at year end, summarising completion of the full QI cycle, key findings, tested changes, and outcomes.
- Participation in national evaluation and learning to support dissemination of learning at national and regional levels
    - All participating practices will be required to complete an evaluation survey to support the national evaluation of the project. This survey will capture information on year 2 activity and key barriers and enablers to implementation.
    - Practices may be invited to contribute to additional evaluation activities, such as participation in case studies or the collection of patient experience. Participation will be on a voluntary basis and is outside the core requirements of this specification.

3. Use of Toolkit Resources:

Practices should utilise the RCGP Toolkit and the University of Bristol Continuity of Care measurement tool provided at the start of Year 2 for all measurement and reporting activities.

Collaborative/Cluster-Level Requirements

- Facilitate sharing of learning, challenges, and best practice.
- Support practices in benchmarking and peer review.
- Identify opportunities for collaborative/system-wide improvement.

Health Board-Level Requirements

- Verify completion using the nationally agreed poster/report template to ensure consistency across Wales. Local amendments or alternative formats should not be required.
- Collate and review outcomes for thematic analysis and national learning with outputs made accessible to the national evaluation team to support Wales-wide monitoring, thematic synthesis, and dissemination of learning.

DHCW-Level Requirements

- Maintain and update the PCIP tile for displaying required data and for practice upload of project materials for verification purposes.
- Continue to develop and support templates and digital tools to assist practices in measuring continuity of care and its impact

Appendices and Resources

Practices are encouraged to consult the RCGP Toolkit (with additional resources here) and the Continuity Counts website for the latest evidence and practical resources.

The University of Bristol Continuity of Care Calculator can be found here

Bristol Continuity of Care Calculator | Centre for Academic Primary Care | University of Bristol and a YouTube video on how to use the tool can be found here

Bristol Continuity Demo

CONTINUITY OF CARE CALCULATOR HEALTH WARNING – It is important to recognise that if you have migrated from Vision to EMIS within the past 12 months you may notice your continuity of care score is decreasing despite putting actions in place to improve. This is a data issue where appointment data does not migrate from Vision to EMIS. As that data is collected with time in EMIS the score will stabilize. We are aware of this issue, and it will be taken into account when looking at the end-of-year reports/posters.

References and Further Reading

A full list of references and further reading is provided in the Year 1 specification and remains relevant for Year 2.