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RESEARCH ARTICLE OPEN ACCESS

Explaining Continuity in Contemporary Primary Care: The *CAP Continuity* Theory

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ABSTRACT

Objectives: Continuity is associated with improved outcomes for patients, clinicians and health systems, yet remains difficult to achieve in contemporary primary care. This study introduces *CAP Continuity*, an empirically grounded, realist-informed, explanatory theory that accounts for how continuity is generated or disrupted in context. *CAP Continuity* conceptualises continuity as emerging from the interaction of three domains—competence, attitude and provision.

Methods: A realist evaluation examined continuity for people with mesothelioma in UK general practice. Nine longitudinal patient case studies were developed using longitudinal realist interviews with patients, their healthcare professionals ($n = 12$) and close persons ($n = 9$). Analysis involved reflexive thematic coding, development of Context–Mechanism–Outcome configurations and theory refinement informed by Burden of Treatment Theory and the Candidacy Framework.

Results: *CAP Continuity* proposes that continuity depends on (1) competence—the capabilities of patients, close persons, and professionals to understand, navigate, coordinate, and engage with care; (2) attitude—the relational, moral, and motivational orientations that shape whether people prioritise continuity and (3) provision—the organisational and system-level arrangements that enable or constrain continuity. Continuity is most likely when these domains align; misalignment explains why continuity breaks down even when individual relationships appear strong.

Conclusions: *CAP Continuity* offers an explanatory structure that integrates existing definitions with attention to context, mechanisms and system conditions. Developed in the context of mesothelioma and UK general practice, the theory is transferable—subject to contextual fit—to other community-based settings where multidisciplinary care, workload and system pressures shape the possibilities for continuity.

1 | Background

Continuity of care is consistently associated with improved outcomes across high-income health systems, including reduced mortality [1, 2], better adherence to treatment [3], more appropriate prescribing [4], lower staff burnout [5, 6], reduced healthcare costs [7] and fewer hospital admissions and emergency attendances [8]. Despite this extensive evidence base,

continuity has become increasingly difficult to achieve. Once embedded within small-scale general practice, it is no longer structurally or culturally ingrained within the NHS or many comparable international systems [9]. As a result, efforts to defend the value of continuity risk overshadowing a more pressing challenge: understanding *how* continuity can be delivered flexibly and responsively in contemporary primary care, in line with individual patient preferences [10].

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Continuity is not a discrete intervention but a relational and organisational phenomenon that unfolds over time and across contexts. This paper adopts the definition of continuity as “the extent to which a person experiences an ongoing relationship with a clinician and the coordinated clinical care that progresses smoothly as the patient moves between different parts of the health service” [11]. Although continuity matters across all healthcare settings, its foundations lie in primary care, where clinicians are expected to integrate information, coordinate care and maintain responsibility across multiple encounters and services. Understanding continuity, therefore, requires attention to the conditions under which it is generated, sustained or lost.

1.1 | Conceptual Ambiguity in Existing Literature

Attempts to theorise continuity remain limited. Pereira Gray et al. published a theory in 2003 that emphasised the benefits of a personal doctor whose accumulated knowledge of a patient's history, values and concerns enables more efficient and satisfying care [12]. While foundational, this work focused primarily on relational continuity and ‘repeated contact’ with the same clinician; an assumption increasingly difficult to uphold in modern primary care [13].

More recent research distinguishes *relational continuity* (seeing the same clinician over time) from *relationship-based care* (the quality of interpersonal connection within any given encounter). The Royal College of General Practitioners (RCGP) notes that rapport, trust and empathy can be established within a single consultation and that repeated encounters do not automatically produce a meaningful relationship [14]. Empirical studies similarly show that patients may receive highly personal care from unfamiliar clinicians when communication is skilled and care is individualised and that clinicians' sense of ownership and responsibility can foster continuity even without long-term relationships [15, 16].

