

Evidence Search results	
Search topic:	Long term high frequency attenders in primary care
Date requested:	18/09/2025
Date completed:	16/12/2025
Search completed by:	Roxanne Hart
Number of results selected:	49
Time taken:	24 hours

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Summary of results
<p>Persistent frequent attenders</p> <p>Santalahti et al 2021 A typical pFA seems to be a woman, aged about 55 years with depressive episodes, asthma or COPD, and lower back pain.</p> <p>Malins et al 2016 UK study addresses those who are likely to continue frequent attendance for several years by offering cognitive behaviour therapy (CBT) to long-term frequent attenders. This feasibility study suggests that long-term frequent attendance can be reduced and general mental health improved by offering CBT.</p> <p>Patel et al 2015 persistent frequent attendance is associated with poor QOL, high clinical complexity and diverse and often persistent physical and mental multimorbidity. They suggest a brokerage model with GPs working in close liaison with skilled psychological therapists is required to manage such persistent complexity.</p> <p>Pymont et al 2015 Persistent frequent attendance was specifically associated with gender, baseline reports of depression, self-reported physical conditions and disability, and medication use.</p> <p>Koskela et al 2010 In our model, the most influential predictive risk factors for persistent frequent attendance in an FA population were female gender, body mass index above 30, former frequent attendance, fear of death, alcohol abstinence, low patient satisfaction, and irritable bowel syndrome.</p> <p>Smits et al 2009's study suggested that 1 out of every 7 1 year frequent attenders becomes a persistent frequent attendee. PFAs are diagnoses with more somatic diseases, more social problems, psychiatric problems, and medically unexplained symptoms.</p>



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Due to the paucity of research on long term frequent attenders a more broad search on frequent attenders was conducted and follows:

Scope of the issue, research has suggested that frequent attendance is increasing all the time, with GP face to face consultations for frequent attenders (FAs) increasing from a median of 38% in 2000-2001 to a median of 43% in 2018-2019. Frequent attenders progressively contributed to increased workload in general practices across the UK from 2000 to 2019 ([Kontopantelis et al 2021](#)). [Chappell et al 2023](#) Although frequent attenders represent just 10% of the patient population, they consistently accounted for almost a third of all requests. The persistence of frequent attendance may indicate that FAs' primary care is fragmented and not effective in meeting their needs and maintaining overall wellbeing. These reasons [...] can lead to seeking help elsewhere from the health system. [Virtanen et al 2023](#)

Frequent attenders are not a heterogeneous group so it is worthwhile spending time digging into patterns of usage at your practice and establishing who these patients are. The frequent attenders may be quite diverse in their age, health status, problems etc.

[Haroun et al 2016](#)'s systematic review concluded that despite frequent attendance being a regular phenomenon in general practice it does not seem to allow for a uniform approach but instead should be viewed as a trigger for stratification and differentiation according to individual patient's underlying conditions. Although it is opinion based you may find [this blog](#) helpful in terms of suggesting a way to begin to assess your high frequency users, or for more official guidance [see this from NHS England in 2022](#). There has also been a suggestion that frequent attendance in primary care is an early warning sign of A&E attendance also (British Red Cross, [Nowhere else to turn](#)). Or patients attending frequently in primary care may already be presenting frequently at A&E also.

For this reason you may find it helpful to consider partnerships in creating a solution for your high intensity users. For example locally [there is an award winning service being delivered at SFT](#). In its first year supporting 141 HIU patients, there has been a 48% reduction in the use of A&E by this group, saving an estimated £250,000. There is a contacts section if you wish to get in touch with the people running this program. [Here is an example from a PCN in Camden](#) who looked at how A&E attendance compared with GP attendance and put an intervention into place consisting of care coordinators, advanced practitioners, health and wellbeing coaches and social prescribers – to provide 19 hours of care per patient per year. This case study will be of interest if [deprivation](#) is a factor in your population.

NHS Confederation, [the future of primary care](#) contend that a new model is needed which complements the NHS bio-medical model with a psycho-social approach. This would focus on seeing patients 'in the round', helping them solve whatever problems are most standing in their way.

A thread running through many of the interventions seems to be a non judgemental approach [Pulse 2024](#); [Malins et al 2016](#); [King's Fund 2019](#) "Patients attribute much of the value of the services to the non-judgemental and relational nature of the support."

Some attempt has been made to characterise from the literature a picture of frequent attenders however as also shown in the research frequent attenders are heterogeneous as a group so this section may not apply to your population. Also a portion of this literature is from other countries. Nevertheless [you may find the table I created helpful for getting an overall picture.](#)

[Hajek et al 2021](#) systematic review of longitudinal studies found frequent attendance in primary care to be associated with lower age and unemployment.

[Margo-Dermer et al. 2019](#) Psychological distress is prevalent in frequent users and has a significant association with frequent use

[Hajek et al 2017](#) In our study, frequent attendance in primary care was positively associated with increased perceived stress and a decreased optimism

[Baudier et al. 2023](#) study from Switzerland introduced some interesting concepts such as the idea that GP and practice characteristics may also play a part in patterns of frequent attendance. To this point they found that shared medical records were negatively associated with consultation frequency, whereas long GP working hours (≥ 50 h) per week was positively associated with consultation frequency.

