From the Interim Permanent Secretary and HSC Chief Executive

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Our Ref: SCORR-0056-2025

Date: 23 October 2025

Dear Daniel,

NIAO report 'Access to General Practice in Northern Ireland'

Following the Public Accounts Committee evidence session on the NIAO report 'Access to General Practice in Northern Ireland' held on Thursday 6th March 2025, and in the subsequent letter to you from my predecessor dated 1st April 2025, the Committee was advised that the GP Access Working Group was overseeing the development of a suite of guidance to cover good practice in demand management.

I write to confirm that the best practice guide, 'Making All Contacts Count', has now been finalised and was disseminated to all GP Practices on 10 October 2025. I enclose a copy of the guide for the Committee's information.

Yours sincerely

MIKE FARRAR

Enc

Making all Contacts Count

An improvement guide for General Practice

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Executive summary

This guide, Making all Contacts Count, has been developed to empower GPs and primary care teams with evidence-based strategies to make the most of every patient encounter, focusing on holistic, patient-centred care. Each contact presents a powerful opportunity to support health, prevent illness, and connect patients to additional resources.

Understanding the needs of a practice population and implementing more efficient working methods will improve patient experience and create happier teams. Proactively managing demand can reduce the feeling of being overwhelmed.

A systematic approach means Practice teams can dedicate more time to patients with complex needs, work with a safe number of patient contacts, focus on team development, and have control over their working day.

A whole-system approach to general practice access brings together the multiple components needed to deliver good access and includes:

- **Making all contacts count**
- **A whole-system approach**
- **A whole-team approach**
- **Embracing quality improvement (QI) approaches**
- **Integrating whole-system, whole-team, and QI approaches**

How to use this guide

Purpose and Scope

This guide is designed as a reference tool to support quality improvement (QI) initiatives in general practice aimed at making all contacts count. It is not intended to be read in its entirety but rather to be used as a resource to support specific QI efforts as needed. The guide does not constitute a benchmarking tool but serves as a practical framework for identifying and implementing improvements within practice settings.

Structure of the guide

Each section of the guide contains:

- **Background information:** context and rationale for the QI topic.
- **Potential QI initiatives:** key areas where improvement efforts may be focused.
- **Potential change ideas:** specific interventions and strategies that could drive improvement.
- **Using a QI approach:** guidance on applying QI methodologies to the identified issues.

Dedicated QI support sections

- **How-to QI section:** a focused area providing step-by-step instructions on applying QI methodologies effectively.
- **QI cheat sheet:** a quick reference tool summarising essential QI concepts and processes: - https://primarycare.hscni.net/download/DocLibrary/GMS/qi_improvement/qi_correspondence/qi_2425/QI-Cheat-Sheet_NI-November-2024-fv.pdf.

Navigating the guide

The Contents page has been developed to assist users in navigating this guide. Simply click on the section required to access relevant information quickly.

A living document

This guide is intended to be a live document, evolving over time to reflect good practices and local examples. Updates will be made periodically to incorporate new insights, case studies, and user feedback.

By using this guide flexibly, practices can tailor QI efforts to their unique contexts, ensuring meaningful and sustainable improvements in patient care.

Introduction

Making all contacts count

General Practice in Northern Ireland serves as the cornerstone of patient care, with each contact presenting a powerful opportunity to support health, prevent illness, and connect patients to additional resources.

This guide, Making all Contacts Count, has been developed to empower GPs and primary care teams with evidence-based strategies to make the most of every patient encounter, focusing on holistic, patient-centred care.

The 2024 Access to GP in Northern Ireland audit report sheds light on key challenges within General Practice, revealing that over 40% of patients reported difficulty securing timely appointments, with even higher demand in rural and socioeconomically disadvantaged areas.

With the pressures of increasing patient numbers and complex needs, there is a growing urgency to adopt sustainable, innovative approaches that enhance access, streamline care delivery, and reduce inequities.

A whole-system approach

A whole-system approach is essential to realising the goals of this guide. By recognising that each interaction with a patient is part of a broader network of health and social care, primary care teams can work collaboratively with community services, social care, and voluntary sectors to deliver comprehensive care. The audit report highlights that a lack of integrated pathways often results in fragmented care, especially for patients with complex needs.

This guide, therefore, encourages GPs to leverage a whole-system approach to ensure that patients are linked with the appropriate services, reducing unnecessary appointments and fostering continuity of care. By embracing a whole-system model, GPs can play a pivotal role in addressing social determinants of health and reducing hospital admissions, ultimately leading to more resilient and responsive care for all.

A whole-team approach

Given the significant demand for GP services, adopting a whole-team approach is crucial for optimising practice capacity and improving patient access. The audit report indicates that a substantial proportion of GPs' time is spent on tasks that could be effectively managed by other skilled professionals within the practice team.

By expanding roles for nurses, pharmacists, administrative staff, and allied health professionals, practices can not only distribute workloads more effectively but also ensure that patients see the right person at the right time in the right place. This team-based approach is instrumental in alleviating appointment bottlenecks and freeing up GPs for cases that require their expertise.

By implementing shared responsibilities and encouraging cross-functional collaboration, primary care teams in Northern Ireland can manage demand more effectively and provide more holistic patient care.

Embracing quality improvement (QI) approaches

To support these goals, this guide emphasises the importance of embedding quality improvement (QI) approaches into everyday practice. QI frameworks offer practical methods for continuously identifying, testing, and refining processes, helping practices adapt and respond to evolving patient needs and system pressures.

By employing QI tools, such as Plan-Do-Study-Act (PDSA) cycles and root cause analysis, practices can systematically address inefficiencies, track outcomes, and adapt interventions based on real-time feedback. This commitment to continuous improvement not only enhances operational efficiency but also fosters a culture of proactive, responsive care that benefits both patients and staff.

Integrating whole-system, whole-team, and QI approaches

By combining whole-system, whole-team, and QI approaches, practices can create an environment where every patient interaction is maximised for both health and efficiency. GPs can focus on complex cases while other team members address preventative and routine care, leveraging external partnerships to support patient needs beyond the practice.

Through this integrated approach, primary care in Northern Ireland can enhance access, reduce inequalities, and improve outcomes, embodying the principles of Making all Contacts Count to deliver a sustainable, high-quality service for all.

General Practice activity

How General Practice set up appointment systems, measure what work is undertaken and respond to patient demand and need, enables an effective and equitable access system.

During 2023/24 practices focused on the standardisation of GMS activity and introducing a standard process for capturing appointment and non-appointment activity.

The activity data collected is based on the numbers of “encounters” as recorded in Practice Clinical Systems, by the corresponding “healthcare professional role”. Both are available as a by-product of documenting routine clinical care. However, recording behaviour varies across and within practices.

Part of the challenge is that clinical systems can generate encounters as part of their routine processing although often not consistently across the systems and practices, for example test results. It is important to note that this data does not reflect all activity carried out in a practice, only those recorded as encounters, and nor does it take account of how long the encounter lasts or the complexity.

That said, this is an important step in quantifying more accurately the volume and diversity of activity undertaken in GMS practices. The aim is to assess, understand and improve the availability and consistency of activity data from in-hours General Practice. This will embed the accurate, capture and publication of activity data across General Practice in Northern Ireland.

Activity data alone cannot deliver improvements, it needs to be part of a system change.

Activity data in general practice can present a number of benefits at:

1) Practice level
2) Local level
3) Regional level

General practice activity data practice level benefits

- A better understanding of practice activity, mapped by encounter types.
- Data and learning experiences can be shared with other practices to support improvement.
- Supports service development at practice level to best meet patient needs.
- Clear and consistent appointment names will make it easier for patients using online booking through online patient facing services.
- Meets requirements for appointment mapping.
- Identify potential pressure points enabling flex of capacity to times of peak demand.
- Plan best-value deployment of team members and skill mix.

General practice activity guidance documentation

Points of access

Ensuring patients have equitable and efficient access to General Practitioner services is essential to the effective delivery of healthcare. In Northern Ireland, GPs face unique challenges due to rural and urban divides, varying patient needs, and increasing demand. Below we focus on the points of access for GP services, exploring key strategies and examples of good practice that ensure patients can connect with their healthcare provider promptly and appropriately.

In person

Physical access to GP practices is a fundamental aspect of healthcare. Ensuring that premises are easy to find, well-signposted, and accessible to all patients, including those with disabilities, is crucial.

Suggested good practice:

- **Accessible facilities:** Ensure the practice building complies with the Disability Discrimination Act, providing ramps, automatic doors, accessible toilets, and clear signage. The practice should also offer wheelchairs or hearing loops where necessary.

- **Transport links and parking:** Practices could consider providing information on public transport options and ensure where possible there is ample parking, including disabled parking spaces.

- **Flexible appointment times:** To accommodate those with work commitments or other barriers.

Telephone access

Phone lines remain one of the primary points of contact for GP services. Efficient, well-managed telephone access is vital for patients to book appointments, seek advice, and access urgent care.

Suggested good practice:

- **Multiple phone lines:** Providing enough phone lines during peak hours is crucial. Practices should consider adding extra lines or implementing a call-back service to prevent long waiting times and reduce patient frustration.
- **Automated systems:** Interactive voice response (IVR) systems can direct patients to the right service (e.g. booking appointments, repeat prescriptions, or speaking with a nurse). This reduces administrative burden and provides quicker access to care.
- **Phone triage:** Consider having a GP or trained nurse conducting phone triage, assessing whether the patent's medical complaint requires an in-person visit, telephone consultation, or emergency referral.

Online access and digital solutions

The digital revolution has transformed patient access to GP services, with online portals, apps, and digital tools offering increased convenience. Practices should maximise the use of digital platforms to meet the growing demand for remote services.

Suggested good practice:

- **Online appointment booking:** Allowing patients to book and manage appointments online, as well as cancel appointments if necessary, can reduce the pressure on reception staff and phone lines.
- **Online consultation:** E-consultation services allowing patients to describe their symptoms and receive a response from their GP without needing to attend in person can reduce unnecessary appointments and improve access to care for minor ailments.
- **Digital repeat prescriptions:** Patients can request repeat prescriptions online, reducing the need for phone calls or in-person visits. This not only improves access but also enhances efficiency and safety.
- **Patient communication:** SMS or email notifications can be used to remind patients of upcoming appointments, health campaigns, or results from recent tests.

Appointment types

In modern general practice, a variety of consultation methods can improve patient care, increase efficiency, and cater to different patient needs. Choosing the most appropriate consultation type involves considering the clinical context, patient preferences, and access to resources. Below is guidance on when to use each type of GP consultation.

Suggested good practice:

Choose a range of appointment types that take into consideration

- **Patient preference and digital literacy:** Always consider the patient's access to and familiarity with technology. Some patients, especially the elderly, may feel uncomfortable with video consultations or secure messaging.
- **Clinical need:** Certain conditions may necessitate physical examination or visual inspection that can only be achieved with face-to-face or video consultations.
- **Time sensitivity:** For urgent issues, a quicker, more accessible consultation method (such as phone) may be more appropriate than waiting for a face-to-face appointment.
- **Efficiency:** For minor issues or routine follow-ups, text messaging or a phone call may save both patient and practitioner time.
- **Flexible appointment slots:** Offer a mix of routine, same-day(urgent), and emergency appointments. Prioritise urgent cases while ensuring non-urgent patients are not left waiting for long periods. Practices should offer a range of appointment types of reasonable length on at least five mornings and four afternoons per week.
- **Bank holidays:** Ensure adequate same day(urgent) appointments for the working week of bank holidays.
- **Access for vulnerable groups:** Ensuring equitable access to GP services for vulnerable groups such as the elderly, disabled, ethnic minorities, and homeless populations requires targeted strategies (see equity section).

Face-to-face consultations

Face-to-face (F2F) consultations remain the gold standard for many clinical scenarios where physical examination is necessary, complex diagnoses are involved, or when the patient's condition cannot be fully assessed remotely.

Best used when:

- A physical examination is required (e.g., abdominal pain, musculoskeletal issues, suspicious lumps).
- Complex or multiple issues are being discussed, such as co-morbidities or when patients have difficulty communicating remotely.
- Mental health concerns where face-to-face interaction may help build rapport and trust (e.g., severe depression or anxiety).
- Non-verbal cues are important for diagnosis (e.g., cognitive impairment, dementia).
- Invasive procedures are needed (e.g., injections, dressing changes).

Considerations:

- Ideal for vulnerable or elderly patients who might struggle with technology.
- May require more in-clinic resources.

Video consultations

Video consultations can be a convenient option for patients, reducing travel time and increasing access to care. They offer many of the advantages of face-to-face interactions but without physical contact. Whilst not currently in widespread use across Northern Ireland, there is potential for growth in this area as digital platforms develop and become more integrated with clinical systems.

Best used when:

- **Routine follow-ups** (e.g., management of stable chronic conditions like diabetes or hypertension).
- **Mental health consultations,** especially where visual cues add value (e.g., mild depression, anxiety management).
- **Assessments of visual symptoms,** such as skin rashes, swelling, or bruises, that can be shown on camera.
- **Patient convenience** e.g. for those who are housebound but require visual interaction.
- Situations where **visual assessment** of the patient is important (e.g., mild respiratory conditions where breathing effort can be assessed visually).

Considerations:

- Not ideal when a physical examination is required or for patients with limited access to or familiarity with technology.
- Patient consent and understanding of confidentiality in remote settings are essential.

Telephone consultations

Telephone consultations are one of the most accessible forms of contact and are often used for straightforward clinical issues where a visual examination is not necessary.

Best used when:

- **Brief consultations** (e.g., medication reviews, test results, prescription requests).
- **Triage** for determining the need for face-to-face or video consultation.
- **Follow-up** on stable chronic conditions that do not require physical examination.
- **Quick assessments for minor conditions** or initial advice (e.g., cold and flu symptoms, UTI symptoms, mild allergic reactions).
- Patients who **lack access to technology** for video consultations.

Considerations:

- Suitable for patients who are comfortable discussing issues over the phone.
- Not appropriate if visual assessment is needed or if patients have hearing difficulties.

Home visits

Home visits are a more resource-intensive option and are typically reserved for patients who are unable to attend the practice due to medical or mobility reasons.

Best used when:

- Patients are **housebound**, severely ill, or at the end-of-life stage (e.g., palliative care).
- **Frail elderly patients** with mobility issues or those with severe disabilities.
- **Acute medical conditions** that make travel to the surgery impossible (e.g. bedbound patients with infections).

Considerations:

- Should be reserved for patients who genuinely need them due to the higher time and resource demands on GPs.
- Remote consultations can often be used to assess if a home visit is required.

Text and secure messaging consultations

Text-based communication or secure messaging platforms are increasingly used in GP practices to offer quick access for administrative or low-risk clinical advice.

Best used when:

- **Follow-up on non-urgent issues**, such as routine advice on lifestyle, ongoing treatment plans, or administrative queries (e.g., appointment reminders, requests for repeat prescriptions).
- **Quick queries** that do not require in-depth clinical discussion.
- **Younger patients** or those comfortable with technology, for convenience and time efficiency.

Considerations:

- Not suitable for complex, urgent, or highly emotional conversations.
- Ensure a secure messaging system that complies with confidentiality and data protection regulations.

Need, demand and capacity

Matching capacity and need/demand requires regular attention, the best appointments systems are flexible and constantly refined in response to data and staff and patient feedback. Demand and capacity are a measure of how much work a practice is faced with day to day (demand) and the total resource available to meet that demand (capacity).

Measuring and understanding demand and capacity is not a solution in itself, but it does help clearly demonstrate the nature of the current workload and the challenges it presents.

A better understanding of demand and capacity can provide the data needed to support decision making within the practice to help meet demand/need, for example managing the appointment book, allocating resources and better managing of workload across the day, week, month and year.

A good place to start is by mapping your current processes.

Definitions

Demand	What patients ask for including what we didn't have capacity to provide.
Need	The capacity to benefit from healthcare.
Activity	What is actually being done (same as supply).
Capacity	What we could be doing.
Backlog (queue)	Build -up of uncompleted work e.g. Number of people who requested an appointment but couldn't be offered one or the number of days wait for a routine appointment.
Failure Demand	Duplication, waste and inappropriate use of time.

Need is the capacity to benefit from healthcare, and includes sub-definitions of need such as: expressed need – capacity to benefit and asking for help.

Unexpressed need – capacity to benefit but not asking for help expressed.

Unmet need – capacity to benefit but no supply to help. This is what forms the backlog or queue.

Addressing demand and capacity

Demand

Smooth demand

- Consider timing in the week of routine and follow-up appointments (e.g. avoiding Mondays when acute demand is high).
- Consider timing in the year of long-term condition recall against capacity.