Continuity has long been viewed as rooted in the ongoing relationship between a patient and their clinician. Pereira Gray et al. described continuity as developing through repeated encounters with the same doctor, enabling familiarity, trust and mutual responsibility to build over time [12]. Sidaway-Lee et al. later outlined the key dimensions of continuity and the pathways through which continuity may influence outcomes, providing an important conceptual foundation. Their work focused on describing continuity and its consequences, rather than examining how continuity is achieved or how it varies across settings [17]. More recently, Ladds and Greenhalgh have offered a perspective tailored to multidisciplinary primary care, showing how different forms of continuity can be produced collectively by teams through shared information systems, communication practices and organisational arrangements. They further highlight how the work of sustaining continuity is distributed across patients, clinicians and organisations and the coordinated effort required to maintain coherence in care [18]. While this offers valuable insight into the activities that support continuity, it leaves open questions about the conditions that enable this work and the circumstances in which it becomes more challenging within complex systems.

Taken together, this evidence shows that continuity cannot be reduced to frequency of contact. It depends on how clinicians approach the relationship, how patients experience the

interaction and how responsibility is enacted across encounters. The literature also exposes persistent conceptual imprecision of continuity: definitions vary, boundaries blur and constructs are inconsistently applied across studies and settings. This limits the ability to translate continuity into practice and policy and constrains efforts to design interventions that work across diverse organisational contexts [13].

1.2 | Why a New Explanatory Theory is Needed

Existing models describe what continuity is but offer limited insight into how continuity is produced or disrupted within contemporary primary care [13, 19], particularly in multidisciplinary, high-pressure systems where responsibility is distributed across teams [18, 20]. No existing theory integrates individual, relational, organisational and system-level influences nor explains the mechanisms through which continuity emerges or breaks down in context [21, 22]. A theory that conceptualises continuity as the product of interacting capacities, orientations and system conditions is, therefore, needed; one that is empirically grounded, sensitive to context and capable of informing the design and evaluation of continuity-enhancing interventions [23, 24].

1.3 | Introducing CAP Continuity

This paper introduces the *CAP Continuity* theory, developed through a realist evaluation of continuity in general practice for people with mesothelioma [25]. *CAP Continuity* offers an explanatory structure that integrates existing definitions and typologies with attention to context, mechanisms and system conditions. It conceptualises continuity as emerging from the interaction of three linked domains—competence, attitude and provision—within and across clinical relationships and healthcare organisations. By articulating how these domains align or misalign, *CAP Continuity* explains why continuity succeeds or fails in contemporary primary care and provides a conceptual basis for designing and evaluating continuity-enhancing practices and policies.

2 | Methods

2.1 | Study Design

A realist evaluation was undertaken to examine how continuity of care is generated, sustained or disrupted for people with mesothelioma in UK general practice [25]. Realist methodology is well suited to complex primary care phenomena because it seeks to explain *what works, for whom, in which circumstances and through what mechanisms* [23]. Continuity was explored as an emergent property of interactions between individuals, relationships, organisational structures and wider system conditions.

2.2 | Sampling and Recruitment

Nine patient case studies were developed using longitudinal realist interviews. Each case study included the patient and, where possible, a nominated close person and a healthcare professional involved in their care. To broaden perspectives and achieve data saturation, additional interviews were conducted with healthcare professionals ($n = 12$) and close persons ($n = 9$).

Five general practitioners (GPs) initially approached did not respond; recruitment was, therefore, widened through professional networks, resulting in six further GP participants. Although these GPs were not directly linked to the case-study patients, their insights into general practice processes and mesothelioma care were analytically valuable. In total, 54 interviews were conducted with 30 participants. All but eight participants took part in at least two interviews, generating 30.8 h (1848 min) of data. Ethical approval was granted by the University of Sheffield (REF 039695), and the study adhered to RAMESES II quality standards for realist evaluations [26].

