## Continuity of Care in General Practice Improvent Programme

## Advisory Group

## Terms of Reference

March 2019

# Background

The theme of continuity of care was identified following the publication of a piece of research by the Data Analytics team at the Health Foundation in January 2017. The paper demonstrated that patients who experience higher continuity of care (that is, those who see the same GP a greater proportion of the time) have fewer unplanned hospital admissions related to ambulatory care sensitive conditions. The research paper concluded that there are clear benefits around improved continuity of care, and highlighted a number of improvement approaches that can be used to increase continuity at GP practice level.[[1]](#footnote-1) Our finding was consistent with research findings by others working in this area.[[2]](#footnote-2)[[3]](#footnote-3)[[4]](#footnote-4)

The focus of this programme is on how to enable greater continuity of care in practice, with the aim of surfacing learning on the effectiveness of different structural solutions, enabling technologies and cultural conditions required to successfully increase continuity of care in a primary care setting.

Through the evaluation, the programme will also aim to understand whether the changes made to improve continuity of care result in impact on emergency admissions or other outcomes for patients.

The programme will explore the relationship between increased continuity and increasing access to primary care services. It will seek to identify the possibilities, benefits and unintended consequences of increasing continuity of care in the current context, where the GP workforce is under strain,[[5]](#footnote-5) there is concerted policy pressure to increase access[[6]](#footnote-6) , and patients are becoming more complex[[7]](#footnote-7).

The primary aim of the programme is to increase continuity of care in the specific primary care sites chosen to take part in the programme, and to understand how that might impact on patient outcomes.

How continuity will be defined will be different for each site based on their local context but regardless, we will be looking to understand:

* The implementation opportunities and challenges associated with increasing continuity in order to share learning on what makes an improvement intervention successful or not;
* Whether there are any unintended consequences that result from increasing continuity of care, for example reducing access, in order to be able to contribute to the wider policy conversation around the future of general practice and GP work at scale;
* The impact of continuity on patient outcomes;
* Patient experience around continuity so that we can test the hypothesis that patients prefer continuity of care;[[8]](#footnote-8)
* Staff experience around continuity of care.

# Purpose & role of the group

## Purpose

The purpose of the advisory group is to provide strategic and academic direction, as well as constructive challenge and rigour, to all elements of the design and delivery of the programme and its evaluation, ensuring it meets its overarching aims and objectives.

The group will help to ensure a balance between academic rigour and actionable learning, and to support the programme and evaluation teams to situate the programme, its evaluation and its findings within the wider academic and policy environments relating to continuity of care in the NHS.

The group will provide stewardship to **the programme** against a number of criteria, including:

* Quality of the work of the project teams, linked to their reported progress, learning and impact and their contribution to programme events/workshops;
* How the programme’s outputs have been used and whether the programme’s purpose, aims and objectives have been realised;
* Potential impact of the programme (on policy, for example), derived from its outputs and outcomes;
* Sustainability: the extent to which findings from the programme are likely to be catalytic in deepening the knowledge base surrounding continuity of care.

The group will provide stewardship to **the evaluation** against a number of criteria, including:

* Quality of the work, including its methodological rigor;
* Suitability and relevance of the evaluation to the wider academic, practice and/or policy environment;
* How the evaluation’s outputs have been used and whether the evaluation’s purpose, aims and objectives have been realised;
* Potential impact of the evaluation (on policy, for example), derived from its outputs and outcomes;
* Sustainability: the extent to which findings from the evaluation are likely to be catalytic in deepening the knowledge base surrounding continuity of care.

# Role of members

Members of the advisory group will bring comprehensive, practical and theoretical knowledge to provide:

* Expertise in service improvement interventions across complex systems with a deep understanding of the programme’s topic;
* Advice on applying and evaluating improvement methodologies using mixed methods in a range of settings and sites which are testing a variety of interventions;
* Quality assurance of key outputs to identify and troubleshoot, in advance, and any potential risks to the programme and evaluation;
* Advice on dissemination plans and communication opportunities surrounding findings from the programme, through project team reporting and the evaluation, as they emerge.

## **Activities**

The Health Foundation therefore asks the advisory group to engage in the following activities:

* Receive and review updates from the programme and the evaluation;
* Advise the programme team on strategies to overcome methodological / analytical / management challenges, and on the interpretation of the outcomes;
* Advise the evaluation team on strategies to overcome methodological / analytical challenges and obstacles, and on the interpretation of the findings;
* Advise the Health Foundation on progress, risks and opportunities for the programme and evaluation;
* Provide overarching peer review of outputs from the evaluation, including the evaluation framework, and interim and final reports alongside the final reports from the project teams;
* Provide overarching peer review of the learning reports generated by the support partner;
* Assist in identifying opportunities for dissemination and policy impact for the evaluation and wider programme of work;
* Provide the Health Foundation and researchers with external context, intelligence and connections relevant to the outputs of the programme.

# Frequency of meetings

The advisory group will meet in person bi-annually. The first meeting will be in July 2019. All meetings will be held at the Health Foundation’s offices in central London.

The Health Foundation will endeavour to set meeting dates 4-5 months in advance and to circulate agendas and papers two weeks before each meeting. Advisory group members may be required to undertake a small amount of preparatory work ahead of the meetings and follow-up actions/work arising from the meeting. A small amount of work may also be required outside of meetings to provide technical input and advice to the evaluation.