Reduce demand

- Increase use of self-care and self-referral services, ensure website and social media pages are up-to-date (see working with patients section).
- Increase use of online services.
- Optimise use of SMS to communicate with patients (see working with patients section).

Reduce failure demand

- Optimise care navigation: right person; right place; right time.
- Create effective practice systems to ensure that the Practice team have a consistent approach to, e.g. prescribing, signposting, referrals, document management (see work flow optimisation).
- Work with system partners to reduce transfer of work (Working Better Together).
- Consider failure demand generated by the system, e.g. no time given for telephone consultations.
- Introduce a tailored appointment system for 'Patient who need additional support'.
- Consider putting systems in place for continuity of care.
- Look at Did Not Attends (DNAs).

Capacity

Smooth capacity

- Agree cover arrangements to provide stable weekly capacity.
- Timing of annual leave and mandatory training.
- Contingency plans in place for unpredictable events, such as clinician illness (All practices should have a Business continuity plan which is reviewed on an annual basis).
- Historic practices e.g. staff start times, home visit patterns, blocking of appointments.
- Have a clear policy for using locums for planned and unplanned leave.
- Ensure enough capacity for non-clinical work (work flow optimisation).

Increase capacity

- Recruit additional specific roles e.g. Practice Nurse, ANP, phlebotomist etc.
- Review appointment book to ensure slot lengths are appropriate to time needed.

Better match capacity to demand

- Changing shift patterns and capacity to match demand.
- Adjust capacity of specific roles to match demand.
- Improve use of care navigation to appropriate healthcare professional.
- Consider variation across the day as well as seasonal variation.

Ideas to start help address demand and capacity

The following are ideas from practices for places to start:

Use your telephony data

Cloud based telephony systems can allow you to look at your data across the day and identify peaks in call demand. Understanding this can then allow administrative capacity to be altered through the day, for example reassigning staff from other duties such as document scanning at times of peak demand. This can reduce call waiting times and patient complaints.

Look at your Mondays

Mondays are often the busiest day of the week. Reviewing demand data on a Monday can help to decide how much routine work to reassign to other times of the week and help to free up capacity to meet demand. Improving the management of demand at the beginning of the week will often positively impact on days later in the week.

Measure your unmet demand

Demand can often feel overwhelming and out of control. Measuring the number of patients asked to phone back and added on as ‘urgent extras’ on top of the anticipated activity can help give an understanding of the scale of demand that is not being met which can help it feel more manageable.

Review your care navigation processes

Carrying out an audit of potentially avoidable appointments can help identify where improvements can be made to the care navigation process to support patients in other ways, both inside and outside of the practice.

Review your non-clinical activity

Consider when your non-clinical activity is being undertaken such as practice meetings and training and consider moving them to days or times when acute demand is lower.

Start with your “pain points”

Start by looking at a specific area of demand that is causing most impact on staff or patients. An example of this might be the on-call list or the extras added into the day.

For more information and tools to help align capacity with demand go to:

NHS England » How to align capacity with demand in general practice

Management of Did Not Attends (DNAs)

'To reduce non-attendance, it appears that the appointment system needs to change, not the patient', Tom Margham

Reducing missed appointments in general practice: evaluation of a quality improvement programme in East London | British Journal of General Practice (bjgp.org).

Did Not Attend (DNA) appointments, where patients fail to show up for scheduled consultations, place a significant burden on GP practices. DNAs not ony waste valuable time and resources but also reduce access for other patients. Managing DNAs efectively can improve access, patient satisfaction, and practice efficiency.

We aim to outline a QI approach to managing DNAs in GP practices across Northern Ireland, offering good practices, actionable strategies, and real-life examples to help reduce DNA rates.

Understanding the impact of DNAs

Before implementing interventions, it is important to understand the impact of DNAs on your practice:

- Missed appointments lead to wasted clinical time, reducing availability for other patients.
- Increased waiting times for all patients, especially those in need of urgent care.
- Financial implications for the practice, as unused appointments represent lost revenue. For example, Enhanced Services such as minor surgery or LARC.
- Patient outcomes can suffer when missed appointments delay diagnosis, treatment, or follow-up care.

A well-structured QI approach can help reduce DNAs by identifying the root causes, testing potential solutions, and scaling successful interventions.

Step-by-step QI approach for managing DNAs

1. Data collection and analysis

The first step in a QI approach is understanding the scale and pattern of DNAs within the practice.

- **Collect baseline data:** Track the number of DNAs over a specified period (e.g., 6–12 months), noting the time of day, day of the week, and type of appointments (GP, nurse, etc.). This will help identify trends.
- **Identify patient groups:** Analyse whether certain patient groups (e.g., age demographics, chronic disease patients) are more likely to miss appointments.
- **Examine appointment types:** Investigate whether DNAs occur more frequently with routine appointments compared to urgent or follow-up consultations.
- **Use electronic health records:** Leverage your GP practice management software to generate reports on DNA patterns.

2. Engage with patients to understand root causes

Understanding the reasons behind DNAs is essential for designing effective interventions.

Potential ways to engage with patients:

- **Patient surveys:** Send brief, anonymous surveys to patients asking about barriers to attending appointments (e.g., transportation issues, forgetfulness, inconvenient times, etc.).
- **Patient focus groups:** Organise focus groups with a diverse range of patients to explore reasons for DNAs. This allows for deeper insights into patient behaviour.
- **Staff feedback:** Consult with receptionists, practice nurses, and GPs about common reasons they hear from patients who miss appointments (e.g., miscommunication, difficulty in cancelling, etc.).

3. Test small-scale interventions (PDSA cycles)

Using the Plan-Do-Study-Act (PDSA) cycle approach, practices can test small, manageable changes to reduce DNAs and evaluate their effectiveness before scaling them up.

- **Plan:** Identify a specific, manageable intervention (e.g., SMS appointment reminders) and set clear objectives for what you hope to achieve.
- **Do:** Implement the intervention on a small scale (e.g., trial SMS reminders for one type of clinic or for a specific group of patients).
- **Study:** Monitor the impact of the intervention by comparing the DNA rates before and after implementation.
- **Act:** If the intervention is successful, scale it across the entire practice. If not, adjust and re-test.

Potential intervention ideas:

- **SMS reminders:** Send patients an SMS reminder 24–48 hours before their appointment. Include instructions on how to cancel or reschedule if necessary.
- **Phone call reminders:** For high-risk patients (e.g., those with multiple DNAs), a personal call from a staff member can serve as a stronger reminder.
- **Online cancellation systems:** Make it easy for patients to cancel or reschedule appointments online, reducing the friction involved in contacting the practice by phone.
- **Appointment flexibility:** Offer patients more flexibility in their appointment times to reduce the likelihood of DNAs for those with work or caregiving commitments.
- **Length of advance booking:** 75% of DNAs occur when the time between booking and attending an appointment is more than one day. Consider reducing length of time to one day. Reducing missed appointments in general practice: evaluation of a quality improvement programme in East London |British Journal of General Practice (bjgp.org).

4. Develop clear communication strategies

Clear communication about the importance of attending appointments and the consequences of missing them can help reduce DNAs.

- **Appointment confirmation:** Ensure patients receive a clear confirmation when they book an appointment, either via email, SMS, or a printed card for in-person bookings.
- **Reiterate the cost of DNAs:** Without being punitive, explain to patients the broader impact of DNAs on the healthcare system. For example, display posters in the waiting room, post on website/social media or include a message in appointment reminders explaining how DNAs reduce access for other patients.
- **Encourage accountability:** Use language in reminders and communications that encourages patients to take responsibility for managing their appointments, such as, “If you can’t attend, please let us know so someone else can take your place.”
- **Make cancelling easy:** Provide clear, easy-to-follow instructions on how to cancel or reschedule, including via telephone, online, or through a mobile app.

5. Focus on high-risk patient groups

Certain patient groups are more likely to miss appointments, such as those with chronic conditions, mental health issues, or social barriers. By identifying and addressing the needs of these groups, practices can reduce DNA rates.

- **Chronic disease management**: Use proactive care planning for patients with long-term conditions. Offer regular reminders for routine appointments and follow-up care to ensure they stay engaged with their care.
- **Mental health support:** Patients with mental health challenges may struggle to keep appointments. Consider offering flexible appointments or additional support, such as check-in calls, for these patients.

6. Vulnerable patients

Consider safeguarding concerns for vulnerable patients who miss appointments, for example, children who are not brought to their appointment for childhood vaccinations.

- If an acutely unwell patient does not attend, demonstrate and document that you took all reasonable and timely steps to investigate the circumstances and need for care.
- **Agree a practice system follow up for:**
  - Children who are not brought to their appointment (hospital, childhood vaccination etc) Rethinking 'Did Not Attend' (youtube.com).
  - DNA from a red flag referral Missed appointments - The MDU.

7. Review and monitor progress

Ongoing monitoring is essential to sustaining improvements and ensuring that DNA management strategies continue to be effective.

- **Regular review of DNA data:** Routinely monitor DNA rates and identify any changes or trends over time. Adjust interventions based on this data.
- **Patient feedback:** Continue to gather patient feedback on how easy they find the appointment process, including booking, attending, and cancelling appointments.
- **QI meetings:** Incorporate regular QI team meetings to discuss DNA data, review the effectiveness of interventions, and develop new strategies if needed.

Self-care

Self-care is the actions that individuals take for themselves, on behalf of and with others in order to develop, protect, maintain and improve their health, wellbeing or wellness.

The **Self Care Forum** is the national charity which aims to further the reach of self-care and embed it into everyday life.

Self-Care Best Practise - Self Care Forum

Fact Sheets - Self Care Forum

Tips for practices in supporting self-care

- **All clinicians, healthcare assistants and receptionists** should agree on the advice they give patients for common self-limiting illnesses.
- **Involve all clinicians** in prescribing approaches and policies to ensure consistency.
- **Promote high-quality self-care information** on the practice website.
- **Make the best use of the team to support self- care** and signpost to local support when appropriate.
- **Have a self-care champion in the team** and encourage team members to use Self Care Forum resources and look out for self-care training.

Equity in general practice

The availability of good medical care tends to vary inversely with the need for it in the population served" The Inverse Care Law, Dr Julian Hart 1971 THE INVERSE CARE LAW - The Lancet

'There can be no more important task for those concerned with the health of the population than to reduce health inequalities. Review what can be done to reduce health inequalities and then do it. Social justice demands it.' Michael Marmot

(There can be no more important task than to reduce health inequalities - The Health Foundation)

'Of the constituent countries of the UK, Northern Ireland is the most deprived with 37% of the population living in areas in the most deprived fifth of the UK' Adjusted indices of multiple deprivation to enable comparisons within and between constituent countries of the UK including an illustration using mortality rates | BMJ Open

Equality and equity

Equality does not mean **Equity**

The image above is decorative.

Equality

Means each individual or group of people is given the same resources or opportunities.

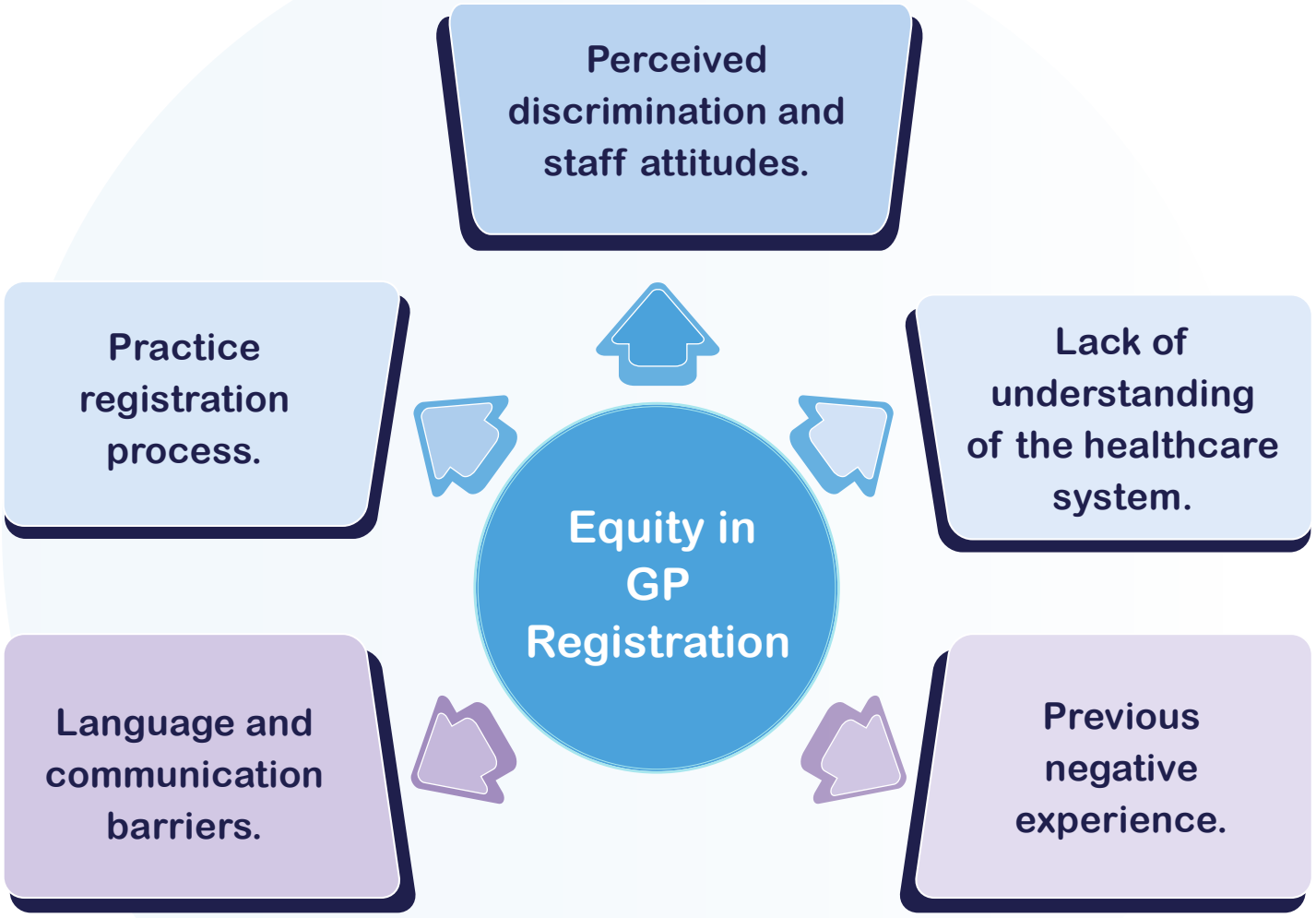
Equity

Recognises that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.

Equity in registering with a GP practice

Socially excluded patients are less likely to register with a GP, contributing to poorer health outcomes in the most vulnerable groups. Practice access policies should work to reduce barriers to GP registration and provide staff with training in equity of registration.

There are several factors that impact on equity in patient registration



Practice registration process

The biggest barrier to general practice registration is the inability to provide paperwork: 39% of registration refusals were due to lack of ID and 36% to lack of proof of address. A request of proof of address presents a barrier for individual sleeping rough or living in temporary accommodation.
inequalities-resource-sep-2018.pdf (england.nhs.uk)

For patient's transferring from one GP surgery to another within Northern Ireland, proof of lawfulness is not required, only a valid medical card, issued in Northern Ireland.

Although only a valid medical card is required for internal transfers, a GP surgery may request additional information such as: proof that the patient resides within the surgery catchment area and the provision of suitable ID, to assist the GP surgery in verifying the identity of the patient presenting to them.

In the unlikely circumstances, where a patient would not be in possession of photographic identification (e.g. those experiencing homelessness), the GP surgery can discuss with the patient or their representative(s) what alternative documents are available that would be acceptable.

The surgery may contact Medical Registrations BSO 0300 555 0113 to seek assistance, if required. General Public Information - GP Registrations - Business Services Organisation (BSO) Website (hscni.net)

Proof of ID or address should not be a barrier in registering with a GP Practice.

Patients have a right to choose a practice that best suit their needs. Registration can only be refused if there are reasonable grounds for doing so, for example:

- **The patient resides outside the practice boundary**
- **The practice has a list closure as agreed with SPPG**

The reasonable grounds should not relate to the applicant's race, gender, social class, marital status, age, religion, political opinion, sexual orientation, appearance, disability, medical condition or whether or not the applicant has dependants.