2.3 | Data Collection

Interviews were conducted between January and April 2023. Realist interviewing techniques were used to elicit participants' reasoning, experiences and interpretations of continuity. Interviews explored experiences of accessing and navigating general practice, interactions with clinicians and multidisciplinary teams, perceptions of responsibility and ownership and contextual factors shaping continuity. All interviews were audio-recorded, transcribed verbatim and anonymised. Transcripts were checked against recordings for accuracy and imported into NVivo for data management [27].

2.4 | Analysis

Analysis proceeded through three interconnected components: reflexive thematic analysis, development of Context–Mechanism–Outcome configurations (CMOCs) and theory-informed refinement using Burden of Treatment Theory and the Candidacy Framework [28, 29].

2.4.1 | Transcription, Data Handling and Coding

Transcripts were read repeatedly by EC to support familiarisation. Coding was conducted inductively and reflexively, with codes capturing actions, reasoning, contextual influences, and relational dynamics. Coding was undertaken by EC, with regular discussions involving CG, SM, and SEM to enhance reflexivity and ensure conceptual coherence. Codes were iteratively refined as new interviews were added, and emerging interpretations were documented.

2.4.2 | Development of Themes and CMOCs

Codes were grouped into preliminary themes that described recurring patterns in participants' experiences of continuity. These themes were then examined through a realist lens to identify underlying mechanisms (e.g., trust, responsibility, relational orientation and navigation work), contextual conditions (e.g., multidisciplinary team (MDT) complexity, access systems and GP workload) and resulting outcomes (e.g., sustained continuity, fragmentation and disengagement). CMOCs were developed by linking these elements into explanatory propositions. For example, "When patients encounter complex MDT structures (context), they rely on personal agency and health literacy to navigate care (mechanism), resulting in variable continuity depending on individual capacity (outcome)." CMOCs were iteratively refined through team discussion and tested against the full dataset.

2.4.3 | Integration of Existing Theory

Two existing theories were used to deepen and structure analysis:

- The *Burden of Treatment Theory* illuminated how patients' capacity, workload and relational networks shaped their ability to achieve continuity [28].
- The *Candidacy Framework* helped explain how patients and clinicians judged eligibility, legitimacy and responsibility within the care pathway, particularly in relation to GP roles and MDT boundaries [29].

These theories were applied deductively to refine CMOCs, ensuring that mechanisms were theoretically grounded and that contextual influences were fully articulated. A mapping exercise aligned CMOCs with constructs from both theories, supporting the synthesis of findings into the *CAP Continuity* framework.

2.4.4 | Synthesis Into the CAP Continuity Conceptual Framework

CMOCs were organised into three overarching domains—competence, attitude and provision—which consistently accounted for variation in continuity across cases. From this, a conceptual framework of the *CAP Continuity* theory was developed. It offers an explanatory structure showing how continuity arises from the alignment (or breaks down through the misalignment) of individual capabilities, relational orientations and system-level conditions. Rather than functioning as a traditional logic model with a linear sequence from inputs to outcomes, the framework groups the key dimensions and challenges that shape continuity. It foregrounds how systemic, personal and cultural aspects interact within healthcare delivery, emphasising dynamic interdependencies rather than a stepwise process (Figure 1: *CAP Continuity Conceptual Framework*).

3 | Results

The analysis demonstrated that continuity of care for people with mesothelioma in general practice is shaped by the interaction of three interdependent domains: competence, attitude and provision. These domains capture the mechanisms through which continuity is generated or disrupted across individual, relational, organisational and system levels. *CAP Continuity* proposes that continuity is most likely when these domains are aligned; when competent actors who value continuity work within systems that resource and prioritise it. Misalignment between domains helps explain why continuity breaks down, even when individual relationships appear strong.