# Quorum requirements

Advisory group meetings are subject to a quorum of 50 per cent of the membership, plus the Chair. Apologies for absence should be sent to the Secretariat no later than 3 working days prior to the meeting.

# Decision making and reporting

Decisions on matters arising during the programme and its evaluation will be made by the programme team. This means that the advisory group can advise on decisions, risks and approaches but the final decisions will sit with the programme team or evaluation working group.

**Governance Structures**

There are two distinct groups that connect to the advisory group:

**Programme Team** – This team is comprised of the Assistant Director of Improvement Programmes, the Programme Manager and the Programme Officer for Continuity of Care along with the Research Manager at the Health Foundation, who is responsible for commissioning and managing the evaluation. The programme team will provide leadership and strategic oversight to the Programme and the evaluation as well as manage the Support Partner.

**Evaluation Working Group (EWG) -** The Research Manager will report related matters from the advisory group to the EWG. The EWG will be the forum for directing, designing and co-producing the day to day activities and delivery of the process evaluation, working closely with the evaluators. The EWG will meet monthly up to 6 months into the evaluation when the EWG may switch to every other month. The EWG will sign off all tools, methods to be deployed, interim and final reports through strategic direction, and ratification (where necessary) from the advisory group. The Programme Manager will sit on both the programme team and the EWG.

Also part of the programme are two evaluation teams and our support partner:

**Improvement Analytics Unit** – a partnership between NHS England and the Health Foundation that provides robust analysis to help the NHS improve care for patients. They are leading the quantitative evaluation and their main aim is *to explore if increasing continuity of care can improve patient outcomes*.

**Mott MacDonald and the University of Manchester** – They are leading the mixed methods evaluation of the programme and their main aim is *to understand whether improvement approaches can be used to increase continuity of care.*

**Royal College of General Practitioners (RCGP)** – the RCGP will be working alongside the programme as our support partner. There primary responsibility is to support learning and dissemination within the Continuity of Care programme. They will work with the programme team and the project teams to design and deliver a series of programme-wide workshops which promote learning and lead the delivery of insight webinars which provide a platform to share insights and learning from the programme with the wider community of interest.

# Term and expenses

The expected term for an advisory group member is two years.

Where members of the advisory group are involved in a professional capacity, the role is voluntary. For patient and public voice (PPV) partners, the Health Foundation adopts the NHS England approach of financial support for PPV involvement. Involvement in the advisory group is deemed by the Health Foundation to be equivalent to an expert advisor role and PPV partners can receive an involvement payment from the Health Foundation of £150 per day (more than four hours) or £75 per half day (four hours or less). PPV partners can choose to refuse the payment or accept a reduced amount should they so wish.

The Health Foundation will reimburse travel and subsistence expenses incurred when attending advisory group meetings.

# Declarations of interest and conflicts of interest

Advisory group members should declare all interests in accordance with the Health Foundation’s policy on declarations and conflicts of interest. Interests should be documented using the declaration of interest form. Interests should also be declared at each setting giving rise to the conflict – e.g. a meeting of the advisory group.

Interests which arise during the programme should be declared to the Secretariat as soon as they arise.

All declared interests will be reviewed by the Health Foundation and the Chair of the advisory group, who will then decide whether, given the circumstances of the interest, the individual should:

* Contribute to the advisory group /take part in the meeting as normal
* Remain privy to information/remain present at the meeting, but not contribute to activities or take part in any discussion specific to the conflict of interest, except to answer any relevant questions that might reasonably be put to them
* Not be privy to information specific to the conflict of interest/leave the meeting for the duration of the meeting item.

# Governance & confidentiality

Members of the advisory group will agree to maintain confidentiality in discussions surrounding the evaluation and of wider programme of work. All discussions and outputs from the programme and its evaluation will not be shared with any third party without the permission of the Health Foundation.

1. “Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data”, Isaac Barker, Adam Steventon, Sarah R Deeny, BMJ 2017; 356; 01 February 2017 [↑](#footnote-ref-1)
2. Tammes P, Purdy S, Salisbury C, MacKichan F, Lasserson D, Morris RW. Continuity of primary care and emergency hospital admissions among older patients in England. The Annals of Family Medicine. 2017 Nov 1;15(6):515-22 [↑](#footnote-ref-2)
3. Roland M. Continuity of care: betrayed values or misplaced nostalgia. Int J Integr Care 2012;12:e200 [↑](#footnote-ref-3)
4. Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. BMJ open. 2018 Jun 1;8(6):e021161 [↑](#footnote-ref-4)
5. “Under Pressure: What the Commonwealth Fund’s 2015 international survey of general practitioners means for the UK”, Edward Davies, Sara Martin, Ben Gershlick, February 2016 [↑](#footnote-ref-5)
6. NHS England. General Practice Forward View. NHS England, 2016 [↑](#footnote-ref-6)
7. “Emergency hospital admissions in England: which may be avoidable and how?” Adam Steventon, Sarah Deeny, Rocco Friebel, Tim Gardner, Ruth Thorlby, Health Foundation briefing, May 2018 [↑](#footnote-ref-7)
8. Saultz JW. Interpersonal Continuity of Care and Patient Satisfaction: A Critical Review. Ann Fam Med 2004;445–51. doi:10.1370/afm.91.INTRODUCTION [↑](#footnote-ref-8)