[Cruwys et al 2018](#) Social isolation predicts frequent attendance in primary care.

[Sirois et al 2023](#) found that people who experience loneliness make a greater number of visits to primary-care practitioners

[Nielsen et al 2025](#) These frequent attenders are in general terms characterised by being female, aged >65 years, having 20 annual contacts to the GP clinic, and having ≥ 10 diagnoses.

The European literature on frequent attendance in later life or among the ‘oldest old’ was linked with ill health, chronic disease, frailty, and widowhood. [Buczak-Stec et al 2022](#) and [Welzel et al 2017](#). We don’t have a UK specific recent picture on factors driving frequent attendance in the oldest old in primary care.

[Buczak-Stec et al 2022](#) in the cohort of the ‘oldest old’ who were persistent frequent attenders, frailty, chronic disease, and widowhood were associated factors.

[Welzel et al 2017](#) found that frequent attendance in later life is linked with severe ill health and a need for treatment.

Interventions:

Social prescribing:

[Lynch et al 2022](#) this small study with 21 participants looked at social prescribing as an intervention for frequent attenders. They found a direct cost saving of £78.37 per participant over the 37 months of the intervention.

[Kiely et al 2022](#) conducted a systematic review of social prescribing link workers on health outcomes and costs. They found: Social prescribing link workers may have little or no impact on primary care visits.

It is unknown if social prescribing link workers reduce hospitalisations because the certainty of the evidence is very low.

Social prescribing link workers may improve self- rated health

Training intervention for physicians:

[Ramos et al 2024](#) training was carried out for 11 primary care doctors (Spain) who had patient lists totalling 20,064 patients. 14% of patients limited the frequency of their visits after the physicians had completed the training. There was an average decrease of 3.1 visits per year by the patients of the physicians who had undergone the training.

[Bellón et al 2008](#)’s Spanish study which delivered 15 hours training to GPs on biopsychosocial, organisational, and relational approaches. The new intervention resulted in a significant and relevant reduction in frequent-attender consultations.

[Barnes et al 2019](#) undertook a trial at 6 UK practices and trained GPs to use the Background, Affect, Trouble, Handling, Empathy (BATHE) technique during consultations. Analysis revealed *some* movement towards higher levels of patient activation, and lower consulting rates in the intervention group.

Targeted Health Promotion

[Kolster et al 2023](#) Since 2015 two nature guides, who are not medically trained, have organized 8-week rehabilitation programs for patients who frequently visit the health center in close co-operation with a team of doctors and nurses. This study was an attempt to formally review impact of the program. It improved sleep, mental wellbeing, mood, energy, perceived ability to deal with problems, self esteem and closeness to others. They either did not track or did not report effect on frequency of attendance.

CBT

[Malins et al 2016](#) UK study addresses those who are likely to continue frequent attendance for several years by offering cognitive behaviour therapy (CBT) to long-term frequent attenders. This feasibility study suggests that long-term frequent attendance can be reduced and general mental health improved by offering CBT. In terms of how many sessions are necessary to have an impact on attendance, [Luutonen et al 2019](#) showed that a single session of CBT is not useful in reducing GP visits or improving mental well-being of long-term frequent attenders.

Nurse led health coaching

[Kivelä et al 2020](#)'s study suggests that nurse-led health coaching may lead to an improvement in the health-related quality of life and blood pressure among frequent attenders.

Case management

[Hudon et al 2019](#) describe the necessity of identifying patients most likely to benefit from case management. They recommend high intensity (ie, small caseload, frequent face-to-face contact with the patient, initial assessment in person, and/or multidisciplinary team meetings) and developing care plans with multiple types of care providers to help improve patient outcomes.

Group Intervention

[Haslam et al 2019](#) put in place a group intervention and found it did reduce symptoms of loneliness however this did not translate into a statistically significant reduction in GP visits.

Whole system

[Hudon et al 2023](#) Integrated CM between primary care clinics and hospitals is a promising innovation to improve care integration for people with complex needs who frequently use healthcare services

[The Strategy Unit 2022](#), What are the recommendations and key success factors of a high intensity use service

[Health equity evidence centre 2024](#), what works: finding better ways to support people who frequently attend A&E

[British red cross](#) recommend social prescribing and also a whole system approach across the local area.

[Transformation Partners](#), Non clinical care coordinator intervention showed a 30% reduction rate in ED attendances (400 reduced attendances to ED within a five month period).

Telemedicine and electronic consultation systems:

[Virtanen et al 2023](#) created 3 profiles of frequent attenders based on their ability to self-manage and then created profiles based on acceptance and use of telemedicine services. [Leung et al 2021](#) intervention focused on high frequency users of an electronic consultation system in general practice.

Expertise in the local area: [There is an award winning service being delivered at SFT](#). In its first year supporting 141 HIU patients, there has been a 48% reduction in the use of A&E by this group, saving an estimated £250,000.