3.1 | Overview of the CAP Continuity Domains

3.1.1 | Competence

Competence refers to the capabilities of patients, close persons and healthcare professionals to understand, navigate and coordinate care within a complex system [13]. Participants described competence not only as clinical expertise but as the ability to communicate effectively, coordinate care and navigate a fragmented system. Healthcare professionals highlighted the complexity of the system and the challenges it posed for their

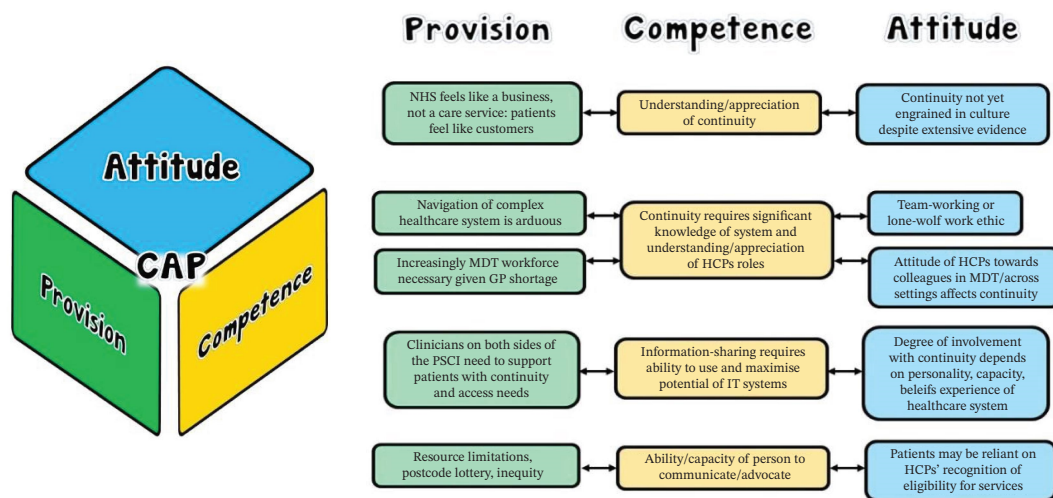


FIGURE 1 | CAP continuity conceptual framework.

own competence. They discussed how this navigation work is shaped by health literacy, confidence and prior experiences of the healthcare system. Several GPs and Mesothelioma UK Clinical Nurse Specialists (MCNSs) described feeling overwhelmed when navigating care for themselves or family members, acknowledging that patients with fewer resources or less confidence were at risk of falling through gaps.

GP: “If you don’t have someone who knows how the system works, and has the power and the privilege and looks like they’re the kind of person who can get things done, but in a nice polite middle-class way... You know? There are so many intersections around how inequalities interact with all of this.”

Patients and close persons frequently discussed the work required to access care, interpret information and manage multiple appointments.

Patient 2, female, pleural mesothelioma: ‘It probably doesn’t apply to me because I will fight regardless, but I think a lot of people would have given up, been put off. You know? You come across a barrier it’s very easy just to think, “oh I’ll leave it, or I’ll wait until a couple of days”.’

Mechanisms influencing competence included the following:

- The effort required to overcome gatekeeping and access appointments
- The ability to interpret and act on clinical information
- Familiarity with MDT roles and referral pathways
- Accumulated knowledge of the patient and their history

The increasingly multidisciplinary nature of general practice amplified the importance of competence. Participants described uncertainty about the roles of different MDT members, which sometimes hindered coordination and diluted responsibility. For GPs to act as coordinators or sign-posters, they needed awareness of available services and clarity about their own role within the wider team; conditions that were not always present.

3.1.2 | Attitude

Attitude captures the relational, moral and motivational orientations that shape whether individuals and teams prioritise continuity and take responsibility for sustaining it [21]. This domain emerged as a central, often hidden mechanism shaping continuity. Patients described how personal dispositions, such as being ‘not a pushy type of person,’ affected their willingness to seek help, challenge decisions or request continuity. These dispositions influenced whether patients persisted in navigating barriers or accepted fragmented care.

Patient 6, male, pleural mesothelioma: ‘You know, it’s my personality... I don’t really try and bother people if I can deal with it myself. Maybe that is a wrong attitude on my part.’

Clinicians’ attitudes were equally influential. Participants described how continuity often depended on whether a clinician ‘went above and beyond,’ took ownership or viewed continuity as integral rather than optional.