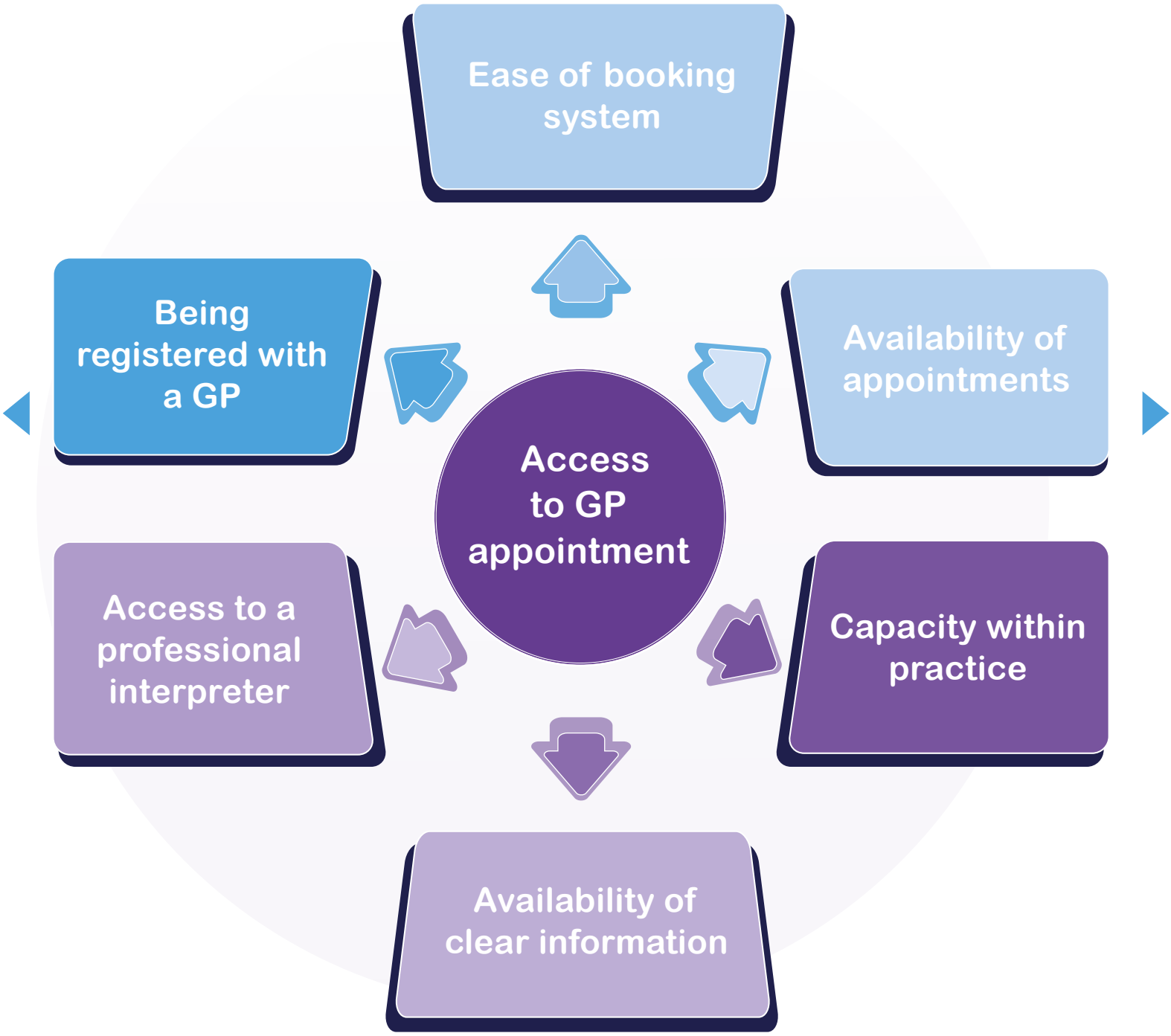
Reason for a refusal must be notified to the applicant in writing within 14 days and the practice needs to keep a written record of refusals and the reasons for them. This record should be available to SPPG on request.

Practices should provide immediately necessary treatment to all who require it. Patients are effectively registered with the Practice as soon as they complete and return the registration form.

Practices should not impose unnecessary barriers to patients wishing to register e.g. waiting lists for registration or excessive waiting times for registration appointment. Patients do not have to wait for a registration appointment with the Practice to avail of practice services or see a GP.

Microsoft Word - GMS CONTRACT REGS BM3.doc (hscni.net)

Equity of access for registered patients



Access to a professional Interpreter

Interpreting support is needed for all patients who do not have sufficient proficiency in English language. This ranges from those with no English at all, to those with intermediate level English that may well be satisfactory socially but not enough for health and social care situations.

Communication barriers prolong appointments, and create strong potential for misdiagnosis, misunderstanding and non-consent to examination, treatment or care.

There are cases of persons who were not provided with interpreters returning to see Practitioners on numerous occasions and going through various treatments until their condition was addressed.

Providing an Interpreter:

- Improves access to services.
- Minimises the risk of misdiagnosis, misunderstanding and non-consent.
- Raises awareness in relation to religious/cultural needs and different health belief systems.
- Reduces the use of untrained interprets.
- Reduces the likelihood of repeat appointments, prolonged appointments, or unnecessary admission to hospital.
- Increases patient satisfaction.
- Complies with legislative requirements – The Race Relations (Northern Ireland) Order 1997 (legislation.gov.uk), Northern Ireland Act 1998 (legislation.gov.uk)

Face to Face foreign language interpreting services is provided by Business Services Organisation (BSO) Health and Social Care Interpreting Service. For further information on how to book an interpreter and guidance on their use, please visit Information for HSC Staff and Practitioners - Business Services Organisation (BSO) Website (hscni.net)

Use of untrained interpreters (family members/friends)

Using an untrained person as an ‘interpreter' does not reflect good practice.

Risks of using untrained interpreters include:

- Lack of fluency.
- Inaccurate interpreting or lack of Interpreting Skill.
- No obligation to maintain confidentiality, honesty and impartiality.
- Lack of knowledge in the subject matter and terminology.
- Possible misuse of trust, power and information (domestic abuse/human trafficking).
- Information may be withheld (for example if deemed embarrassing).
- Consent for examination, treatment or care could be compromised if the patient has not been given the correct information.
- Conflict of interest.

Interpreting places an unnecessary strain on family members who may be worried about the potential consequences if they misunderstand or misinterpret what is said.

If a patient insists that they want to use a friend or family member as an interpreter it is essential to inform them of the importance and their right to a professional interpreter.

It should be highlighted that the service is confidential and free of charge to the patient.

Telephone Interpreting Service

It is not always possible to have time to arrange a face to face interpreter. The Big Word Telephone Interpreting Services has been contracted by HSCNI to provide telephone interpreting services [The Big Word Telephone Interpreting Service - Business Services Organisation (BSO) Website (hscni.net).](#) This is a use resource as it is available on demand, can be accessed 24/7 and can support unplanned interpreting requirements.

When to use telephone interpreting

- When the content to be discussed is relatively simple.
- When it is preferable not to have another person in the room i.e. when anonymity or modesty might be a consideration.
- When there are health issues such as highly infectious diseases.
- For follow up appointments when a face to face interpreter is not essential.
- In an emergency situation where time is limited.
- To aid the booking of an appointment and establish patients needs.
- When a face to face interpreter is not available.
- For appointments less than 30 minutes.

When to use face to face interpreting

- For a new patient's initial visit.
- When the appointment is sensitive in nature i.e. delivering test results which may be distressing.
- Consultations involving two or more participants i.e. family conferences.
- When the patient has specific communication needs and/or where non-verbal cues are needed.
- When the patient indicates that they are not comfortable with telephone interpreting.
- For any sight translation where a document needs to be read to the patient/client.
- For appointments more than 30 minutes.

Access for patients with hearing loss

Successive research reports have shown that for people with hearing loss, getting equal access to health services remains a problem. This was made even worse during the Covid 19 pandemic, with this group of patients particularly disadvantaged as practices moved to telephone consultations.

Approximately 12 million people in the UK have a hearing loss. Estimates suggest by 2035, about 14.2 million people in the UK will have hearing loss - that's one in five of the population.

7 million people could benefit from hearing aids but only about two million people use them.

About 12,000 people in the UK use cochlear implants.

When considering improving GP access for this group, the journey of a deaf patient should be considered:

- **Making an appointment**
- **Visiting the GP**
- **In the waiting room**
- **In the consultation room**
- **Telephone appointments**
- **Leaving the practice**
- **Awareness of services available**

Do not assume that all deaf people are the same. Some deaf people may be oral but still require communication support.

Deaf people who are born deaf or experience hearing loss before spoken language is acquired and regard their deafness as part of their identity and culture rather than a disability, may identify themselves as Deaf with a capital ‘D’. They form the deaf community and are predominantly British Sign Language (BSL) or Irish Sign Language (ISL) users.

There are other deaf people who have become deafened or hard of hearing in later life, after they have acquired a spoken language and so may identify themselves as part of the hearing community. They are more likely to use hearing aids and develop lip reading skills. They usually would identify themselves as deaf with a small ‘d’.

There are different types of communication support:

- British Sign Language (BSL) or Irish Sign Language (ISL) interpreter
- Lip-speaker
- Induction loop
- Video Relay Service (VRS)
- Text messaging
- Email
- Next Generation Text (NGT) but this is less useful

Suggested recommendations to consider for Primary Care setting:

1. All clinical and administration staff should receive **deaf awareness training**.
2. **Consider offering a range of different methods to contact** the GP surgery:
   a. **Text messaging** (it is important to ensure that the patient can reply. Enable two-way text messaging or email communication, particularly for urgent appointments).
   b. **Email**
   c. **VRS**
3. **Consider offering an online appointment system** to book appointments, which includes an option alerting staff that they require an interpreter, or other type of communication support.
4. **Provide a Sign Language interpreter** for appointments and allow extra time i.e. double booking.
5. **Consider the use of VRS** for ease of accessibility, or as a second option if you are unable to secure a **BSL interpreter** at short notice.
6. **Promote services** to inform deaf patients that they can request communication support.
7. If there is a screen in the waiting room, ensure that there are **subtitles for accessibility.**
8. **Use the screen in the waiting room to inform deaf patients** that they can request communication support or other preferences.

Suggested recommendations to consider for Primary Care setting:

Continued

9. **Meet the patient in the waiting room**; don't call out their name unless it has been con irmed that there is an interpreter with them.

10. **Offer alternative methods** for telephone advice such as VRS and email.

11. **Monitor the number of appointments where a BSL interpreter is required** but has not been booked (and whether this leads to cancellations).

12. **Adding summary BSL/ISL clips to the website** will inform deaf people of the services available.

13. Managers need to **be aware of the number of deaf patients** they have and to monitor the support available.

14. **New registration forms** need to have a box to state what kind of communication support is required i.e. BSL interpreter, VRS, induction loop etc.

Identify

Ask the deaf patient how they want to communicate. Enable the deaf person to receive support in their preferred language and communication methods. Offer a range of different methods to contact the practice.

Record

Make a note in the patient's records of their communication support needs. Record whether they are deaf and need an interpreter, have a carer or personal assistant with them, and if they are happy to use VRS.

Flag

Make sure you record the person's communication support needs e.g. BSL interpreter, Induction Loop etc. Don't just write 'deaf'.

Share

Make sure you document your patient's communication needs in any referral letters or paperwork. Inform colleague's e.g. Nurses or secondary care doctor that the patient is deaf and needs an interpreter or other type of communication support.

Meet

Make sure you ask if patients require an interpreter when sending out appointment letters. When you send out a letter, provide an alternative mobile phone number for the deaf person to text a message and an email option.

For further information on how to book an interpreter please visit HSCNI Communication / Language Support – Primary Care Intranet Sensory Support Teams

https://setrust.hscni.net/service/sensory-support/

http://www.northerntrust.hscni.net/services/sensory-support-team/

https://belfasttrust.hscni.net/service/sensory-support/

https://westerntrust.hscni.net/service/sensory-services/

BSO Regional interpreting service

Patient factors likely to impact on equity of access

Protected characteristics

Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

Socio-economic deprived population

Includes impact of wider determinants (eg) education, low income, occupation, unemployment and housing.

Inclusion health and vulnerable groups

(eg) Travellers, Roma, people experiencing homelessness, offenders, former offenders and sex workers.

Geography

(eg) Population composition, built and natural environment, level of social connectedness and features of specific geographies such as urban rural and coastal.

Digital Inequity

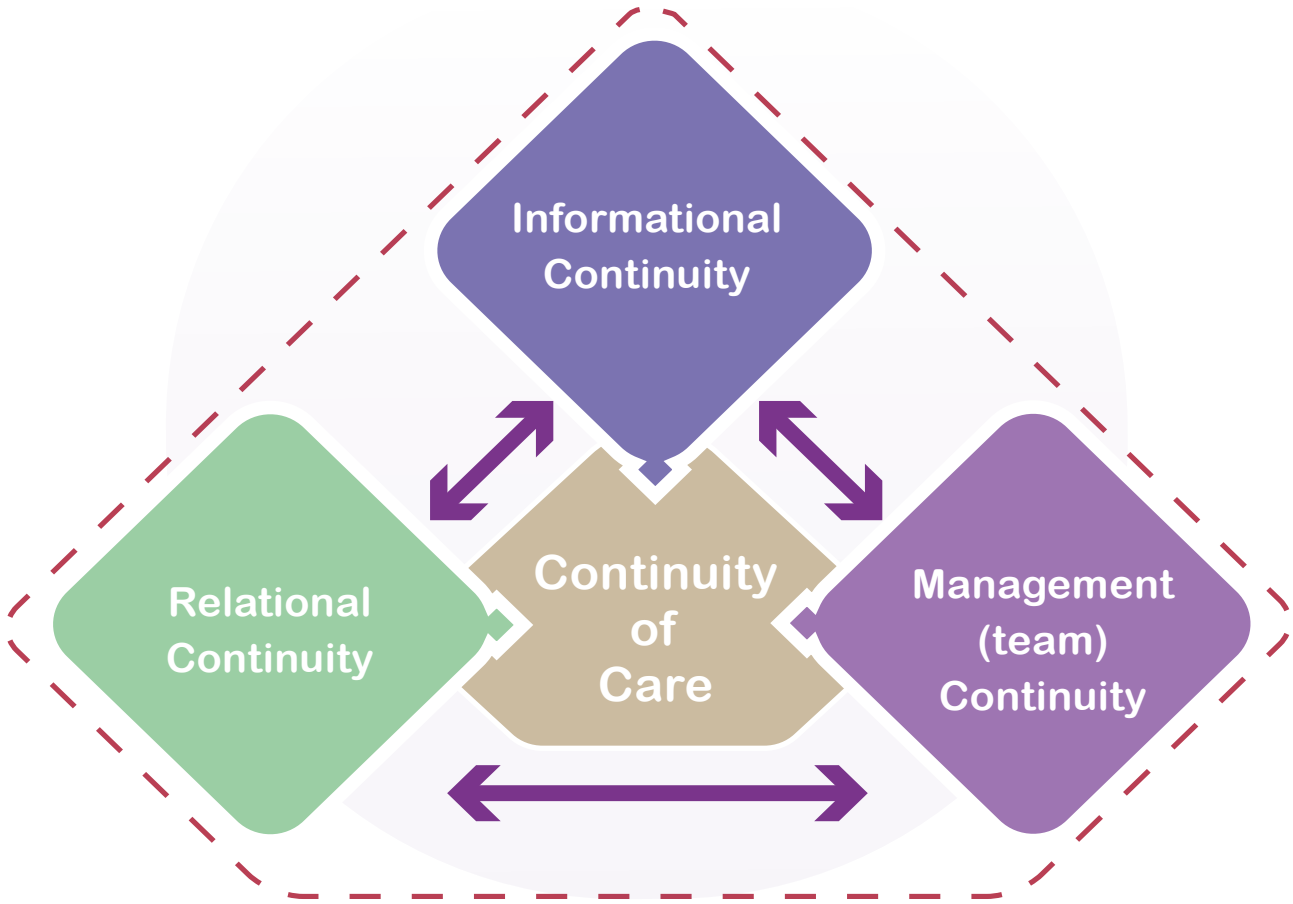
Digital exclusion can compound health inequalities by exacerbating challenges with access to healthcare, skills and capability to navigate and use services, and the general resources needed to lead a healthy life. The above groups may not only face a higher risk of health inequality, but also risk being digitally excluded.

Continuity of care

“Patients who receive continuity of care in general practice have better health outcomes, higher satisfaction rates and the healthcare they receive is more cost effective.” Continuity of care: still important in modern-day general practice - PMC (nih.gov

Types of continuity

Continuity of care is defined as the interaction of a patient and healthcare team and has three aspects : [continuing-care-summary-final-.pdf (nuffieldtrust.org.uk)]



The contents of this image are explained below.