I hope this is helpful. Please contact the Library if you would like any further information or would like to revise your search: library@somersetft.nhs.uk.

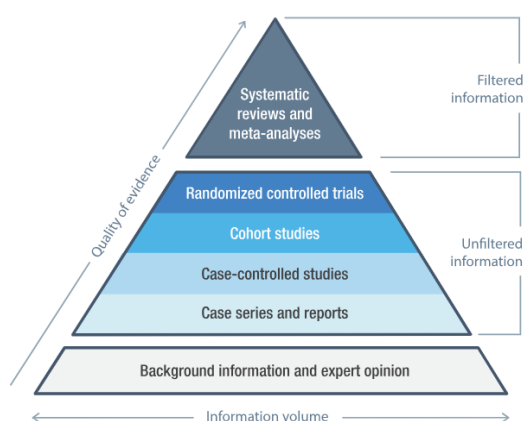
We would like to capture information about the impact this evidence search has had on your practice or decision—making. We can use this to promote this service to others within the Trust and it also ensures this service continues to develop and meet the needs of everyone who uses it. Please take a few moments to complete our short [impact survey](#).

Search results

Full-text access:

Abstracts are provided where available. To check if the full-text of an article is available, click on the links provided and log in with your NHS OpenAthens username and password, if prompted. You can register for an NHS OpenAthens username and password at: <https://openathens.nice.org.uk>. If there is no link, or the full-text is not available to you, please send the details of the article to library@somersetft.nhs.uk or and we will try and find it for you.

For your information, and to help you assess the quality of the research, here is a [hierarchy of the quality of evidence](#) that you may find useful:



Journal articles on PERSISTENT frequent attenders

Research on frequent attenders

- [Case studies](#)
- [Characteristics and associations with frequent attendance \(FA\)](#)
 - [Table of factors associated with usage of primary care](#)

- [Interventions](#)
- [Telemedicine and electronic consultation systems](#)
- [Whole system approaches](#)
- [Contacts](#)

Journal articles on persistent frequent attenders

Santalahti, A., Luutonen, S., Vahlberg, T., Moen, H., Salanterä, S., & Rautava, P. (2021). [How GPs can Recognize Persistent Frequent Attenders at Finnish Primary Health Care Using Electronic Patient Records.](#) *Journal of Primary Care & Community Health*, 12.

A typical pFA seems to be a woman, aged about 55 years with depressive episodes, asthma or COPD, and lower back pain

Malins, S., Kai, J., Atha, C., Avery, A., Guo, B., James, M., Patel, S., Sampson, C., Stubley, M., & Morriss, R. K. (2016). [Cognitive behaviour therapy for long-term frequent attenders in primary care: a feasibility case series and treatment development study.](#) *British Journal of General Practice*, 66(651), e729-e736

CBT appears feasible and acceptable to a subset of long-term FAs in primary care who halved their primary care use. With improved recruitment strategies, this approach could contribute to decreasing GP workload and merits larger-scale evaluation. Of 462 FAs invited to interview, 87 (19%) consented to assessment. Thirty-two (7%) undertook CBT over a median of 3 months. Twenty-four (75%) attended at least six sessions. Eighteen FAs (86%, n = 21) reported overall satisfaction with treatment. Patients reported valuing listening without judgement alongside support to develop coping strategies. Thirteen (54%, n = 24), achieved clinically important improvement on the SF-36 Mental-Component Scale at 6-month follow-up and improved quality of life, but no improvement on other outcomes. Primary care use reduced from a median of eight contacts in 3 months at baseline (n = 32) to three contacts in 3 months at 1 year (n = 18).

Patel, S., Kai, J., Atha, C., Avery, A., Guo, B., James, M., Malins, S., Sampson, C., Stubley, M., & Morriss, R. (2015). [Clinical characteristics of persistent frequent attenders in primary care: case-control study.](#) *Family practice*, 32(6), 624–630.

Persistent frequent attendance in primary care was associated with poor quality of life and high clinical complexity characterized by diverse and often persistent physical and mental multimorbidity. A brokerage model with GPs working in close liaison with skilled psychological therapists is required to manage such persistent complexity.

Pymont, C., & Butterworth, P. (2015). [Longitudinal cohort study describing persistent frequent attenders in Australian primary healthcare.](#) *BMJ Open*, 5.

Persistent frequent attendance was specifically associated with gender, baseline reports of depression, self-reported physical conditions and disability, and medication use.

Koskela, T., Ryyanen, O., & Soini, E. (2010). [Risk factors for persistent frequent use of the primary health care services among frequent attenders: A Bayesian approach.](#) *Scandinavian Journal of Primary Health Care*, 28, 55 - 61.

In our model, the most influential predictive risk factors for persistent frequent attendance in an FA population were female gender, body mass index above 30, former frequent attendance, fear of death, alcohol abstinence, low patient satisfaction, and

irritable bowel syndrome. New observations were high body mass index, alcohol abstinence, irritable bowel syndrome, low patient satisfaction, and fear of death.

