Frequent Attenders – The Power of 3

# Continuity of Care

The evidence shows that continuity is particularly important for frequent attenders because:

* They do not need to repeat their story at each consultation.
* The GP builds a picture of the patient with each consultation.
* A trusting relationship develops between GP and patient.
* It helps avoid late or missed diagnosis.

# The Power of 3

Working with Bristol practices on improving continuity of care for frequent attenders, a pattern began to emerge – some of the good stuff you can do to improve continuity of care falls into groups of 3s: 3 Consultations; 3 Types; 3 Measures; 3 Monthly.

Here we share those ‘power of 3’ ideas.

# Stethoscope outline3 CONSULTATIONS

When a person presents 3 times with similar or possibly linked problems over a period of 3 months, a GP should have heightened awareness and persist in checking all possibilities. It is common in general practice to see a patient where things are uncertain and unclear, but it is how a GP responds that is key in supporting the patient to self-manage or in making a diagnosis.Continuity of care supports all these consultation outcomes.

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| **CONSULTATION** | **SUGGESTED ACTIVITIES** |
| **1** | Duration, Severity & Symptoms | Very short, or long duration of symptoms, reduces the probability of serious illness. Minor symptoms are often, but not always, less serious. | If somebody consults repeatedly for the same problem (and 3 times could count as repeatedly) then explain to them why continuity could help them and explain how to achieve it |
| **2** | Patterns and Precedent | Knowledge of previous patterns of presentation and successful treatment set a precedent to a quicker cure. Patterns are also identified through good record-keeping.  | Think about whether the presenting problem is new - so working in a mind-set of diagnosis and creating a management plan - or whether it’s a recurrence - either of a condition which is intermittent (e.g., inflammatory bowel disease) or which flares up in response to social/personal stresses. |
| **3** | Act and Review | Ongoing symptoms may be serious so arrange review and check for warning signs. Remember anxiety and depression can cause symptoms. | If you reach the point where you think investigations are needed (which may be before the 3rd consultation) - use informational continuity (i.e. scan through the notes) to see if the test you're considering has been done. If it has, think about whether you are in the realm of medically unexplained symptoms which is more common in more frequently attending patients and what the investigation will add. |

# Sling outline 3 TYPES

Providing continuity to patients is important but we must recognise the care of these patients can impact on clinicians particularly when a frequent attender falls into one of the 3 types below:

1. **Heart sink patients** (not always frequent attenders) cause GP anxiety and stress. They are the GP’s problem, not the patients. It is estimated they account for 11% of average GP workload so its important GPs learn how to provide structure to stop a patient rambling. The GP should look to negotiate with a patient which problem needs attention today and set rules e.g. I will see you again in 4 weeks to curb frequent visits. O’Dowd’s paper on heart sink patients is a useful insight ( [BMJ](https://bjgp.org/content/61/586/346) ).
2. **Complex or Difficult patients**

Continuity of care for this group of patients is important as research shows it will reduce the burden on the GP practice and on A&E/Urgent care.

1. **Dependent patients**

Continuity of care can exacerbate patient dependency on a GP. Dependency may be part of a patient’s way of relating to others as they may be emotional/lonely or have a mental health problem. In Bristol, some practices have linked patients into social prescribing to guide the patient towards alternative, more suitable support.

Support your GP colleagues: this can happen informally with lunch time chats with colleagues, or through a buddy system or mentoring programme within (or beyond) the practice, or perhaps look at a Balint Group.

Consider putting in place management plans for these patients. Start with a longer-than-usual consultation to give you time to listen to the patient, and then with the patient set goals and parameters, including ways to help them cope.

# Alterations & Tailoring outline 3 MEASURES

Practices using the One Care Continuity of Care Tool look at 3 measures:

1. the **number of frequent attenders** at the practice during the past 12 months and their **consumption of appointments.** You can compare your results to those practices that participated in the One Care project.
2. frequent attenders with very high appointments and very **low continuity** and who are **circulating through the GP team.**
3. the **distribution o**f frequent attenders across the GP workforce checking if some GPs are bearing the lion’s share of frequent attenders.

# Daily calendar outline3 MONTHLY

Identify patients who have had a consultation 6 or more times in the past 3 months.

Review each patient, separating out who are the patients with a genuine need to attend frequently due to ongoing condition/treatment and who are frequent attenders who need support to lessen their frequency of attendance.

The aim is to improve patient experience and outcomes by lowering time to diagnosis and avoiding these patients becoming persistent frequent attenders.

Notes:

Bristol practices used the Usual GP Tool to support the work to improve continuity for frequent attenders. The accompanying guide includes the benchmarking data.

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