MCNS: “I feel that certainly the GPs I interact with... They’re very receptive, and the gratitude is amazing... It seems there is a thirst to learn but the capacity to take everything on is just, you know, they just can’t do it. I think the will’s there but it’s just maybe a capacity issue.”

Attitudinal mechanisms included the following:

- Clinicians’ sense of responsibility and ownership
- Willingness to invest relationally in patients
- Moral orientation toward personalised care
- Motivation to coordinate across organisational boundaries

These attitudes were not formally recognised or supported within the system, yet they played a decisive role in whether continuity was achieved. Several clinicians noted that continuity was often delivered through discretionary effort rather than structural support, making it vulnerable to workload pressures and burnout.

3.1.3 | Provision

Provision encompasses the organisational and system-level arrangements—such as access systems, staffing models and MDT structures—that enable or constrain continuity [20]. Participants described significant geographical variation in service availability, referral pathways and treatment options.

MCNS: ‘Every meso patient should have a local lung cancer nurse, they don’t all necessarily have a Meso UK nurse.’

Many felt ‘at the mercy of the postcode lottery,’ while clinicians described being constrained by government incentives, access targets and protocol-driven systems.

GP: “Our routine capacity is so under pressure that we’re seeing most things like, I don’t even bother challenging it, but lots of people make same day appointments, and I don’t blame them because the wait for a routine appointment might be a month... I think demand feels like it’s greater than it ever was, and all the numbers say that we’re all providing more appointments than we ever were.”

Mechanisms within provision included the following:

- Appointment systems that prioritised access over continuity
- Part-time working patterns and high staff turnover
- Increasing subspecialisation within general practice
- Variable MDT structures and unclear role boundaries
- Inconsistent informational continuity across the primary–secondary care interface

The shift towards multidisciplinary general practice was particularly influential. While MDTs offered expertise and capacity, they also introduced complexity, uncertainty and fragmentation. Some GPs described stepping back because they assumed specialist teams were already heavily involved; others felt unsure about their role in mesothelioma care. Patients, meanwhile, were often unclear about who was responsible for what, leading to confusion and disengagement.

3.2 | Alignment and Misalignment Across Domains

Continuity was strongest when competence, attitude and provision aligned. For example, when a GP had sufficient knowledge of mesothelioma (competence), valued relational continuity (attitude) and worked within a practice that supported ongoing patient–clinician contact (provision); continuity was sustained even in the context of complex MDT involvement.

Conversely, misalignment across domains explained breakdowns in continuity. A clinically competent (competence) and motivated (attitude) clinician working within an overstretched, inflexible system that limited follow-up and relational contact (provision) struggled to maintain continuity. A patient with strong agency and self-management skills (competence) but limited access to a stable clinician or clear point of contact (provision) encountered fragmented care, despite valuing ongoing relationships and attempting to secure them (attitude).

MDT complexity often created misalignment by obscuring responsibility (competence), diluting relational connections (attitude) and dispersing care across multiple services (provision).

3.3 | Worked Example: MDT Complexity

MDT complexity was a recurrent source of misalignment across cases. As teams expanded and responsibilities became distributed, patients and clinicians described uncertainty about who held ownership for coordination (competence). This ambiguity weakened relational commitment and reduced clinicians’ motivation to maintain continuity (attitude), particularly when workloads were high. At the same time, organisational structures dispersed care across multiple professionals and settings (provision), making it harder for patients to experience a coherent pathway. Patients with high agency could navigate this complexity more effectively, while others experienced disjointed care. The example illustrates how MDT structures generate characteristic patterns of misalignment across the three domains, producing variable continuity.

4 | Discussion

Continuity of care for people with mesothelioma in UK general practice was shaped by how different influences—individual capabilities, relational orientations and organisational conditions—worked together within real clinical and system constraints. The findings show that continuity is generated through the interaction of these factors rather than through structural arrangements or repeated contact alone. While existing continuity research has emphasised capability and system design [20, 21], this study highlights the central role of relational and motivational orientations, which have been comparatively undertheorised.