Smits, F., Brouwer, H., Ter Riet, G., & Van Weert, H. (2009). [Epidemiology of frequent attenders: a 3-year historic cohort study comparing attendance, morbidity and prescriptions of one-year and persistent frequent attenders](#). *BMC Public Health*, 9, 36 - 36.

One out of every seven 1-year-frequent attenders (15.4%) becomes a persistent frequent attender. Compared with non-frequent attenders, and 1-year frequent attenders, persistent frequent attenders consume more health care and are diagnosed not only with more somatic diseases but especially more social problems, psychiatric problems and medically unexplained physical symptoms.

Case studies:

CLEAR 2022

CLEAR, [Central Camden Primary Care Network](#), 2022

A new dedicated HIU service providing proactive, holistic care and support for HIUs including personalised care plans for complex patients.

Four years of data, from September 2017, was extracted and analysed, comparing HIUs who attended ED and those who had more than two GP appointments per month with information on how the wider population used both services. This analysis revealed that 147 were HIUs. The CLEAR national faculty also compared HIU activity with four other PCNs involved in CLEAR transformation projects.

A new HIU service was recommended consisting of care coordinators, advanced practitioners, health and wellbeing coaches and social prescribers – to provide 19 hours of care per patient per year

Blog, [Frequent Attendance – the work of practices and PCNs](#), 2019.

Who are your frequent attenders. We find it helpful to zoom in on the top 100 patient attenders at a practice, to ask the practice to review and spot patterns. It's a large enough number to escape from individual extreme cases.

What patterns exist, also consider Is the practice and it's policies playing a part in creating these patterns?

The nature of frequent attenders is very diverse – young vs old, clinical vs social factors, mental health prevalence and so forth is hugely variable.

If deprivation is a factor for your population:

Pulse, [How this PCN approaches the care of high users of health services](#), 2024.

Case study from another PCN about how they approached it. Their PCN looks after a quite deprived and challenged population. Large proportion are non English speaking and BAME or eastern European background.

Focus on developing a neighbourhood team that improves the response to people who need proactive and preventative management. This project integrated wider primary care, local authority, and voluntary organisations.

Most of the cohort received support by referral to social prescribing services, which identified social, financial, housing, and employment-related issues.

Key learning:

Engaging with patients in such a way that they feel no sense of judgement is crucial. Bringing in partners from the local authority increased solution options and we found using a wide variety of roles in the practices helped to upskill the workforce. And we learned that ensuring staff had training in motivational interviewing was important to equip them for shared decision-making. This enabled more comprehensive support.

Relationship with continuity:

In [McDermott et al.'s 2020](#) study of 7 Bristol practices sampling 35 926 adult patients, they found no association between continuity and reduced attendance among frequent attenders.

McDermott, A., Sanderson, E., Metcalfe, C., Barnes, R., Thomas, C., Cramer, H., & Kessler, D. (2020). [Continuity of care as a predictor of ongoing frequent attendance in primary care: a retrospective cohort study.](#) *BJGP open*, 4(5).

There was no association between continuity and reduced attendance in the FA group in this study.

Characteristics and associations with frequent attendance:

Hajek, A., Kretzler, B., & Koenig, H. H. (2021). [Determinants of frequent attendance in primary care. A systematic review of longitudinal studies.](#) *Frontiers in Medicine*, 8, 595674.

Germany

Our systematic review showed that particularly lower age, unemployment and need factors are associated with the likelihood of becoming a frequent attender.

More precisely, particularly self-rated health, physical functioning and physical illnesses were quite strongly associated with frequent attendance (22–25, 39, 40, 42). It may be worth noting that two studies identified a link between increased medication use (e.g., for sleep problems or high blood pressure) and an increased likelihood of becoming a frequent attender (25, 42).

There is mixed evidence regarding mental health and frequent attendance. For example, while some studies identified a link between mental health, depression, or anxiety and an increased likelihood of becoming a frequent attender (22, 22, 25, 40, 42), other studies did not find a significant link (23–25, 40).

Another study revealed that frequent attendance was significantly related to insecure emotional attachment style(41). Moreover, another study showed that loneliness is not associated with frequent attendance in primary care longitudinally (23).

Kontopantelis, E., Panagioti, M., Farragher, T., Munford, L. A., Parisi, R., Planner, C., ... & Esmail, A. (2021). [Consultation patterns and frequent attenders in UK primary care from 2000 to 2019: a retrospective cohort analysis of consultation events across 845 general practices.](#) *BMJ open*, 11(12), e054666.

Approximately four out of ten consultations of any type concerned frequent attenders and the proportion of consultations attributed to them increased over time, particularly for face- to- face consultations with GPs, from a median of 38.0% (35.9%–40.3%) in 2000–2001 to 43.0% (40.6%–46.4%) in 2018–2019.

Cruwys, T., Wakefield, J. R., Sani, F., Dingle, G. A., & Jetten, J. (2018). Social isolation predicts frequent attendance in primary care. *Annals of Behavioral Medicine*, 52(10), 817-829. For a copy of the full text please email Roxanne.hart@somersetft.nhs.uk

Unmet social needs among frequent attenders warrant closer consideration. Interventions that target social group connectedness show promise for reducing overutilization of primary care services.