Informational continuity:

Ensures that clinicians have access to accurate, up to date, patient records during patient consultations. New, more complex, models of care, will only work if they link up with innovative I.T. systems.

Patients dislike having to explain their symptoms and history to different GPs and informational continuity is a method of tackling this, especially when they cannot see their preferred doctor. Furthermore, informational continuity acts as the backbone for both relational and management continuity.

Management continuity:

Management continuity can be thought of as the ‘seamlessness’ of care. It involves co-ordination and teamwork between care-givers and across organisational boundaries.

It helps the patient navigate the healthcare system as smoothly as possible. It depends on good communication and in the timely and accurate sharing of information. Such informational continuity is an essential part of good care; the completeness, readability and availability of clinical records is very important.

Relational continuity:

Longitudinal, personal, continuing and caring: it implies knowledge of each other within the context of the therapeutic relationship, with commitment and trust. Both doctor and patient contribute to its creation and maintenance.

It can involve more than one clinician and it should be flexible over time, responding to the patient’s changing needs and social context. Continuity of care in modern day general practice (rcgp.org.uk)

Relational continuity of care is a core feature of general practice. It can result in decreased heath utilisation including hospital admissions and emergency department visits, reduction in deaths, increase in the take-up of preventative care, adherence to advice, reduction in socio-economic disadvantage, as well as increased patient satisfaction (The association between continuity of care and outcomes: a systematic and critical review - PubMed (nih.gov) and Improving continuity: THE clinical challenge - Denis Pereira Gray, Kate Sidaway-Lee, Eleanor White, Angus Thorne, Philip Evans, 2016 (sagepub.com)

Seeing a preferred GP is particularly beneficial for certain patient groups and a balance needs to be reached between patients who prioritise access to any GP for short-term illness, and those who would rather wait to see their preferred GP for issues they consider more serious.

Those living with chronic physical and psychological conditions, older people, women and those with poorer health status, and patients receiving terminal care have all been shown to derive particular benefit from receiving relational continuity of care.

There appear to be inequalities in who receives continuity, marginalised groups, may benefit from continuity more than other groups and may find getting continuity more difficult, therefore widening health inequalities. (Continuity of care: still important in modern-day general practice - PMC (nih.gov) and continuing-care-summary-final-.pdf (nuffieldtrust.org.uk)

Continuity can be difficult to achieve for several reasons. With many more GPs choosing to work as sessional, salaried or part-time GPs continuity of care can be difficult for practices to deliver.

Increased work load and pressures to provide same day access may also be at the expense of continuity. That being said there are ways for practice teams to prioritise continuity of care.

Best practice and using a QI approach to continuity:

Access the RCGP Continuity of care resources page (Continuity of Care work at RCGP) which contains:

- The RCGP Guidelines for Continuity of Care (Five steps to improving continuity of care in the modern practice (rcgp.org.uk))

- The Continuity of Care Toolkit (Continuity of care: Download the toolkit | RCGP Learning). This resource Toolkit for GP Practices was developed by Morecambe Bay Primary Care Collaborative and One Care CIC as part of the Health Foundation's Improving Continuity of Care in General Practice Programme. It describes a 6 step guided approach to improving continuity, it also contains helpful tools, templates and resources (Continuity of care: Templates and resources | RCGP Learning) as well as examples of what other practices have done.

QI Approach to improve continuity of care as described by the Continuity of Care Resource Toolkit:

1. Start Out	**AIM** Increase your appetite for continuity of care	**1a.** We understand what continuity of care is and how this sits in our practice. ✔	**1b.** We understand the practice's current state and enthusiasm for continuity of care. ✔	**1c.** We understand where the practice may improve continuity of care. ✔
2. Define & Scope	**AIM** Define your continuity of care ambition	**2a.** We understand what patients and staff believe is important in continuity of care. ✔	**2b.** We understand what is happening within the practice that helps/hinders continuity of care. ✔	2c. We have an aim and agreement to work towards improving continuity of care. ✔
3. Measure & Understand	**AIM** Identify areas for improvement	**3a.** We understand our level of continuity of care and have a way of measuring it again. ✔	**3b.** We understand our practice data and we have identified focus areas to achive our aim. ✔	**3c.** We understand what data we will measure now, during and later. ✔
4. Design & Plan	**AIM** Decide on the changes to make	**4a.** We have identified areas that will achieve our aim ✔	**4b.** We know which cahnges we are starting with ✔	**4c.** We have a plan of action for our changes. ✔ **PDSA**
5. Implement	**AIM** Make the changes	**5a.** We have made changes and recorded the results. ✔ **PDSA**	**5b.** We know if the change was an improvement. ✔ **PDSA**	**5c.** We uhave made a decision on how to respond to the PDSA outcome. ✔ **PDSA**
6. Handover & Sustain	**AIM** Evaluate, share and embed.	**6a.** We know the difference oour changes have made and what we have learned. ✔	**6b.** We have built continuity into business as usual. ✔	**1c.** We have achievements and are connected into the continuity of care community. ✔

PDSA Cycle

Statements within the **Plan Do Study Act** (PDSA) cycle will need to be repeated for each change.

There are some potential drawbacks of continuity which need to be understood and mitigated against:

- High-attending patients can increase workload and the risk of individual clinician burnout.
- When an illness has progressed slowly, a doctor who has seen the patient regularly may miss a diagnosis that is obvious to a newcomer meeting that person with ‘fresh eyes’.
- Continuity can make doctors less objective, affecting their decisions to investigate. They might be reluctant to avoid confrontation.
- A doctor can start to feel paternalistic/maternalistic especially towards vulnerable patients and lose their objectivity.
- A patient may be assigned a doctor in whom he or she lacks con idence, and adherence to medical advice suffers as a result.

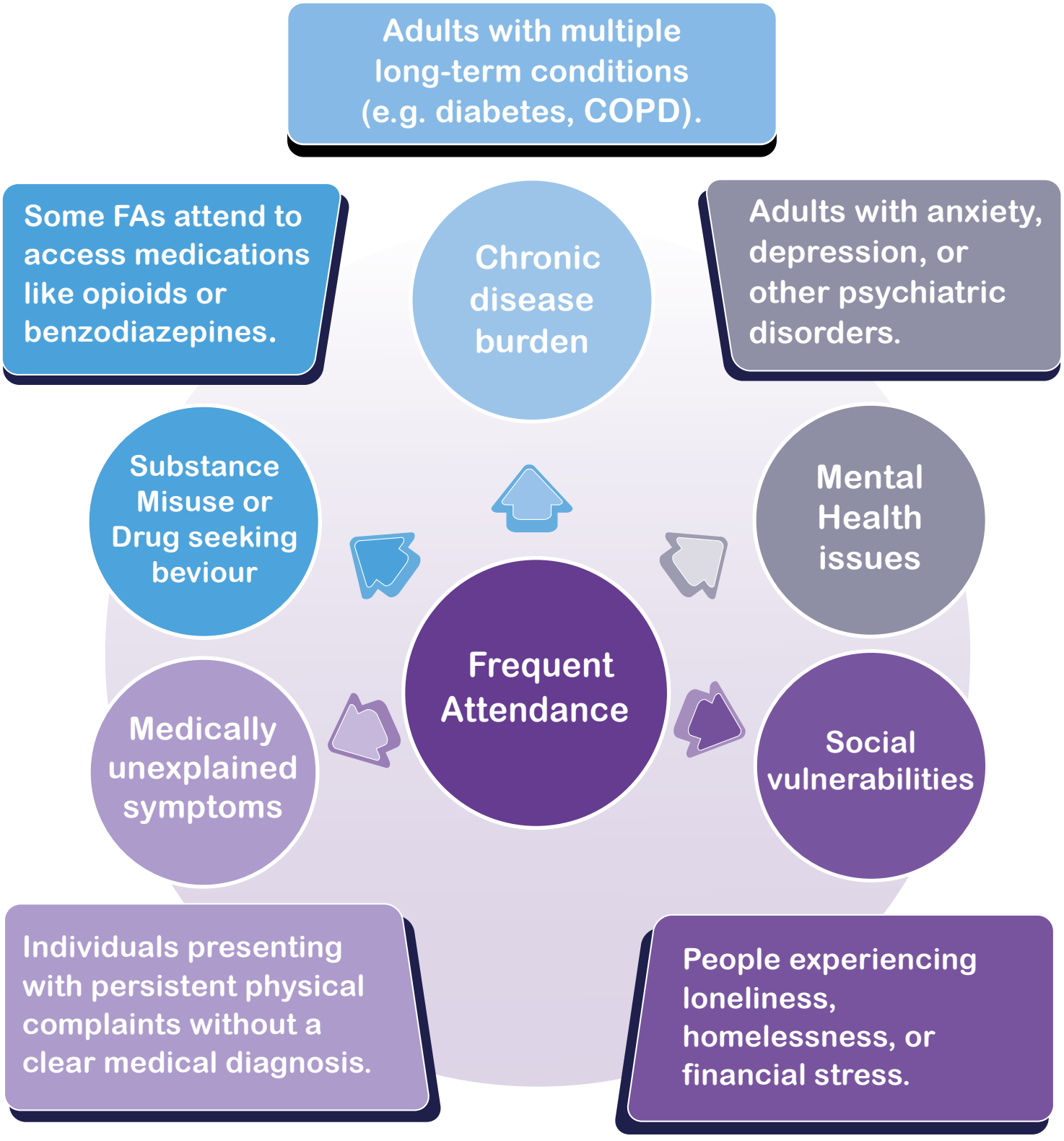
Patients who need additional support

Some vulnerable groups of patients may use GP services and other health services such as A&E, disproportionately, often reflecting underlying complex health, social, and psychological issues.

Their repeated visits can indicate unmet needs, fragmented care pathways, and challenges in self-management.

This guide draws on the Health Foundation's 2017 analysis Chart: Characteristics of frequent attenders at general practice (health.org.uk) and strategies for personalising care through segmentation Personalising care for patient sub-groups in general practice: segmenting within general practice to improve health and increase efficiency to suggest best practices and potential interventions that improve care quality and service efficiency.

Characteristics of those attending frequently



The characteristics of frequent attenders highlights the need for targeted, coordinated care beyond addressing individual appointments, focusing instead on root causes and preventive strategies.

Segmenting patients to provide personalised care

Segmentation within general practice involves grouping patients by shared needs and tailoring interventions accordingly. This helps practices:

- Identify priority groups: e.g. chronic disease patients vs. those with mental health issues.
- Design personalised care pathways that address specific needs efficiently.
- Improve health outcomes by focusing on the underlying drivers of frequent attendance.

For example, patients with long-term physical health conditions may benefit from enhanced chronic disease management, while those with mental health issues might need counselling or integrated care with mental health teams.

Considerations and interventions

1. Developing personalised care plans

- Create care plans with input from multidisciplinary teams (MDTs), including mental health professionals and social workers.
- Assign a ‘Usual GP’ to ensure continuity and proactive management of care (see continuity of care section and the ‘Frequent Attenders- The Power of 3’).
- Set collaborative goals with patients, focusing on both health outcomes and reducing unnecessary visits.

2. Offering alternative consultation methods

- Use remote consultations (e.g. phone) to address non-urgent concerns, offering convenience while reducing the demand for in-person appointment.
- Implement care navigation to direct patients to the most appropriate care pathway efficiently.

3. Proactive monitoring and data use

- Identify frequent attenders through practice-level data and monitor changes over time to spot patterns early.
- Use electronic alerts to flag frequent attenders and schedule regular reviews of their care plans.

4. Community and voluntary sector engagement

- For socially vulnerable patients, link them with community resources (e.g. social groups, housing support, financial services).

5. Collaborating with mental health and substance use services

- Integrate mental health support into primary care to better manage patients with psychological or psychiatric issues.
- For drug-seeking patients, establish clear prescribing protocols and collaborate with substance misuse services to offer alternative treatments.

6. Care pathway coordination across services

- Build strong partnerships with secondary care providers (e.g. emergency departments, Pain Specialists, Mental Health Services) to share data and avoid duplication of care.
- Implement MDT case reviews for high-needs patients to align services and manage care holistically.

Applying a Quality Improvement (QI) framework

A QI approach ensures that interventions for those attending frequently are systematic, iterative, and data-driven. Using the Plan-Do-Study-Act (PDSA) cycle, practices can:

1. Plan:	Identify frequent attenders, segment patients, and co-design interventions.
2. Do:	Implement small-scale changes, such as remote consultations for medically unexpained symptoms (MUS) patients.
3. Study:	Measure impact using metrics like reduced visit frequency, patient satisfaction, and improved clinical outcomes.
4. Act:	Scale up successful initiatives, modify care plans, and iterate as needed based on feedback.

This QI methodology ensures that practices remain responsive to changing patient needs and focus on long-term outcomes and efficiency.

Conclusion

Managing frequent attenders effectively requires personalised care, multi-agency collaboration, and continuous quality improvement. Segmenting patients by need allows practices to design targeted interventions, reduce unnecessary appointments, and improve patient outcomes. By applying QI principles, practices can test, refine, and scale successful strategies, ensuring sustainable improvements in care delivery.

This proactive, patient-centred approach not only enhances individual health outcomes but also alleviates pressure on GP services, promoting a more efficient and equitable healthcare system.

Best practice example

Frequent attenders – The power of 3

Taken from Continuity of care: Templates and resources | RCGP Learning.
See continuity section for more details.

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.

3 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.

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.

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'

The 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)**, as is 'Reframing the "heartsink" feeling can help doctors find resolution".
https://www.bmj.com/content/385/bmj.q1427

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.

3. 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.

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 of frequent attenders across the GP workforce checking if some GPs are bearing the lion's share of frequent attenders.

3 Monthly review

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. With thanks to Dr Hyunkee Kim, Dr Mark Rickenbach and Dr Rebecca Rosen.

Working with patients

Communication with patients

Effective communication is at the heart of a well-functioning GP practice, ensuring patients are informed, empowered, and able to access the services they need. For GP practices in Northern Ireland, communication strategies must be adaptable to a diverse population, addressing various needs and preferences.

This part of the chapter outlines key methods for communicating with patients, including posters, practice websites, leaflets, social media, phone messages, and other relevant channels. It also highlights Quality Improvement (QI) approaches.

Posters and noticeboards

Posters and noticeboards provide a reliable way to communicate with patients visiting the practice. Despite advances in digital communication, physical displays continue to be essential for relaying immediate and practical information.

- **Targeted messaging:** Use posters to convey important, time-sensitive messages, such as changes in opening hours, vaccination schedules, or special clinics. Display these prominently in waiting areas and near reception.
- **Clarity and simplicity:** Ensure posters are easy to read with a clear structure. Use plain language and avoid jargon, and if possible, provide posters in multiple languages reflective of the local population.
- **Accessible design:** Use large, easy-to-read fonts, high-contrast colours, and visuals where applicable. For visually impaired patients, consider including QR codes leading to audio descriptions.
- **Regular updates:** Maintain updated content to avoid confusion and ensure patients have access to the most current information.

Practice websites

A well-maintained website is often the first place patients turn for information. GP practices should prioritise user-friendly design and accessibility to meet patients' needs.

- **Comprehensive content:** Ensure the website includes essential information such as opening hours, contact details, services offered, and clear instructions on how to book or cancel appointments.
- **Online services:** Facilitate the booking of appointments and ordering repeat prescriptions via online portals. This reduces administrative workload and offers convenience for patients.
- **Mobile optimisation:** Ensure the website is mobile-friendly, as many patients will access it from their smartphones. Responsive design is critical to usability.
- **Accessibility:** Make the website accessible to all patients by following web accessibility guidelines, including options for text-to-speech, large fonts, and alternative text for images.
- **Patient education:** Offer resources on common medical conditions, preventative health tips, and self-management of chronic diseases.

Practice leaflets

Leaflets remain a key tool for conveying critical information to patients, particularly those who may not have easy access to the internet or digital platforms.

- **Clear, concise language:** Use plain English or offer versions in different languages depending on the practice's patient demographics. Avoid medical jargon and make the leaflets as user-friendly as possible.
- **Key information:** Include essential information such as services provided, appointment booking procedures, out-of-hours contact details, and public health messages (See schedule 3 in NI Contract - Mar 04 (health-ni.gov.uk).
- **Regular review:** Ensure that the information in the leaflets is regularly updated and reflects current services and policies.

Social media

Social media is increasingly used by GP practices to engage with patients, provide updates, and promote public health campaigns. It allows practices to communicate quickly and interactively, especially with younger populations.

- **Regular updates:** Keep social media profiles updated with practice news, appointment availability, service updates, and health promotion information.
- **Engagement:** Once established, encourage two-way communication by responding to patient comments and messages promptly, while redirecting sensitive issues to private communication channels.
- **Visual and interactive content:** Use infographics, videos, and polls to increase engagement and share information in a more digestible format.
- **Privacy considerations:** Ensure that all public posts respect patient confidentiality and data protection rules. Direct specific medical inquiries to private conversations.