4.1 | The Role of Competence, Attitude and Provision

The analysis demonstrate that competence, attitude, and provision are distinct yet interdependent domains that together shape continuity. The novel contribution of *CAP Continuity* lies in recognising attitude as a core mechanism. While competence and provision are widely acknowledged in continuity research, the attitudinal domain—comprising motivation, ownership, relational orientation and moral commitment—has been undertheorised [30]. This study shows that continuity often depends on discretionary effort, relational investment and clinicians’ willingness to ‘go above and beyond.’ These mechanisms are rarely visible in policy or measurement frameworks, yet they are central to whether continuity is achieved [25, 30].

4.2 | Advancing Existing Continuity Models

Existing definitions and typologies describe the forms of continuity—relational, informational and management continuity—but do not explain how continuity is actually produced or lost in practice [13]. Although continuity is widely recognised as beneficial, the evidence base offers limited insight into the mechanisms through which it is generated or disrupted in contemporary, multidisciplinary primary care [18, 19, 21].

Recent theoretical work has begun to address this gap [17, 18], and *CAP Continuity* extends this trajectory by explaining

continuity as an emergent product of competence, attitude and provision. This framework clarifies why experiences vary between individuals, relationships and practices—for example, why continuity can be strong even without long-term relationships and why it can falter even when clinicians are committed to providing it. By identifying the mechanisms that align or misalign these domains, *CAP Continuity* offers a more granular explanation of how continuity is generated or disrupted in context.

4.3 | Understanding Continuity in Multidisciplinary Primary Care

The increasingly multidisciplinary nature of general practice was a dominant contextual influence across the dataset. MDT structures not only offered expertise and capacity but also introduced complexity, uncertainty and fragmentation. Patients were often unclear about who was responsible for what, and clinicians described ambiguity about their role in mesothelioma care. These dynamics shaped competence (e.g., knowledge of MDT roles), attitude (e.g., sense of ownership) and provision (e.g., access systems and staffing models), illustrating how MDT complexity can either support or undermine continuity.

CAP Continuity, therefore, provides a way to understand continuity within modern primary care systems where responsibility is distributed, workloads are high and relational connections are fragile. It explains why continuity can neither be assumed simply because MDTs exist nor guaranteed by structural arrangements alone.

4.4 | Divergent Perspectives and Their implications

Comparing perspectives across participant groups revealed important divergences. Patients and close persons emphasised the emotional and practical work required to navigate care, while clinicians highlighted workload pressures, system constraints and uncertainty about their role. These differences shaped expectations of continuity and influenced how competence, attitude and provision interacted. *CAP Continuity* accommodates these divergent perspectives by explaining how continuity emerges through the interplay of individual agency, relational orientations and organisational conditions.

4.5 | Transferability and Contextual Boundaries

This study was conducted within the specific context of mesothelioma and UK general practice. Mesothelioma presents unique challenges, including rapid disease progression, high symptom burden and extensive involvement of specialist teams [31–33]. However, the mechanisms identified—navigation work, relational orientation, ownership, MDT complexity and system constraints—are not unique to mesothelioma ([13, 21]; [18]; [20]). The *CAP Continuity* framework is, therefore, transferable, subject to contextual fit, to other conditions and settings characterised by multidisciplinary care, high workload and fragmented systems. Its value lies in offering a mechanism-based explanation that can be adapted to different organisational environments.

4.6 | Implications for Practice and Policy

CAP Continuity highlights that continuity is generated through the interaction of individual capabilities, relational orientations

and organisational conditions. Improving continuity, therefore, requires coordinated action across these areas rather than reliance on structural fixes alone.