Sirois, F. M., & Owens, J. (2023). [A meta-analysis of loneliness and use of primary health care](#). *Health psychology review*, 17(2), 193-210.

The findings from this first comprehensive meta-analysis of the association of loneliness with use of primary care indicate that people who experience loneliness make a greater number of visits to primary-care practitioners. This evidence highlights the practical impact of loneliness on health-care use when viewed at the population level.

Margo-Dermer, E., Dépelteau, A., Girard, A., & Hudon, C. (2019). Psychological distress in frequent users of primary health care and emergency departments: a scoping review. *Public health*, 172, 1-7. For a copy of the full text please email Roxanne.hart@somersetft.nhs.uk

Psychological distress is prevalent in frequent users and has a significant association with frequent use. As such, psychological distress should be evaluated by physicians to prevent or reduce frequent use and to identify candidates for interventions.

Hajek, A., Bock, J. O., & König, H. H. (2017). [Association of general psychological factors with frequent attendance in primary care: a population-based cross-sectional observational study](#). *BMC Family Practice*, 18(1), 48.

Germany

Multiple logistic regressions showed that being a frequent attender was positively associated with less life satisfaction [OR: 0.79 (0.70–0.89)], higher negative affect [OR: 1.38 (1.17–1.62)], less self-efficacy [OR: 0.74 (0.63–0.86)], less self-esteem [OR: 0.65 (0.54–0.79)], less self-regulation [OR: 0.74 (0.60–0.91)], and higher perceived stress [OR: 1.46 (1.28–1.66)], after adjusting for sociodemographic factors, morbidity and lifestyle factors.

Nielsen, J. B., & Andersen, H. S. (2025). [Characteristics of patients with frequent contact with general practice](#). *BJGP open*.

Within our Danish patient population, 22% had >11 annual contacts to their GP clinic. These frequent attenders are in general terms characterised by being female, aged >65 years, having 20 annual contacts to the GP clinic, and having ≥10 diagnoses.

Jørgensen, J. T., Andersen, J. S., Tjønneland, A., & Andersen, Z. J. (2016). [Determinants of frequent attendance in Danish general practice: a cohort-based cross-sectional study](#). *BMC family practice*, 17, 9.

Frequent attenders accounted for 40% of all face-to-face GP consultations with a mean 12 visits/year. Women were more likely to be frequent attenders, in crude (Odds ratio: 1.95; 95% Confidence Interval: 1.85-2.06) and fully adjusted (1.26; 1.09-1.47) model. In a fully adjusted model, strongest determinants of frequent attendance were pre-existing medical conditions, with hypertension (2.58; 2.42-2.75), diabetes (2.24; 1.94-2.59), and

mental illness (2.29; 2.09-2.52) more than doubling the odds of being FA. High education (0.63; 0.57-0.69, >4 years higher education vs. no vocational training) and employment (0.61; 0.57-0.65) were inversely associated with frequent attendance. Finally, obesity (1.54; 1.14-2.08), smoking (1.21; 1.12-1.30, current vs. never), physical activity (0.84; 0.80-0.89), alcohol consumption (0.83; 0.78-0.87 above vs. below recommended level), and hormone therapy in women (1.52; 1.42-1.63) were all significant determinants of frequent attendance.

In a fully adjusted model, the effect of age was insignificant. However, when considering the effect of age separately for men and women, age was significantly modified by gender. Women aged 60–65 years had significantly smaller (0.89; 0.81–0.98) while men aged 60–65 had significantly higher odds (1.37; 1.21–1.55) of being FAs as compared to 50–54 old women and men, respectively. This variation may be explained by higher utilization related to menopause and menopausal symptoms (other than use of HT) among women in the age group of 50–59 years when most women experience onset of menopause.

Haroun, D., Smits, F., van Etten-Jamaludin, F., Schene, A., van Weert, H., & Ter Riet, G. (2016). [The effects of interventions on quality of life, morbidity and consultation frequency in frequent attenders in primary care: a systematic review](#). *European Journal of General Practice*, 22(2), 71-82.

Frequent attendance is a regular phenomenon in general practice and may be a burden to the GP, practice staff and work-flow. However, it does not seem to allow for a **uniform approach or simple interventional procedures, but should perhaps be viewed as a trigger for stratification and differentiation according to individual patient's underlying conditions**, adaptive selection and design of interventions, and professional staff's reflection on own attitudes and involvement. In depth analysis among GPs assessing a particular patient's reasons for frequent attendance and corresponding tailored actions may decrease consultation frequency.