Potential intervention ideas:

- **Use SMS:** Send patients an SMS with a link to the Practice social media page.
- **Use a Facebook Post Planner:** Plan your Facebook posts 30 days with relevant practice and healthcare content How To Schedule Facebook Posts - A Step by Step Guide (magicbrief.com).
- **Resources:** For more resources on how to get the most out of your social media visit PICRT Resources - PICRT

Phone messages and telephone communication

Phone messages are critical in ensuring patients can easily access services and get clear guidance, particularly for urgent inquiries.

- **Efficient phone systems:** Install automated systems that allow patients to book, change, or cancel appointments via interactive voice response (IVR) menus. Provide options to access different departments (e.g., prescriptions, general inquiries).
- **Up-to-date recorded messages:** Recorded messages should provide concise, clear information on opening hours, emergency contacts, and how to access care outside regular hours.
- **Queue management:** Offer an estimated wait time or a call-back feature to reduce patient frustration during busy periods.
- **Personalised care:** While automation is helpful, ensure that patients can still speak to a staff member when needed, especially for more complex inquiries.
- **Direct lines:** Offer direct line contact numbers for communication with other healthcare professionals who may need to communicate with you urgently regarding vulnerable groups (Community Pharmacy, District Nurses, Hospice Nurses, Nursing/Residential Homes).

Text messaging (SMS)

Text messaging has become an invaluable tool for communicating with patients quickly and efficiently, especially for appointment reminders and urgent updates.

- **Appointment reminders:** Send SMS reminders for appointments to reduce no-shows and ensure patients remember their scheduled visits.
- **Health alerts:** Use SMS to inform patients about vaccination drives, seasonal health risks (e.g. flu season), or urgent changes in practice services.
- **Consent and data protection:** Ensure patients have given consent for SMS communication and that data is managed in compliance with GDPR guidelines. Ensure consent is visible in the medical record via a pop-up or on the 'problem page'.

9NdP.00 Consent given for communication by SMS text messaging
9NdQ.00 Declined consent for short message service text messaging

Intervention ideas on how to increase patient consent to sms:

1. Explain the benefits clearly

- Inform patients about the advantages of receiving text messages, such as reminders for appointments, test results, and health tips.
- Highlight how text messaging improves their care and convenience by reducing the need for phone calls.

2. Integrate consent as part of registration

- Include an opt-in option for text messaging in new patient registration forms and emphasize it during onboarding.
- Ensure the process is simple and accessible for all patients.

3. Use multichannel communication

- Inform patients about the option via multiple channels: in-person, over the phone, on your website, or via leaflets in waiting rooms.
- Use friendly, inclusive language that appeals to different demographics.

4. Highlight security and privacy

- Assure patients that their information is secure and text messages comply with data protection laws (e.g. GDPR in the UK).
- Clearly explain that only essential information is shared and that messages are sent securely.

5. Offer flexibility in messaging preferences

- Allow patients to choose the types of messages they wish to receive (appointment reminders, health tips, follow-up care, etc.).
- Make opting out easy so patients feel in control, which may increase their willingness to opt in initially.

6. Train staff to promote messaging during appointments

- Train receptionists and clinical staff to explain the benefits and answer questions about text messaging at each patient interaction.
- Encourage staff to request consent during appointments, especially if a patient expresses an interest in easier communication methods.

7. Display benefits on signage

- Place posters and digital screens in the practice waiting area with information on text messaging benefits and how patients can opt in.

8. Use patient feedback to improve messaging practices

- Survey patients about their preferences for text communication to understand and address any concerns they may have.
- Tailor the messaging approach based on this feedback to ensure it's as user-friendly and relevant as possible.

9. Incorporate text messaging success stories

- Share anonymised success stories that demonstrate the benefits of receiving important health information and appointment reminders via text.

Quality improvement (QI) approaches to communication

Adopting a QI approach to communication helps practices continuously improve their methods, ensuring they meet patient needs effectively.
Key QI Strategies:

- Patient feedback: Regularly collect feedback on communication channels (e.g., through surveys or focus groups) and act on suggestions to improve services.
- Monitoring and data collection: Track metrics such as website visits, social media engagement, SMS response rates, and phone call waiting times. Use this data to assess the effectiveness of each communication method.
- Plan-Do-Study-Act (PDSA) cycle: Use the PDSA model to test small changes in communication strategies (e.g. introducing new text reminder services), monitor outcomes, and scale successful changes.
- Staff training: Ensure all staff are trained in the use of communication tools, from handling phone inquiries to managing social media interactions.

The General Practice team

The General Practice (GP) team plays a crucial role in delivering General Medical Services to communities across Northern Ireland.

General practice serves as the first point of contact for patients within Health and Social Care (HSC) and provides comprehensive healthcare ranging from preventive care to management of chronic conditions, referrals to specialists in secondary care, and support for mental health needs.

In recent years across, the role of the General Practice team has expanded, evolving to address the growing demands on healthcare services and the challenges associated with an aging population, increasing chronic disease rates/ complex co-morbidities, and workforce shortages.

The general practice team in Northern Ireland consists of a variety of professional and administrative staff who collaborate to meet the healthcare needs of patients.

The General Practice team consists of:

General Practitioners (GPs)

GPs are doctors with specialised training in primary care. They are responsible for diagnosing and treating a wide range of health conditions, providing ongoing care for chronic illnesses, and referring patients to secondary care or specialised services when necessary.

GPs often build long-term relationships with patients, gaining an in-depth understanding of their health history, lifestyle, and individual needs.

The Royal College of General Practitioners (RCGP) describes the skills of the future GP to include not only the generalist clinical skills that are familiar, but a ‘stretch’ to include leadership, educational skills, business management and IT skills to support the leadership of multidisciplinary teams.

These skills are important but potentially take GPs away from patient-facing care, impacting on access and reminding us of the importance of the wider team in delivering patient care.

GPs should clearly define their patient-facing commitments on a daily or weekly basis to maintain stable capacity. Some GPs may prefer to focus on management and IT responsibilities, while others may be more inclined toward regularly seeing patients for ongoing health issues rather than handling same-day demand.

Regular team meetings allow for workload reviews, ensuring fair deployment of all team members and promoting continued skill development and growth.

Practice nurses

Practice nurses support GPs by providing a range of nursing services, including immunisations, health screenings, wound care, and management of chronic diseases such as diabetes and asthma.

They play an essential role in preventive healthcare, offering education on lifestyle modifications and healthcare management. Practice nurses provide significant capacity for patient-facing care, contributing to good access. But they also need time for administrative work, meetings and for personal development to ensure they feel valued and are supported to learn, develop and progress in their career.

Advanced Nurse Practitioner (ANP)

ANPs provide high-quality patient centred care in the Primary Care setting.

ANPs are highly trained practitioners with advanced clinical skills that allows them to assess, diagnose and manage a range of acute and chronic health conditions. ANPs support General Practitioners helping alleviate pressures on the system and help improve patient access.

Healthcare assistants (HCAs)

HCAs work under the supervision of practice nurses and GPs, assisting with routine tasks such as taking blood samples, measuring blood pressure, and conducting basic health assessments all of which contributes to good access.

Their work allows GPs and nurses to focus on more complex patient needs. HCAs need regular training, supportive supervision and appraisal, working best with clear, agreed pathways and accessible senior support when seeing patients and dealing with any questions that arise

Pharmacists

In many practices, pharmacists have become integral members of the General Practice Team.

They conduct medication reviews, advise on medication management, and support patients in managing conditions like hypertension, diabetes, and COPD.

Pharmacists help reduce the workload on GPs by addressing medication-related queries and ensuring safe prescribing practices whilst improving patient access.

Physiotherapists

Physiotherapists are often part of the extended GP team, offering musculoskeletal assessments and treatment plans.

This addition helps reduce referrals to secondary care and supports the Practice team in managing conditions such as back pain and joint issues.

With the high number of musculoskeletal contacts in general practice, first-contact physiotherapists can give improved patient care and open GP capacity for other patients.

Practice based Social Workers

Practice-based social workers within GP practices play a vital role in addressing the social determinants of health and supporting patients with non-medical needs.

They work collaboratively with healthcare teams to provide early intervention, advocacy, and tailored support to individuals and families facing challenges such as mental health issues, housing instability, financial hardship, or social isolation.

By offering holistic assessments and linking patients to community resources and services, Practice-based social workers enhance overall well-being and reduce pressures on healthcare and General Practices systems, ensuring more integrated and person-centred care.

Mental Health practitioners

The inclusion of mental health practitioners within GP teams is an emerging practice aimed at addressing mental health needs directly in primary care settings.

These practitioners assess, support, and refer patients with mental health issues, improving accessibility to mental health services can give improved patient care and open GP capacity for other patients.

Practice Manager/administrative team

The administrative team, including Practice Managers, receptionists and administrators are essential to the smooth functioning of General Practice.

They manage appointments, patient records, and day-to-day operations and serve as the first point of contact for patients accessing care.

Practice managers, reception and administrative staff have a pivotal role in order to ensure good patient access. They have a central influence on patient outcome, safety and satisfaction.

Roles of the General Practice team

The General Practice team responsibilities encompass a wide range of services designed to meet primary healthcare needs of its registered population.

Some of the core services provided include:

Acute and chronic disease management: GPs and Practice Nurses work together to manage acute illnesses and long-term conditions. They monitor and adjust treatment plans, provide lifestyle counselling, and coordinate care for complex, multi-morbid patients.

Preventive care: The team plays a central role in preventive healthcare by administering vaccinations, offering screening programs (e.g., cervical, bowel cancer screening), and providing primary healthcare advice.

Mental health support: GP teams provide essential support for conditions like anxiety, depression, and stress. They offer initial assessments, counselling, and referrals to specialised mental health services, integrating mental health care into routine primary care.

Medication management: Pharmacists within the GP team help ensure that medications are prescribed safely and effectively. They perform medication reviews, counsel patients on proper use, and adjust prescriptions as needed to optimise outcomes.

Care for vulnerable groups: GP teams are increasingly focused on delivering care to vulnerable populations, including elderly patients, those with disabilities, and patients with complex social needs.

Challenges facing General Practice teams

General practice teams across Northern Ireland face significant challenges to include:

Workforce Shortages:

There is a well-documented shortage of GPs in Northern Ireland and across the UK, with many nearing retirement and fewer young doctors entering the profession. Recruiting and retaining GPs, as well as other primary care staff, remains a major challenge.

Increasing Demand for Services:

The aging population and higher prevalence of chronic conditions increase the demand for primary care services. Many patients require more frequent visits and more complex care, placing additional pressure on general practice teams.

Funding Constraints:

Like many parts of the HSC, General Practice operates within budgetary constraints. Practices are often limited in their ability to expand services, hire additional staff even when these investments could alleviate some pressures.

Administrative Burden:

GP teams often face high administrative loads, with complex requirements for record-keeping, reporting, and compliance. This administrative burden can detract from time spent on direct patient care.

Developments and innovations

To support General Practice, innovations and changes have been introduced across Northern Ireland to include:

Multidisciplinary teams (MDTs):

The use of MDTs, has been encouraged to provide comprehensive patient care and alleviate GP workload. MDTs enhance the scope of services within primary care, allowing patients to access specialised support without needing to visit secondary care.

Digital Health initiatives:

The integration of telemedicine, electronic patient records, and digital consultation options has been accelerated. Digital health solutions improve access to care, streamline processes, and support remote management of chronic diseases.

The General Practice model/team is evolving to better serve patient needs through innovations in team composition, healthcare management and technology. These efforts aim to ensure that General Practice/Primary Care remains a cornerstone of the HSC in Northern Ireland, delivering high-quality, patient-centred care.

Care navigation

Care navigation in general practice is a patient-centred approach designed to guide individuals to the most appropriate care, support, and services in Health and Social Care.

Care navigation is a pivotal approach in modern general practice, ensuring patients are directed to the most appropriate healthcare professional or service at the right time. In Northern Ireland, the demands on GP services continue to rise, and effective care navigation can enhance patient care while alleviating pressures on GP practices.

This guide will outline good practices, strategies for implementation, and the benefits for both patients and practices.

What is Care navigation?

Care navigation involves trained, non-clinical staff (e.g. receptionists or “care navigators”) who guide patients to the most suitable care pathways, whether within the GP practice or external services.

It allows patients to access care from a broader range of healthcare professionals, including pharmacists, physiotherapists, mental health workers, and social care teams.

Key Functions of Care navigation

- Triaging patient needs and directing them to the correct service.

- Providing patients with the information needed to access these services.

- Ensuring patient flow is streamlined and GP time is preserved for more complex cases.

Benefits of Care navigation

Benefits for patients:

- **Timely and appropriate care:** Patients get faster access to the right care, reducing waiting times.
- **Improved patient satisfaction:** Care navigation provides clarity on where and how to seek help, leading to higher satisfaction.
- **Empowered decision-making:** Patients are more informed about their health options, supporting self-management.

Benefits for practice:

- **Reduction in GP workload:** Freeing up GP appointments for more complex cases by directing patients to alternative professionals where appropriate.
- **Efficient use of resources:** Maximises the use of a multi-disciplinary team, ensuring each professional operates at the top of their license.
- **Enhanced practice reputation:** Practices that effectively implement care navigation are often seen as more patient-centred and efficient.

How to implement Care navigation

Laying the foundations

Staff training

- **Receptionists and non-clinical staff:** These staff members should receive comprehensive training, enabling them to become care navigators.
- **Training should include:**
  - Local service directories and referral pathways.
  - Effective patient communication skills, including motivational interviewing and handling sensitive conversations.
  - Patient confidentiality and data protection (GDPR compliance).
- **Intervention:** Introduce regular care navigation training sessions and refresher courses, ensuring staff are up-to-date with service changes.

Service mapping

- **Create a detailed directory of local services:** This should include healthcare services (e.g., community pharmacists, physiotherapists, opticians) and social services (e.g., mental health support, housing advice, etc).
- **Service relationships:** Establish connections with external providers to ensure seamless referrals and communication between services.
- **Intervention:** Develop and maintain a “live” directory that can be easily updated as services change.

Engaging patients

Raising Awareness

- **Patient education:** Ensure patients are aware of the care navigation system through lea lets, posters, practice websites, and social media. Clear messaging helps patients understand why they may be directed to a different service and how this bene its them.

- **Consistency in communication:** Use standardised scripts to ensure all staff communicate effectively and consistently with patients.

- **Intervention:** Hold patient engagement sessions to introduce care navigation and gather feedback. Co-produce educational materials with Patient Participation Groups (PPGs) to ensure the messaging resonates with the local population.

Managing patient expectations

- **Transparency:** Make it clear to patients why they are being directed to alternative services, emphasising the benefits of quicker and more specialized care.

- **Handling resistance:** Equip care navigators with communication skills to address any patient concerns or resistance effectively.

- **Intervention:** Develop “patient pathways” for common conditions (e.g., back pain, mental health concerns) that visually guide patients on how care navigation works, ensuring transparency.

Technology integration

- **Utilise digital tools:** Invest in electronic triage systems or care navigation software to help identify the most appropriate service for the patient based on their symptoms.
- **Online appointments and referrals:** Enable patients to book appointments directly with other healthcare professionals (e.g., pharmacists or physiotherapists) through online systems.

Collect patient feedback regularly: Use surveys and patient focus groups to assess the effectiveness of care navigation.

Monitor outcomes: Track clinical outcomes and GP appointment availability to assess the impact on practice efficiency.

Action:

Challenges and solutions

CHALLENGE	SOLUTION
Patient reluctance or confusion	Conduct regular education campaigns and provide clear explanations of the benefits of care navigation.
Inconsistent service availability	Maintain close relationships with service providers and keep the directory updated to avoid misinformation.
Staff resistance to change.	Involve staff early in the implementation process and offer comprehensive training and support.

For further details on adopting a QI approach visit:
How to improve care navigation

Workflow optimisation in General Practice

Workflow optimisation in general practice is crucial to enhancing efficiency, improving patient care, and reducing staff burnout. In Northern Ireland, where demand for General Medical Services is high, adopting good practice in workflow optimisation/management can help ensure sustainable, high-quality General Medical Services delivery.

Team approach to patient care

- **Delegation of Tasks:** Assign appropriate tasks to non-clinical staff, such as prescription requests, routine follow-ups, and patient reminders. This allows GPs to focus on more complex clinical cases.

- **Skill Mix Utilisation:** Incorporate advanced nurse practitioners (ANPs), pharmacists, and healthcare assistants into the practice. These professionals can handle chronic disease management, medication reviews, and minor ailments (where clinically appropriate).

