

Debate & Analysis

Tackling multimorbidity in primary care:

is relational continuity the missing ingredient?

INTRODUCTION

The GP registration system in the NHS encourages a relationship between a primary care team and a local population over time. Historically, the small size of practice teams and the stability of communities created very strong personal continuity. However, as general practices have become increasingly larger and as people move around and commute more, the likelihood of a strong personal relationship between doctor and patient has been offset against factors such as appointment availability, lead clinicians being responsible for specific conditions, and patients' choices and priorities. Good and lasting therapeutic relationships flourish when organisations offer sufficient opportunities for a patient to see the same clinician when requested.^{1,2} However, there is a need for more evidence about how prioritising relational continuity improves overall care outcomes, especially in patients in whom a combination of socioeconomic disadvantage and complex comorbidities prevent effective engagement with health and social services.

DEFINING RELATIONAL CONTINUITY OF CARE

The term 'continuity of care' refers to a complex and multifaceted concept that has been difficult to define.³ Three types of continuity of care are generally accepted: 1) informational continuity, which describes the sharing of patient information between professionals and service providers; 2) management continuity, which describes a timely and complementary delivery of services from different providers; and 3) relational continuity, which describes an ongoing therapeutic relationship between a patient and one or more providers. Relational continuity is associated with improved patient satisfaction, care coordination, and selected patient outcomes.⁴ It implies a sense of affiliation and mutual commitment between patient and clinician. This affiliation improves reciprocal trust and responsibility, and reduces the 'collusion of anonymity', where a succession of clinicians deals only with the most immediately pressing problem. Relational continuity is therefore not only seeing the same clinician over time (known as longitudinal continuity) but also includes a dimension of 'trust' and 'confidence' in the clinician (known as interpersonal continuity).⁵

A recent King's Fund report has outlined

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the benefits of relational continuity of care.² This includes enhanced mutual loyalty and an increased sense of trust between patients and clinicians, which also increases patients' readiness to believe in and accept medical advice, as well as adhere to long-term preventive treatments. Relational continuity is also associated with patients' willingness to pay more for health care in order to see their chosen clinician. It increases early diagnosis rate for selected chronic conditions, especially for diabetes. Evidence also shows a reduction in healthcare costs, with fewer prescriptions, laboratory investigations, emergency department attendance, and unplanned hospital admissions.⁵ Although caution suggests that relational continuity may sometimes lead to problems, such as 'loyal' patients tolerating inappropriate and detrimental waits for their chosen clinician, it is largely seen as a good thing.⁶⁻⁸ Indeed, when care is fragmented (care discontinuity), patients will often choose to attend an emergency department instead of their usual GP.

Despite these benefits, relational continuity is actually declining in the UK. It is suggested that this is the fact of more policies prioritising access, usually to the detriment of continuity, general practices merging into larger 'super practices', making it harder to maintain continuous personal contact with the same clinician, and the increasing move of the primary care workforce towards seasonal and part-time work.⁹ Work pressures are also listed, encouraging practices to adopt models of care such as exclusive triage systems, which may improve access but affect continuity adversely. Although access and continuity are not necessarily incompatible, especially if both are seen as equally important,¹⁰ in recent years continuity has received less

policy attention and intervention success than access. This suggests that aforementioned benefits of relational continuity are currently not fully harnessed by the health system, leading to poorer care outcomes, particularly for complex patients and those with multimorbidity.¹¹ Improving continuity today therefore seems a pressing need.

THE PROBLEM: MIXED MULTIMORBIDITY AND ITS LINKS WITH DEPRIVATION

Caring for patients with two or more long-term conditions (multimorbidity) is becoming increasingly common. Managing this in a system built around single disease specialties is a major challenge facing the NHS.¹² More than 15.4 million people in England live with a long-term condition, accounting for about 70% of total national healthcare spending. Disease-related disability amplifies this economic impact, particularly for younger patients. Approximately 40% of these patients also suffer from a mental health problem, raising their individual care cost by at least 45%. Resulting disability is greatest for those suffering from both mental health and physical health issues (mixed mental and physical health multimorbidity or 'mixed multimorbidity'), especially when they are economically deprived.¹³