Baudier, L., Senn, N., Wild, P., & Cohidon, C. (2023). [Consultation frequency and general practitioners' and practices' characteristics](#). *BMC primary care*, 24(1), 39. Switzerland

Factors such as being female [1, 2, 4, 7–12], older [1, 3, 4, 7–9, 11, 13, 14], having one or more physical illnesses [2, 4, 8, 10–13, 15] and having a psychiatric disorder [8, 11, 12] have been recurrently associated with frequent consultations. Ferrari et al. [2] even found that the odds of being an FA increased by 2.83 with each additional diagnosis. Factors like having too high or too low a body mass index (BMI) [3, 12–14], a lower level of education [2, 3, 12, 16], medically unexplained symptoms [3, 16, 17], and social [2, 4, 8, 12] and economic [2, 8, 13, 15] difficulties have also repeatedly shown associations. Conversely, protective factors against frequent consultation are a higher level of education [10, 12], higher income [10], employment [12] and exercise [12, 13].

An aspect of frequent attendance which may not always be discussed is the extent to which GPs themselves (add refs) and also practice characteristics play a part in patterns of frequent attendance.

A high self-perceived health status, physical exercise, less compliance, a higher educational level and female sex were the patient-related factors associated with lower use of primary care in this study. On the contrary, sleeping problems, moderate to severe psychological distress, chronic disease and treatment involving medication,

particularly anticoagulants, were associated with higher use of primary care. As for practice characteristics, shared medical records were negatively associated with consultation frequency, whereas long GP working hours (≥ 50 h) per week was positively associated with consultation frequency.

However, as mental health issues are one of the most predictive characteristics for more consultations with a GP, some patients might not be in the right place and would benefit from specialist care, which would help diminish the frequency of consultations and GPs' work loads. Integrating psychologists into group practices might help solve this problem.

Self-perceived health status being mentioned as the most significant factor influencing consultations with GPs

Kivela K, Elo S, Kaariainen M. [Frequent attenders in primary health care: A concept analysis](#). *Int J Nurs Stud*. 2018;86:115–24.

Injuries were seven times more common among frequent attenders compared to other patients in primary health care (Bergh et al., 2005).

Cruwys, T., Wakefield, J. R., Sani, F., Dingle, G. A., & Jetten, J. (2018). [Social isolation predicts frequent attendance in primary care](#). *Annals of Behavioral Medicine*, 52(10), 817-829.

Unmet social needs among frequent attenders warrant closer consideration. Interventions that target social group connectedness show promise for reducing overutilization of primary care services.

Overall picture on changes in general practice:

Chappell, P., Dias, A., Bakhai, M., Ledger, J., & Clarke, G. M. (2023). [How is primary care access changing? A retrospective, repeated cross-sectional study of patient-initiated demand at general practices in England using a modern access model, 2019–2022](#). *BMJ open*, 13(8), e072944.

Although frequent attenders represent just 10% of the patient population, they consistently accounted for almost a third of all requests.

Long term frequent attenders among oldest old

Buczak-Stec, E. W., Hajek, A., van den Bussche, H., Eisele, M., Oey, A., Wiese, B., ... & König, H. H. (2022). [Factors contributing to persistent frequent attendance in primary care among the oldest old: longitudinal evidence from the agecode-agequalide study](#). *Frontiers in medicine*, 9, 815419.

Our study stressed the longitudinal association between frailty and widowhood as well as chronic diseases and persistent frequent attendance among the oldest old in Germany.

Welzel, F. D., Stein, J., Hajek, A., König, H. H., & Riedel-Heller, S. G. (2017). [Frequent attenders in late life in primary care: a systematic review of European studies](#). *BMC family practice*, 18(1), 104.

Severe ill health and the need for treatment serve as the main drivers of frequent attendance in older adults. As results were scarce and divergent, future studies are needed to provide more information on this topic. Since prior studies have offered only a snapshot of this service use behaviour, a longitudinal approach would be preferable in the future.

Table of factors associated with usage of PC

Please note I have not conducted a systematic review to generate this table. It is therefore not an exhaustive list of references and is intended to give a general overview of associated factors. If there is a specific factor you would like more information on I can conduct a more detailed search for that factor.

Factor	Association with usage of PC	References
Higher self perceived health status	↓	Baudier et al. 2023 ; Kivela et al 2018 (discusses inverse)
Physical exercise	↓	Baudier et al. 2023
Less compliance (with medical prescriptions)	↓	Baudier et al. 2023
Higher education	↓	Baudier et al. 2023 ; Jørgensen et al 2016 inverse discussed (Jyväsjärvi et al., 2001 ; Kersnik et al., 2001 ; Little et al., 2001 ; Vedsted and Olesen, 2005 ; Al-Kandari et al., 2008 ; Robles et al., 2009 ; Koskela et al., 2010 ; Gili et al., 2011 ; Norton et al., 2012 ; Gomes et al., 2013 ; Rifel et al., 2013 ; Kaattari et al., 2015 ; Patel et al., 2015 ; Jørgensen et al., 2016)
Female	↑	Baudier et al. 2023 ; Jørgensen et al 2016 (authors theorise may be to do with menopause and or use of hormone therapy) there is further nuance to the gender and age factor to read it see here Nielsen et al 2025
Sleeping problems	↑	Baudier et al. 2023
Psychological distress	↑	Baudier et al. 2023 ; Margo-Dermer et al 2019
Chronic disease	↑	Baudier et al. 2023 ; Kivela et al 2018 ; Jørgensen et al 2016 (specifically hypertension, diabetes, mental illness)
Number of diagnoses	↑	Nielsen et al 2025 ≥10 diagnoses.
Lower quality of life	↑	Kivela et al 2018