- **Clarity of roles and responsibilities**: Ensure every team member understands their roles and responsibilities to avoid duplication of efforts and improve task ownership.

Effective and efficient appointment systems

Triage Systems: Implement a robust triage system to prioritise patients based on clinical need. Telephone or online triage can ensure urgent cases are seen promptly, while routine concerns are scheduled as appropriate.

Flexible appointment types: Offer a mix of face-to-face, telephone, and online consultations to meet patient needs. This reduces the burden on physical appointments and can help improves access.

Use of technology/patient facing services: Leverage technology and patient facing services such as online appointment booking, ordering of repeart prescriptions to streamline processes and reduce the Practices administrative workload.

Streamline administrative processes

Automate routine tasks: Use automated systems for sending reminders, managing repeat prescriptions (where appropriate), and test results. This minimises manual intervention and speeds up processes.

Standardised protocols: Develop clear, standardised protocols for common administrative tasks such as referral processes, document handling, and coding. This ensures consistency and reduces errors.

Task management: use task management software to help improve coordination and track task completion.

Data driven decision making

Regularly review appointment utilisation rates, DNAs, activity data, and staff workload. This helps identify areas for improvement.

Demand/Capacity Planning: Use data and to forecast demand and allocate resources effectively, especially during peak periods like Winter Season/after a bank holiday.

Patient education/Self care

Education:

Provide patients with educational materials and resources to encourage self-care of minor conditions and chronic diseases.

Continuous quality improvement and feedback

Regular team meetings:

Hold regular team meetings to discuss workflow challenges, share best practices, and collaboratively develop solutions.

Quality improvement:

Undertake regular Quality Improvement projects using established QI methodologies and share the learning/improvement with the Practice team.

Patient feedback:

Actively seek and act on patient feedback to improve service delivery and patient satisfaction.

Training and development:

Invest in continuous development for all staff to keep up with good practices.

Wellbeing and workload management

Staff Wellbeing Initiatives: Prioritise staff wellbeing to prevent burnout. Workload Balancing: Distribute work evenly among team members, preventing overburdening of specific roles

By implementing workload optimisation/management, General Practices across Northern Ireland can enhance efficiency, improve patient outcomes, and create a more sustainable environment.

Digital platforms in General Practice

A valuable digital platform for enhancing communication between patients and general practice staf in Northern Ireland can present huge benefits. Digital platforms have grown to support multiple functions, from remote consultations to documentation of patient interactions.

Below we outline good practices for using a digital platform in Northern Ireland's primary care settings to streamline workflows and improve patient care.

1. Understanding functions and applications

Digital platforms offer a variety of tools tailored to improve communication and efficiency in GP practices:

- **SMS messaging:** Practices can send secure SMS messages to patients to remind them of appointments, request information, or provide follow-up instructions. This minimises unnecessary calls and ensures patients are informed about their care.
- **Video consultations:** Can integrate with video consultation software, allowing clinicians to conduct virtual appointments. This can be especially helpful for patients in remote areas or those who have difficulty attending in-person appointments.
- **Patient triage and documentation:** Patients can complete digital forms or questionnaires before their appointment, providing clinicians with detailed information to inform consultations. These can also be used to send documents for electronic signature, enhancing record accuracy and reducing paperwork.

2. Enhancing patient communication

Effective use of digital platforms can greatly improve communication between GPs and patients by:

- **Providing timely updates:** Use SMS features to inform patients of appointment changes, medication updates, or other time-sensitive information.
- **Clarifying instructions:** By sending instructions in writing, helps reduce the likelihood of patients forgetting or misunderstanding verbal guidance. This is particularly helpful for those managing chronic conditions or complex treatment plans.
- **Increasing accessibility:** Can help remove barriers for patients with mobility or transport issues, offering them flexible access to healthcare support without needing to attend the clinic in person.

3. Integrating digital platforms into clinical workflows

Digital platforms work best when fully integrated into daily workflows:

- **Documenting communications:** Ensure that all interactions with patients are documented accurately. Digital platforms integrate with many electronic health records systems, making it easier to maintain thorough, centralised patient records.
- **Using templates and automations:** To save time, practices can create templates for common messages, such as appointment reminders, pre-consultation forms, and follow-up instructions. Automating these processes reduces administrative burdens and allows more time for patient care.
- **Training and familiarity:** Ensure that all practice staff are familiar with the features and security protocols. Comprehensive training for reception staff, healthcare assistants, and GPs helps maintain a consistent, effective use of the platform.

4. Ensuring compliance and security

Patient confidentiality is paramount in healthcare. It is essential that digital platforms are compliant with GDPR and provide a secure method of communication:

- **Patient consent:** Obtain consent to use SMS and digital communication. Inform patients about the types of messages they might receive and assure them of the platform's security.
- **Data Protection:** the use of encryption to protect patient data. However, it's crucial that all users are mindful of data handling best practices, ensuring that patient information is only shared as necessary.

5. Evaluating and improving use

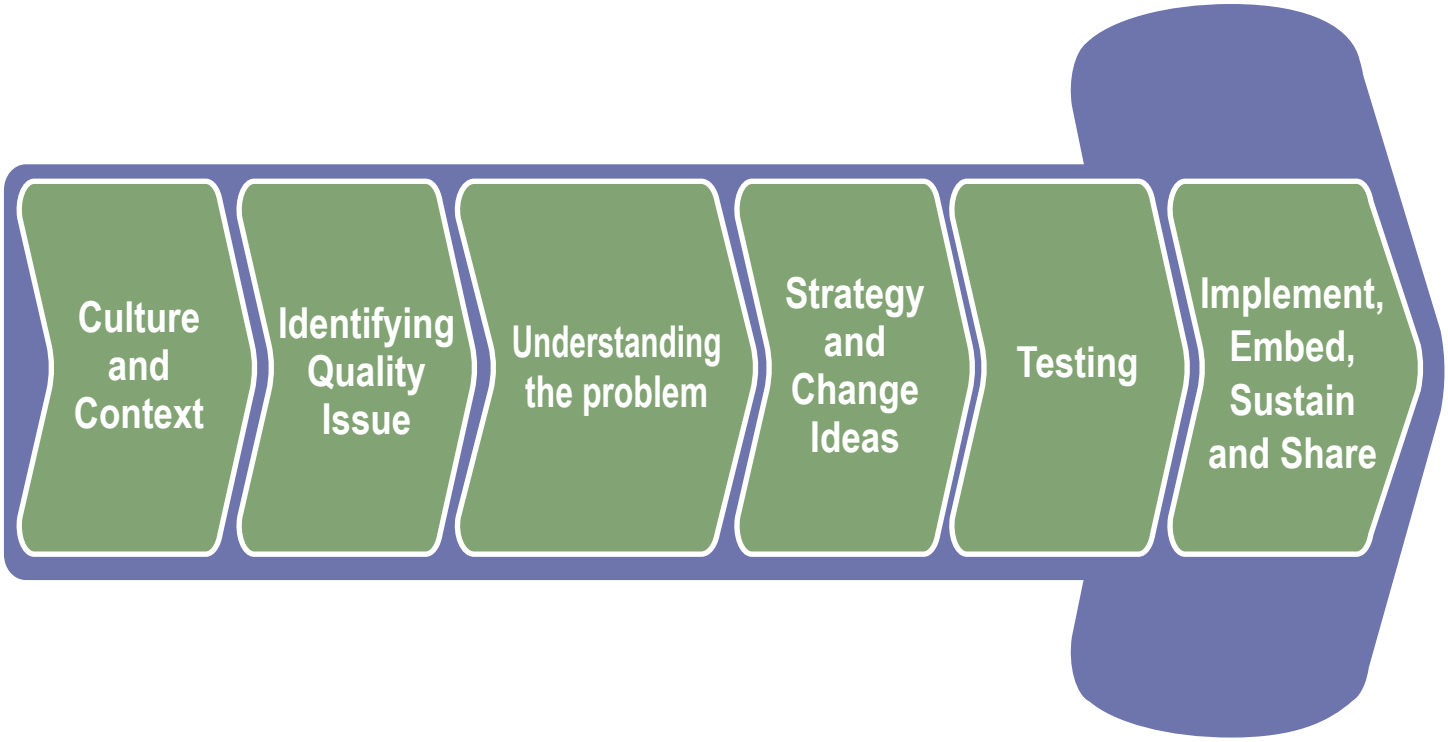
Periodically assess how the digital platform is being used in the practice:

- **Collect deedback from patients and staff:** Regularly gather feedback to identify areas for improvement. Patients' insights on SMS reminders, remote consultations, or document-sharing functions can be invaluable for enhancing service delivery.
- **Stay updated with new features:** Providers continually releases new tools to adapt to changing healthcare needs. Staying updated with these developments can provide your practice with new capabilities to support patient care.

Conclusion

Digital platforms are a powerful tool for modernising patient communications, increasing accessibility, and reducing the administrative workload within GP practices in Northern Ireland. By following good practices, healthcare providers can ensure they are using the features and functions effectively and securely, enhancing the overall patient experience and streamlining practice operations.

Quality Improvement in General Practice



The image shows the various stages a Practice goes through on the quality improvement pathway. From culture and context through to understanding the problem, testing best practice and then implementation.

'Every system is perfectly designed to get the results it gets'

W. Edwards Deming

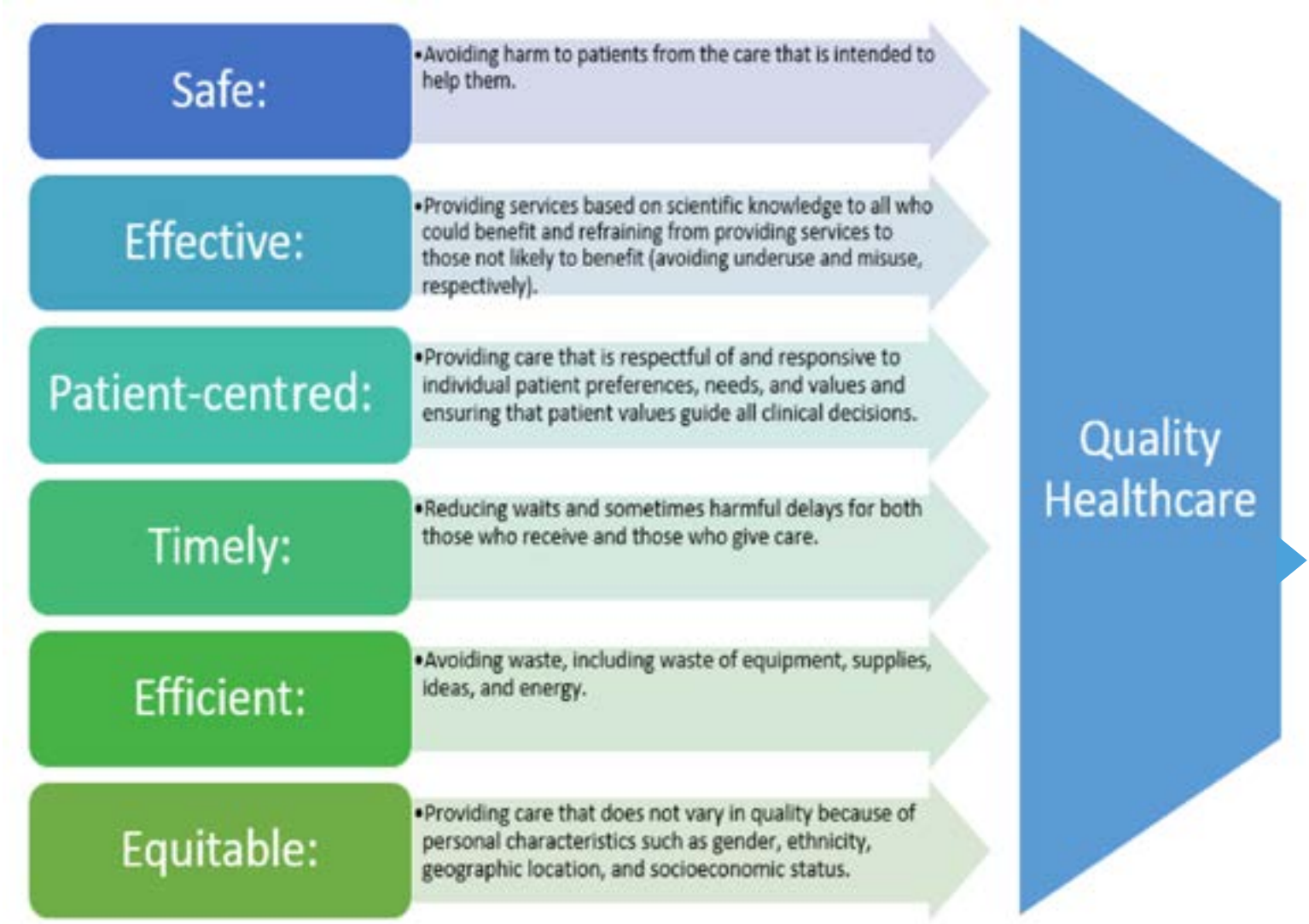
What Is Quality Improvement?

Quality improvement is:- 'A commitment to continuously improving the quality of healthcare, focusing on the preferences and needs of the people who use services'

It encompasses a set of values (which include a commitment to self-reflection, shared learning, the use of theory, partnership working and leadership) and a set of methods (which include measurement and benchmarking and a set of tools and techniques).

In General Practice, QI focuses on enhancing patient care, increasing efficiency and fostering a culture of continuous improvement. By using data and team collaboration, QI empowers practices to adapt to challenges and meet the evolving needs of patients.

What is high quality care?



Quality improvement in healthcare is an attitude, an approach, a method and a visible cultural commitment within our workplaces to find ways to incrementally improve care and the healthcare system in which it is delivered.
No-one knows the system better than the people working within it.

The graphic outlines the six key elements of high quality care. It must be safe, effective, patient-centred, timely, efficient and equitable.

A QI approach calls on us to combine:

- Curiosity and always asking ‘why?’. We want our teams to be curious and notice waste; to stop doing what doesn’t work.
- Not being afraid to test new ideas; to figure out things that work or don’t.
- Use the systematic approach of an engineer. We want systems thinking rather than short term ‘solutions’ and work arounds.
- The mutual commitment of great teams to make the system work better for everyone. Quality Improvement requires the commitment of the whole practice team.

A perpetual commitment to QI within our teams will incrementally help us to make healthcare safer and more effective, patient-centred, timely, efficient and equitable.

One of the biggest barriers to change is time. For some, finding time seems like an impossible ask in the current climate. However, we need to allow ourselves the time to engage in quality improvement activity as this will ultimately create more time as systems become more efficient and effective. The aim is to slowly and deliberately engage and embed a QI culture into routine clinical care.

Culture and context

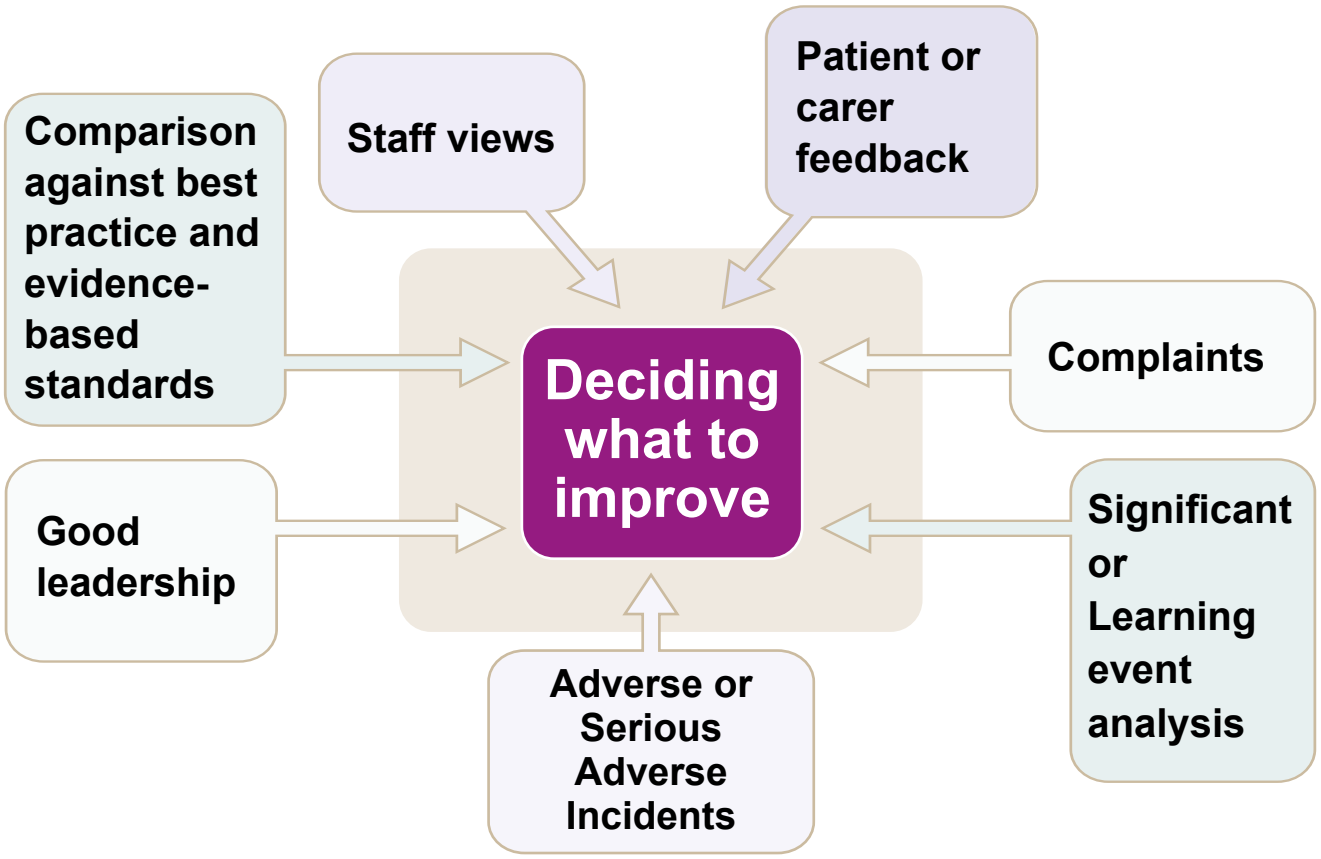
Before engaging in any QI activity, it is important that there is an understanding of the culture and context required to ensure QI ideas can succeed.