Current government strategies to tackle multimorbidity are difficult to implement in this group, as they are hard to engage, and there are currently no direct incentives to increase relational continuity at practice level. For example, a recent policy aimed at assigning a named GP for all patients aged 75 or older in England, in order to improve relational continuity and care outcomes, was not successful.¹⁴ Similarly, and as primary care teams expand, clinicians other than GPs (such as practice nurses or community matrons) are increasingly taking similar roles

in coordinating care, or providing long-term conditions management clinics. This input is highly valued by their patients, and may lead to proportionately reduced doctors' continuity. However, patients' routine reviews are often limited to single specialties and based on predesigned templates from which few nurses would stray. Although nurse clinics usually afford good longitudinal continuity, they may not enhance interpersonal continuity, which is an essential component of relational continuity. Therefore, a holistic rapport with a clinician remains needed, as well as alternative methods to achieve better relational continuity in primary care, considering all current barriers.

THE POSSIBLE SOLUTION: MIXED MULTIMORBIDITY AND RELATIONAL CONTINUITY OF CARE

Relational continuity may benefit patients with mixed multimorbidity for many reasons. This may include efficiency (not having to repeat complex histories), effectiveness (greater space for involvement in decision making), and enhanced trusting relationships. It also improves integration and coordination of care, therefore improving management continuity. This means better relational continuity will produce better overall care continuity, leading to better patient outcomes.

For example, Barker *et al* estimated that, if patients had two out of every 10 consultations with their usual GP, this would decrease unplanned admissions by about 6%.¹⁵ Similarly, Tammes *et al* found that patients with poor longitudinal continuity were twice as likely to have an emergency hospital admission compared with those with high continuity.¹⁶ With acute hospital services in England under sustained pressure, interventions to enhance relational continuity could be a crucial asset. However, most recently proposed interventions do not always prioritise relational continuity in its full meaning. Although these interventions persistently highlight the need for better relational continuity, methods used to improve it tend to target only its longitudinal aspects. How to measure and improve relational continuity in both its longitudinal and its interpersonal aspects seems to remain unclear.

CONCLUSION

This analysis points to an opportunity for future research and policymaking to target relational continuity more specifically when attempting to meet the routine care needs of complex patients, especially those with mixed multimorbidity. Interventions may build on the evidence suggesting that a

ADDRESS FOR CORRESPONDENCE

Serge A Engamba

University of East Anglia, Primary Care Research Unit, Norwich Research Park, Orisole Drive, Norwich NR4 7TJ, UK.

Email: s.engamba@uea.ac.uk

strong relationship between patients and clinicians allows both parties to address specific patients' needs more effectively, including complex care coordination. They may also allow GPs to work more effectively with relevant associated health and social care professionals to deliver a multidisciplinary care package that meets the specific needs of the patient. Working in small teams aiming at ensuring relational continuity with more than one clinician at a time may address the issues posed by a part-time workforce and the surge of 'super practices', as well as adapt care to patient preferences. Other interventions may include specifically identifying patients at risk of discontinuity and providing them with a holistic and proactive care plan that the whole practice team can access. This may require a whole GP practice approach and may include additional training for administrative staff and receptionists. Various incentives may also be considered to encourage practices to deliver more continuity. This may be financial (similar to QOF), or simply a requirement to make GP practices or even individual clinician's continuity scores publicly available and accessible to patients, such as on the practice website. Achieving better relational continuity is understandably challenging in the current primary care context, suggesting a complex and comprehensive intervention development process may be needed, including collecting and summarising the views of patients and primary care staff. Similarly, there is also scope for developing further understanding and measurement of the concept of relational continuity itself, both in its longitudinal and interpersonal aspects, in order to define more clearly what it is and why or how it matters.

Serge A Engamba,

GP and Honorary Research Associate, UEA, Norwich.

Nicholas Steel,

Professor of Public Health Medicine, UEA, Norwich.

Amanda Howe,

GP and Professor of Primary Care, UEA, Norwich.

Max Bachman,

Professor of Health Services Research, UEA, Norwich.

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