Diminished ability to cope	↑	Bergh et al., 2006; Bergh et al., 2007). They experienced fear of: serious diseases (Matalon et al., 2002; Matalon et al., 2004
Insecure attachment style	↑	Taylor et al., 2011
Socio-economic status		(Scaife et al., 2000; Vedsted et al., 2004a; Vedsted and Olesen, 2005; Bergh et al., 2007; Jatic and Jatic, 2008; Robles et al., 2009; Diaz et al., 2014; Buja et al., 2015; Kaattari et al., 2015; Dinkel et al., 2016) ↑ usage if money was tight
Unemployment	↑	Hajek et al 2021 ; Scaife et al., 2000; Vedsted and Olesen, 2005; Robles et al., 2009; Gili et al., 2011; Kaattari et al., 2015; Dinkel et al., 2016; Jørgensen et al., 2016 Jørgensen et al 2016 (inverse discussed)
Social isolation/loneliness	↑	Cruwys et al 2018 ; Sirois et al 2023
Age	Research inconclusive/mixed	Hajek et al 2021 ; Nielsen et al 2025 found 65+ was associated with FA.
Perceived Stress	↑	Hajek et al 2017
Decreased optimism	↑	Hajek et al 2017
Long GP working hours (≥ 50 h) per week	↑	Baudier et al. 2023
Obesity	↑	Jørgensen et al 2016

Interventions

--Social prescribing intervention

Lynch, M., & Jones, C. R. (2022). [Social prescribing for frequent attenders in primary care: An economic analysis](#). *Frontiers in public health*, *10*, 902199.

Small study (21 participants) looked at social prescribing as an intervention for frequent attenders. The cost variance when FAs participated in the intervention shows there is a direct cost saving of £ 6,113, or £78.37 per participant over the 37 months of the intervention.

Kiely, B., Croke, A., O'Shea, M., Boland, F., O'Shea, E., Connolly, D., & Smith, S. M. (2022). [Effect of social prescribing link workers on health outcomes and costs for adults in primary care and community settings: a systematic review](#). *BMJ open*, *12*(10), e062951.

Social prescribing link workers may have little or no impact on primary care visits. It is unknown if social prescribing link workers reduce hospitalisations because the certainty of the evidence is very low

Social prescribing link workers may improve self-rated health

Training intervention for physicians:

Ramos, A., Pujol, R., & Palma, C. (2024). [Reducing patients' rate of frequent attendance through a training intervention for physicians.](#) *BMC Medical Education*, 24(1), 758.

Spain

A training programme was carried out for 11 primary care doctors in Barcelona who had patient lists totalling 20,064 patients. 14% of patients (2,809) limited the frequency of their visits to primary care physicians after their physicians had completed the training programme. Meanwhile, the study recorded an average decrease of 3.1 visits per year by the patients of the physicians who had undergone the training. Statistically significant differences between this group and the control group were observed.

A descriptive analysis was conducted in the three primary care centres. The objective was to gain a fuller picture of the profiles of the professionals who would be the recipients of the training, as well as of the centres where they worked and the patient population.

The resulting teaching team was made up of two physicians, included the director and three psychologists, all of whom contributed to shaping the objectives, content and teaching methodology of the programme

Teaching objectives: become familiar with the phenomenon of frequent attendance in primary care; raise awareness of the magnitude of the problem; learn techniques to manage frequent attendance (how to reduce the number of visits); and learn instruments and strategies to prevent job burnout.

- Training content:

- (a) information on overuse based on a literature review, available data, limits and gaps;
- (b) strategies for dealing with patients who overuse resources and professional skills to improve communication with patients (active listening, coaching and counselling);
- (c) strategies to prevent job burnout, including assertiveness, time management and self-knowledge; and
- (d) organization and management of one's own medical practice.

- Teaching methodology: a combination of lectures and practical interactive workshops; a total of 16 h split into two immersive training sessions of 8 h each, held in the classrooms at the CME Centre in July and October 2006. The course was offered free of charge, and physicians were able to attend during their regular working hours.

Bellón JA, Rodríguez-Bayón A, de Dios LJ, Torres-González F. [Successful GP intervention with frequent attenders in primary care: randomised controlled trial.](#) *Br J Gen Pract.* 2008;58(550):324–30.

Spain

GPs allocated to the new intervention received 15 hours' training which incorporated biopsychosocial, organisational, and relational approaches.

Barnes, R. K., Cramer, H., Thomas, C., Sanderson, E., Hollinghurst, S., Metcalfe, C., ... & Kessler, D. (2019). [A consultation-level intervention to improve care of frequently attending patients: a cluster randomised controlled feasibility trial.](#) *BJGP open*, 3(1).

This consultation-level intervention moves away from patient 'treatment' towards what patients and clinicians can do together to improve recognition and support for health

care problems and related needs. The aim is to increase patient independence over time.