Creating the right conditions for quality improvement

Identifying a quality issue

Any quality improvement idea should aim to result in improvement in one of the six domains of quality and should align with wider practice/regional priorities. Engaging with all members of the practice team and beyond from the start will increase the likelihood of success. Inclusion of the whole team will allow the system to be considered from all points of view.

It is also important that all members of the team understand the 'why' behind improvement activity in order to maximise engagement. Improvement is 90% hearts and 10% minds. Ensure to include the patient voice in any improvement activity.
Stakeholder analysis



This image highlights the key issues involved in deciding what to improve at a practice.

Understanding the problem

Gathering information

After establishing an area of potential improvement, a better understanding of the problem is required. The first step is to gather baseline information or data to see the current position. Often, simple searches are available on the clinical system, or can be easily developed. Keeping it simple is the key to success.

Systems thinking

General Practice operates within a complex adaptive system, characterised by numerous interconnected components that interact in dynamic and often unpredictable ways.

Key Features of a complex adaptive system:

- Interdependence: Changes in one part of the system can have ripple effects throughout.
- Adaptability: The system can adapt to changes in its environment.
- Self-organisation: The system can organise itself without external control.

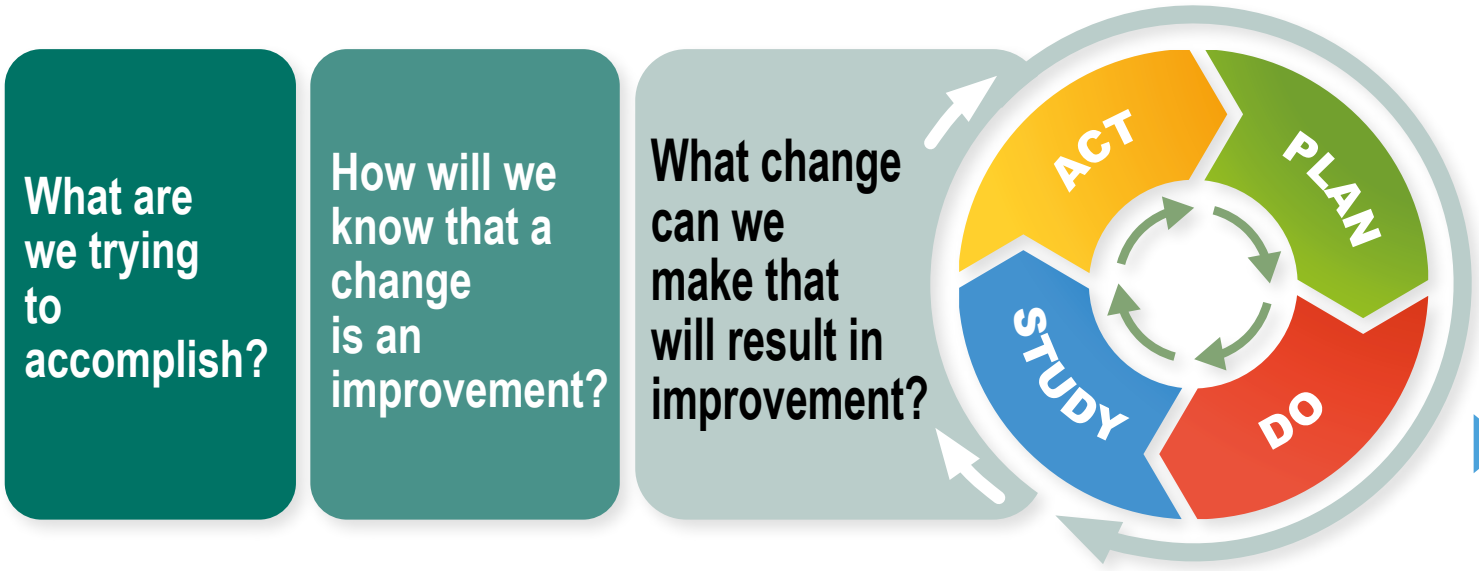
Understanding these characteristics is crucial for effective QI, as it helps practice teams anticipate the potential impacts of changes and adapt their strategies accordingly.

Before deciding on the solution to the problem, it is important to understand the current system. This knowledge will allow the practice team to identify improvement ideas. There are a number of tools available that can help with this. Each tool serves a specific purpose and is best used in collaboration with the whole practice team. (Understanding systems)

QI	Tool	What/Why
Process Mapping	A flow chart or diagram that visually represents the steps in a process, including decision points, inputs, outputs, and interactions.	Helps teams understand how a process currently works, identify inefficiencies, and pinpoints areas for improvement. It is particularly useful for standardising workflows and improving communication.
Fishbone Diagram	A structured diagram that organises potential causes of a problem into categories (e.g. People, Processes, Equipment, Environment, Materials, management). The 'Fishbone' structure helps visualise relationships between causes and effects.	This tool is used to systematically explore all possible causes of a problem, ensuring that teams address root causes rather than symptoms. It encourages collaborative problem-solving and comprehensive analysis.
Pareto Chart	A bar chart that ranks factors (e.g., types of errors, causes of delays), ordered from most to least significant based on the Pareto Principle (80/20 rule).	Helpful tool to prioritise issues by identifying the most significant factors contributing to a problem. Helps focus efforts on the areas that will have greatest impact.
5 Whys	A simple, iterative questioning technique used to explore the cause-and-effect relationships underlying a problem. Each answer forms the basis of the next question.	Helps to drill down to the root cause of a problem by repeatedly asking 'Why?'. Helps uncover deeper issues rather than surface-level symptoms.

Strategy and change ideas

The IHI Model for Improvement



The Model for Improvement is a widely used framework in quality improvement that provides a structured approach to achieving meaningful and sustainable improvements in processes, systems and outcomes.

It consists of two main components:

1. **Three fundamental questions**
2. **The Plan-Do-Study-Act (PDSA) Cycle**

Three fundamental questions

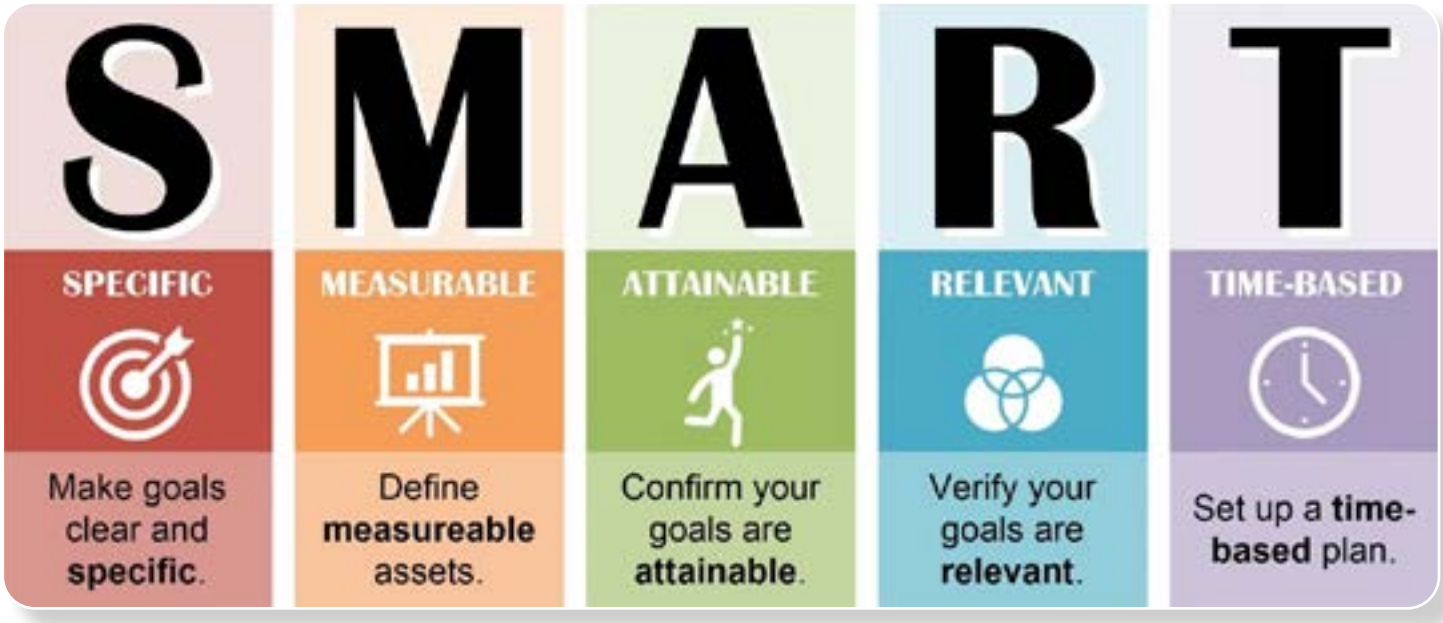
Before making any changes the Model for Improvement encourages teams to answer three key questions to guide their efforts:

What are we trying to accomplish?

‘Soon is not a time, Some is not a number’ *Don Berwick.*

This question helps to define the aim or goal for the improvement effort.
It should be a ‘SMART’ aim; What you want to achieve, by how much, by when.
(SMART Aim)

Example: Reduce the percentage of missed appointments (DNAs) from 20% to 5% by December 2025



This image is decorative.

How will we know that change is an improvement?

This question focuses on identifying measures that will be used to track progress and determine whether the changes are leading to improvement. It is important to think about what data to collect, how to collect it, when to collect it and who is going to collect it.

There are three types of Measurement.

Outcome Measures	Process Measures	Balancing Measures
Typically represent the patient.	Helps you determine if you are doing the right things to achieves your outcome measure.	Helps you determine if the changes you are introducing in one part of your system are impacting another part of your system.
Ensures QI work addresses the six domains of quality.	Act as a 'pulse check' by assessing the inner workings of your system.	Define at the outset of your project and measured throughout the project life cycle.
Helps you determine whether or not your Change Ideas are leading to system improvement.	Helps you to understand if your changes are having a positive or negative impact.	
Directly related to Aim Statements.	Used to determine the efficacy of your change ideas.	
Help you determine whether or not you are achieving your intended outcomes.	Identified after you have developed change ideas.	

Example:

AIM: Reduce the percentage of missed appointments (DNAs) from 20% to 5% by December 2025

Outcome Measure: Percentage of missed appointments

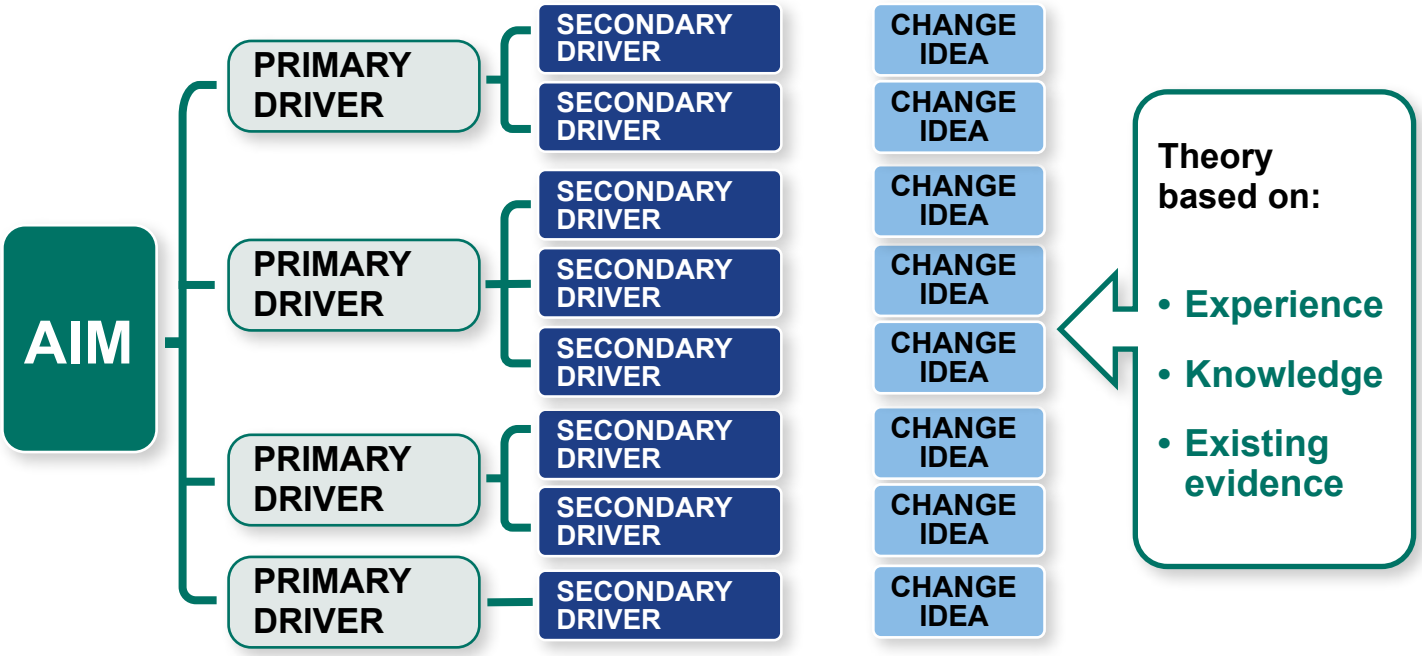
Process Measure: Number of reminder calls made

Balancing Measure: Staff workload related to reminder calls.

What changes can we make that will result in improvement?

The tools used in understanding the system will have identified change ideas. These can be put into a Driver Diagram which can then be used to plan improvement activities.

Driver Diagram: Visually presents a team's theory of how an improvement goal will be achieved. It articulates what parts of the system need to change, and in which way, and includes ideas to make this happen. It is used to help plan improvement project activities and ensure team engagement.



Aim	Primary Driver	Secondary Driver	Change Ideas
No more that one or two sentences that clearly state what will be improved. It includes: • How much improvement will be achieved. • Who the improvement is for. • When will be improvement be achieved	No more than 2-5 sentences of the most important influences on the aim. These are key components of the system that need to change. They are often associated with the process, infrastructure, norms (culture) and people.	Break primary drivers down in to natural subsections or processes. They provide more detail on where interventions to positively influence the primary drivers are required.	The specific ideas that teams can test to see if they influence the secondary drivers and ultimately the aim.

Example:

Potential change ideas:

- SMS reminders: Send patients an SMS reminder 24–48 hours before their appointment. Include instructions on how to cancel or reschedule if necessary.

- Phone call reminders: For high-risk patients (e.g., those with multiple DNAs), a personal call from a staff member can serve as a stronger reminder.