- **Strengthening capability:** Patients, close persons and clinicians need the knowledge and resources to navigate complex care pathways. This includes supporting patients' navigation work, ensuring clinicians understand MDT roles and improving the flow of information across services.
- **Supporting relational work:** Continuity depends on clinicians' willingness and ability to take ownership, invest in relationships, and sustain responsibility across encounters. Recognising this relational and moral labour—and embedding it within professional identity, supervision and organisational culture—is essential.
- **Designing enabling systems:** Access models, staffing arrangements and MDT structures must make it possible for relationships to form and for responsibility to be held. Systems that fragment contact or obscure accountability undermine continuity, regardless of individual effort.

Policy initiatives that rely solely on structural levers (such as appointment systems or named GP schemes) are unlikely to succeed unless they also attend to the relational and motivational mechanisms that underpin continuity. Aligning capability, relational orientation and system design is, therefore, central to any effective continuity-enhancing strategy [13, 18, 20, 21].

4.7 | Strengths and Limitations

This study has several strengths. It provides an in-depth, theory-informed examination of continuity of care within the under-researched context of mesothelioma in general practice. The longitudinal, realist interview design enabled exploration of how continuity is generated or disrupted over time, capturing the evolving experiences of patients, close persons and healthcare professionals. Triangulation across participant groups strengthened the explanatory power of the findings and supported the development of a mechanism-based theory. The analytic process combined inductive coding, CMOC development and theory-driven refinement using Burden of Treatment Theory and the Candidacy Framework ([28]; [29]), enhancing conceptual rigour and grounding the *CAP Continuity* framework in both empirical data and established theoretical constructs.

The study also has limitations. The number of participating GPs was small, and recruitment relied partly on professional networks, which may have introduced selection bias and limited the diversity of GP perspectives. The focus on mesothelioma, while analytically valuable, means that some contextual features—such as rapid disease progression and extensive specialist involvement—may not be directly transferable to all conditions [31–33]. As with all qualitative and realist research, findings reflect the specific contexts in which data were generated; the *CAP Continuity* theory should, therefore, be applied with attention to contextual fit rather than assumed generalisability. Finally, although longitudinal interviews provided rich insights, the study did not include observational data, which may have further illuminated how continuity is enacted within clinical encounters and organisational routines.

5 | Conclusion

Continuity of care is increasingly difficult to sustain in modern primary care, where workload pressures, access models and system fragmentation challenge clinicians' ability to provide coherent, ongoing relationships [20]. This study shows that continuity is not simply a function of repeated contact or organisational design [13, 18, 21] but an emergent property shaped by the interaction of competence, attitude and provision. *CAP Continuity* explains how alignment across these domains supports coherent care and how misalignment leads to fragmentation even when clinicians and patients value continuity.

Developed through a realist evaluation of mesothelioma care in UK general practice [25], this conceptual framework integrates existing definitions with attention to context, mechanism and system conditions. Although grounded in a specific condition, the underlying mechanisms—navigation work, relational orientation, ownership, MDT complexity and system constraints—are common across primary care, making the theory transferable with appropriate contextualisation [13, 18, 20]

CAP Continuity provides a conceptual foundation for continuity-enhancing practices and policies. Strengthening continuity requires supporting capability, recognising relational and motivational work and designing systems that enable responsibility to be held [21, 24]. Structural initiatives alone are insufficient without attention to these mechanisms [18, 19]. *CAP Continuity* offers a way to recentre continuity within modern primary care and to strengthen its delivery in systems where it is most at risk.

Author Contributions

All authors were involved in the conception and design of the study. Couchman, E. collected the data. Couchman, E., Gardiner, C., Mitchell, S. and Ejegi-Memeh, S. were involved in developing the analysis plan. Couchman, E. undertook the data analysis and interpreted the findings. Couchman, E. produced the first draft. All authors were involved in subsequent revisions.

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Disclosure

All authors have approved the final submitted version.

Ethics Statement

This study received University of Sheffield ethical approval on the 24th June 2021. Two ethical amendments were submitted, both on 14th February 2023 (approved on 21st February 2023) and 28th March 2023 (approved on 3rd March 2023).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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