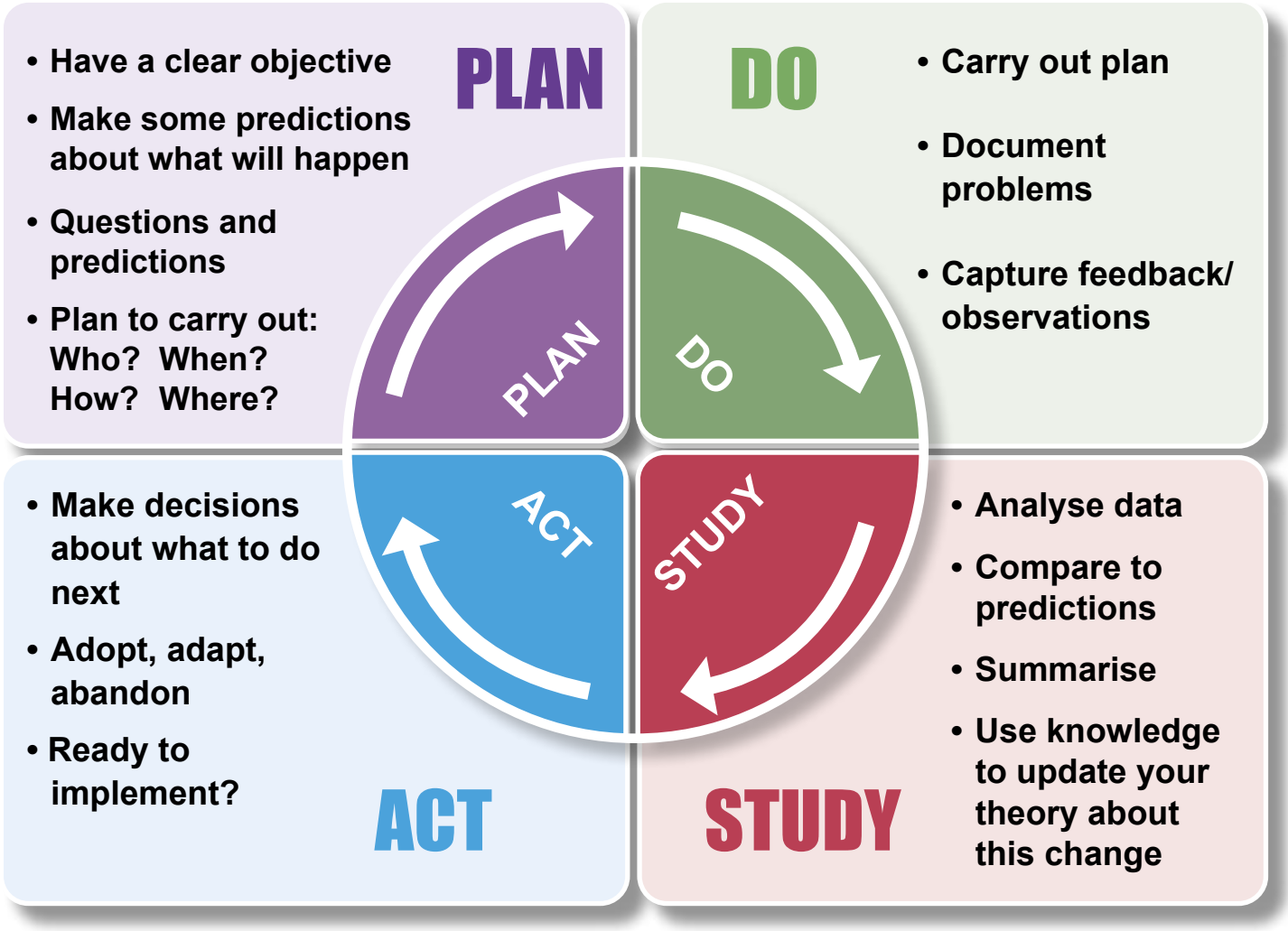
- Online cancellation systems: Make it easy for patients to cancel or reschedule appointments online, reducing the friction involved in contacting the practice by phone.

- Appointment flexibility: Offer patients more flexibility in their appointment times to reduce the likelihood of DNAs for those with work or caregiving commitments.

- Length of advance booking: 75% of DNAs occur when the time between booking and attending an appointment is more than one day. Consider reducing length of time to one day.

Testing

The Plan/Do/Study/Act (PDSA) cycle is an iterative, four step process for testing and implementing changes. It allows teams to start small, learn from each test and refine their approach before scaling up. PDSA cycle. The PDSA image outlines the steps involved in the cycle.



Example:

- **Plan:** Identify a specific, manageable intervention (e.g., SMS appointment reminders) and set clear objectives for what you hope to achieve.
- **Do:** Implement the intervention on a small scale (e.g., trial SMS reminders for one type of clinic or for a specific group of patients).
- **Study:** Monitor the impact of the intervention by comparing the DNA rates before and after implementation.
- **Act:** If the intervention is successful, scale it across the entire practice. If not, adjust and re-test.

Run Chart: A tool for tracking progress over time

A run chart is a simple yet powerful QI tool used to display data over time. It helps teams visualise trends, patterns and variations in a process or outcome, making it easier to identify whether changes are leading to improvement.

It is a line chart that plots data points in chronological order, with time on the horizontal(x) axis and the measure of interest on the vertical(y) axis.

A central line, the median of the data, is added to help identify shifts or trends.

This is an image of a run chart. Further information on how to use a run chart is outlined in the next section.

Why use a run chart?

Run charts are valuable because they:

1. Visualise trends: Show how a process or outcome changes over time.
2. Detect shifts or patterns: Help identify improvements, deteriorations or unusual variations in data.
3. Monitor progress: Provide a clear way to track the impact of changes or interventions.
4. Support decision making: Enable teams to make data driven decisions about whether to adapt, adopt or abandon a change.

How to create a Run chart

1. Collect data: gather data points for the metric of interest over time. Ideally gathering historical or baseline data will help detect a change sooner.
2. Plot the data: Enter the date/time and the metric on a Run Chart Template. This will automatically calculate the median.
3. Analyse the chart: Look for trends, shifts, or patterns in the data.

Interpreting a run chart (run chart rules)

By plotting data over time patterns can start to emerge which can help identify meaningful changes. Once you have at least 10-12 data points there are four simple run chart rules you can use:

1. Shift: occurs when 6 or more consecutive data points fall either above or below the median. This suggests a significant change in the process.
2. Trend: is identified when 5 or more consecutive data points are consistently increasing or decreasing. This indicates a gradual change over time.
3. Random variation(runs): if the data points fluctuate randomly around the median without shifts or trends, the process is considered stable and no significant change has occurred.
4. Astronomical point: characterised by data points that are obviously different from all or most of the other values.

Advantages of run charts:

- Simple and easy to use: requires no complex statistical analysis.
- Visual and intuitive: easy to understand and interpret.
- Real time monitoring: allows teams to track progress and make timely adjustments.
- Versatile: can be used for a wide range of metrics and processes.

Implementing and sustaining quality improvement in General Practice

Quality improvement is not just about identifying problems and testing solutions; it is also about implementing changes effectively and sustaining improvements over time.

The following focuses on the critical steps for successfully implementing QI initiatives and ensuring they become embedded in everyday practice.

It covers strategies for overcoming barriers, engaging stakeholders, and creating a culture of continuous improvement.

Key Steps for implementing QI initiatives

1. Engage stakeholders

Why: Successful implementation requires buy-in from all stakeholders, including clinicians, staff, patients, and leadership.

How:

- Communicate the aim and benefits of the QI initiative clearly.
- Involve stakeholders in the planning and decision-making process.
- Address concerns and provide opportunities for feedback.

2. Develop a clear implementation plan

Why: A well-structured plan ensures that the initiative is rolled out systematically and efficiently.

How:

- Define roles and responsibilities for team members.
- Set a timeline with milestones and deadlines.
- Use tools like Gantt Chart to track progress.

3. Pilot the change

Why: Testing the change on a small scale reduces risk and allows for adjustments before full implementation.

How:

- Use the Plan-Do-Study-Act (PDSA) cycle to test the change in a controlled environment.
- Collect data to assess the impact and identify any unintended consequences.

4. Scale up the change

Why: Once the change has been successfully piloted, it can be expanded to other areas or the entire practice.

How:

- Adapt the change based on lessons learned during the pilot phase.
- Provide training and support to staff as the change is rolled out.
- Monitor progress closely to ensure the change is being implemented as intended.

5. Monitor and evaluate

Why: Continuous monitoring ensures that the change is achieving the desired outcomes and allows for timely adjustments.

How:

- Use run charts to track key metrics over time.
- Regularly review data and share results with the team.
- Conduct periodic evaluations to assess the long-term impact of the change.

Strategies for sustaining QI improvements

1. Embed changes into standard practice

Why: To ensure that improvements are maintained, they must become part of the routine workflow.

How:

- Update policies, procedures, and protocols to reflect the new practices.
- Integrate the changes into staff training and onboarding programs.
- Use checklists or reminders to reinforce the new behaviours.

2. Foster a culture of continuous improvement

Why: A culture that values QI encourages ongoing innovation and problem-solving.

How:

- Celebrate successes and recognise team members' contributions.
- Encourage staff to identify and address new areas for improvement.
- Provide ongoing training and resources to support QI efforts.

3. Engage leadership

Why: Leadership support is critical for sustaining QI initiatives and allocating necessary resources.

How:

- Ensure leaders are visible champions of the QI initiatives.
- Regularly update leadership on progress and challenges.

4. Use data to drive decision-making

Why: Data provides objective evidence of the impact of changes and helps identify areas for further improvement.

How:

- Establish a system for collecting and analysing data regularly.
- Share data with the team to maintain transparency and accountability.
- Use data to identify new opportunities for improvement.

5. Build resilience and adaptability

Why: External factors (e.g., policy changes, staff turnover) can disrupt QI efforts, so practices must be prepared to adapt.

How:

- Develop contingency plans for potential challenges.
- Encourage flexibility and innovation in problem-solving.
- Regularly review and update QI initiatives to ensure they remain relevant.

Overcoming barriers to implementation and sustainability

1. Resistance to change

Barrier: Staff may be reluctant to adopt new practices due to fear of the unknown or lack of understanding.

Solution:

- Communicate the benefits of the change clearly.
- Involve staff in the planning and implementation process.
- Provide training and support to build confidence.

2. Lack of resources

Barrier: Limited time, funding, or staff can hinder QI efforts.

Solution:

- Prioritise QI initiatives based on their potential impact and feasibility.
- Use technology to streamline processes and reduce workload.

3. Inconsistent leadership support

Barrier: Without strong leadership, QI initiatives may lose momentum.

Solution:

- Demonstrate leadership early and often in the QI process.
- Demonstrate the value of QI through measurable outcomes.
- Build a coalition of QI champions within the practice who can drive the initiative.

4. Data collection challenges

Barrier: Collecting and analysing data can be time-consuming and complex.
Solution:

- Use simple tools like run charts or check sheets to track data.
- Automate data collection where possible.
- Provide training on data analysis and interpretation.

Implementing and sustaining QI initiatives in general practice requires a systematic approach, strong stakeholder engagement, and a commitment to continuous improvement.

By embedding changes into standard practice, fostering a culture of innovation, and using data to drive decision-making, practices can achieve lasting improvements in patient care and outcomes.

Overcoming barriers such as resistance to change and resource limitations is essential for ensuring the long-term success of QI efforts. With the right strategies and support, general practices can create a sustainable model for delivering high-quality care.

The Importance of sharing quality improvement work in General Practice

Sharing QI work is a critical component of improving healthcare systems and outcomes. It fosters collaboration, accelerates learning, and ensures that successful initiatives are adopted widely, benefiting more patients and practices.

Below, we explore why sharing QI work is important, the role of Federations, Practice-Based Learning (PBL), Practice Manager Groups, and General Practice Northern Ireland (GPNI).

Why is it important to share QI work?

1. Accelerates learning and improvement

- Sharing QI work allows other practices to learn from successful initiatives, avoiding the need to “reinvent the wheel.”
- It provides real-world examples of what works (and what doesn’t), helping others implement changes more efficiently.

2. Encourages collaboration

- Sharing fosters a culture of collaboration, where practices work together to solve common problems.
- It builds networks of support, enabling practices to share resources, tools, and expertise.

3. Improves patient outcomes

- When successful QI initiatives are shared and adopted widely, more patients benefit from improved care and outcomes.
- It helps reduce variation in care quality across practices and regions.

4. Builds a culture of continuous improvement

- Sharing QI work normalises the idea that improvement is an ongoing process, encouraging more practices to engage in QI.
- It inspires others to start their own QI projects by demonstrating tangible results.

5. Supports evidence-based practice

- Sharing QI work contributes to the evidence base for effective interventions, helping to inform policy and practice at a broader level.
- It provides data and insights that can be used to advocate for systemic changes.

6. Recognizes and celebrates success

- Sharing QI work acknowledges the efforts of teams and individuals, boosting morale and motivation.
- It highlights the impact of QI, encouraging further innovation and engagement.

The role of federations, PBL, and practice manager groups in sharing QI work

Federations

Federations, are groups of practices that come together, to collaborate on shared goals, such as improving patient care, enhancing efficiency, and addressing common challenges. They can often act as a bridge between individual practices and larger healthcare systems.

How can Federations support QI Sharing:

1. Facilitating collaboration:

- Federations provide a platform for practices to share QI work, learn from each other, and collaborate on joint initiatives.
- They organize meetings, workshops, and events where practices can present their QI projects(see below).

2. Providing resources and support:

- Federations often have access expertise that can support QI efforts.
- They help practices develop and implement QI initiatives, ensuring they are sustainable and scalable.

3. Scaling successful initiatives:

- Federations can help spread successful QI projects across multiple practices, ensuring that more patients benefit.
- They can act as a central hub for disseminating best practices and tools.

4. Advocating for systemic change:

- Federations can use aggregated QI data to advocate for policy changes or additional resources at a regional or national level.

Practice-based learning (PBL)

PBL

PBL represents a key potential mechanism for sharing QI work at a grassroots level.

How can PBL support QI sharing:

1.Peer learning:

- Practices can present their QI initiatives to the group, providing an opportunity for feedback and discussion.
- This peer learning approach helps refine and improve QI projects.

2. Collaborative problem-solving:

- Allows the opportunity to work together to address common challenges, sharing resources and expertise.
- Facilitates the adaptation and implementation of successful QI initiatives from other practices in the Federation.

3. Building local networks:

- PBL supports the fostering of strong relationships between practices, creating a supportive environment for QI.

Practice Manager groups

Practice managers play a critical role in implementing QI initiatives, and their networks are a valuable resource for sharing QI work.

How Practice Manager groups support QI sharing:

1. Sharing good practices:

- Practice managers can share practical tips and tools for implementing QI initiatives, such as scheduling systems or patient communication strategies.

2. Providing leadership and support:

- Practice managers often lead QI projects within their practices and can mentor others in their networks.

3. Facilitating collaboration:

- Practice manager groups can organise joint QI projects or share resources across practices.

General Practice Northern Ireland (GPNI) as a way of sharing QI work

GPNI plays a key role in supporting general practice in Northern Ireland, providing resources, training, and opportunities for collaboration. It plays a central role in sharing QI work across the region.

How GPNI supports QI sharing:

1. Developing resources:

- GPNI creates and disseminates resources, such as toolkits and guidelines.

2. QI bitesize

Strategic Planning and Performance Group (SPPG) and GPNI have collaboratively developed 'QI Bitesize', a series of short, accessible practice stories, that provide practical guidance on how to implement QI initiatives.
They take the following format:

- What was the problem?
- How did we approach this from a QI perspective?
- What were the change ideas?
- What was the experience (good and bad / barriers and solutions)?
- What was the outcome for patients and practice?
- What is the future - is there an ongoing improvement or cultural legacy?

Request for consent to share QI work

Why does SSPG request consent to share QI work?
SPPG recognises the importance of sharing QI work to drive improvement across the healthcare system Quality Improvement in Primary Care- Consent to share. By requesting practices to consent to the upload and sharing of their QI work, SPPG aims to:

1. Create a central repository of QI projects:

- A centralised database of QI initiatives allows other practices to access and learn from successful projects.
- It ensures that valuable knowledge is not lost but is instead preserved and made available to others.

2. Promote transparency and collaboration:

- Sharing QI work openly fosters a culture of transparency and collaboration, where practices are willing to learn from each other.
- It encourages a collective approach to solving healthcare challenges.

3. Support the development of QI resources:

- By aggregating QI work, SPPG can develop comprehensive resources, such as toolkits, guidelines, and case studies, to support other practices.
- These resources help standardise QI methodologies and ensure consistency in implementation.

4. Highlight the impact of QI:

- Sharing QI work demonstrates the tangible benefits of improvement initiatives, encouraging more practices to engage in QI.
- It provides evidence of the value of QI, which can be used to secure funding and support for future projects.

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