Targeted Health Promotion

Kolster, A., Heikkinen, M., Pajunen, A., Mickos, A., Wennman, H., & Partonen, T. (2023). [Targeted health promotion with guided nature walks or group exercise: a controlled trial in primary care.](#) *Frontiers in public health*, **11**, 1208858.

Participants (mean age 57 years, 79% female) rated their general and mental health lower than the general population. Participation in the Nature group resulted in improved mental wellbeing (change in WEMWBS by 3.15, $p = 0.008$), with a positive change for feeling relaxed, being cheerful, having energy to spare, feeling able to deal well with problems, feeling good about oneself and feeling close to other people. The Sports-group was beneficial for those initially rating their health as good. Sleep duration improved in the Sports-group, while participants in the Nature-group reported better sleep quality. Following the interventions there was improvement in perceived health and ability to function in both groups, while perceived mental health improved only in the Nature-group.

Since 2015 two nature guides, who are not medically trained, have organized 8-week rehabilitation programs for patients who frequently visit the health center in close co-operation with a team of doctors and nurses. The positive response gave rise to a need for a more systematic evaluation on the impact of the program, resulting in this study. The living premises were the same for both groups and did not change through the study.

CBT

Malins, S., Kai, J., Atha, C., Avery, A., Guo, B., James, M., Patel, S., Sampson, C., Stubley, M., & Morriss, R. K. (2016). [Cognitive behaviour therapy for long-term frequent attenders in primary care: a feasibility case series and treatment development study.](#) *British Journal of General Practice*, **66(651)**, e729-e736

CBT appears feasible and acceptable to a subset of long-term FAs in primary care who halved their primary care use. With improved recruitment strategies, this approach could contribute to decreasing GP workload and merits larger-scale evaluation. Of 462 FAs invited to interview, 87 (19%) consented to assessment. Thirty-two (7%) undertook CBT over a median of 3 months. Twenty-four (75%) attended at least six sessions. Eighteen FAs (86%, $n = 21$) reported overall satisfaction with treatment. Patients reported valuing listening without judgement alongside support to develop coping strategies. Thirteen (54%, $n = 24$), achieved clinically important improvement on the SF-36 Mental-Component Scale at 6-month follow-up and improved quality of life, but no improvement on other outcomes. Primary care use reduced from a median of eight contacts in 3 months at baseline ($n = 32$) to three contacts in 3 months at 1 year ($n = 18$).

Luutonen, S., Santalahti, A., Mäkinen, M., Vahlberg, T., & Rautava, P. (2019). [One-session cognitive behavior treatment for long-term frequent attenders in primary care: randomized controlled trial.](#) *Scandinavian Journal of Primary Health Care*, **37**, 98 - 104.

Finland

A single session of CBT is not useful in reducing GP visits or improving mental well-being of long-term frequent attenders.

Nurse led health coaching

Kivelä, K., Elo, S., Kyngäs, H., & Kääriäinen, M. (2020). [The effects of nurse-led health coaching on health-related quality of life and clinical health outcomes among frequent attenders: a quasi-experimental study](#). *Patient Education and Counseling*, 103(8), 1554-1561. FINLAND

This study suggests that nurse-led health coaching may lead to an improvement in the health-related quality of life and blood pressure among frequent attenders.

Case management

Hudon, C., Chouinard, M. C., Pluye, P., El Sherif, R., Bush, P. L., Rihoux, B., ... & Légaré, F. (2019). [Characteristics of case management in primary care associated with positive outcomes for frequent users of health care: a systematic review](#). *The Annals of Family Medicine*, 17(5), 448-458.

Canada

Analyses revealed that it is necessary to identify patients most likely to benefit from a CM intervention for CM to produce positive outcomes. High-intensity intervention or the presence of a multidisciplinary/interorganizational care plan was also associated with positive outcomes. CONCLUSIONS Policy makers and clinicians should focus on their case-finding processes because this is the essential characteristic of CM effectiveness. In addition, value should be placed on high-intensity CM interventions and developing care plans with multiple types of care providers to help improve patient outcome. High intensity (ie, small caseload, frequent face-to-face contact with the patient, initial assessment in person, and/or multidisciplinary team meetings) and developing care plans with multiple types of care providers to help improve patient outcomes.

Hudon, C., Chouinard, M., Aubrey-Bassler, K., Muhajarine, N., Burge, F., Bush, P., Danish, A., Ramsden, V., Légaré, F., Guénette, L., Morin, P., Lambert, M., Fick, F., Cleary, O., Sabourin, V., Warren, M., & Pluye, P. (2020). [Case Management in Primary Care for Frequent Users of Health Care Services: A Realist Synthesis](#). *The Annals of Family Medicine*, 18, 218 - 226.

Canada

In the context of easy access to an experienced and trusted case manager who provides comprehensive care while maintaining positive interactions with patients, the development of this relationship fosters the engagement of both individuals and yields positive outcomes when the following mechanisms are triggered: patients and clinicians feel supported, respected, accepted, engaged, and committed; and patients feel less anxious, more secure, and empowered to self-manage.

Group Intervention

Haslam, C., Cruwys, T., Chang, M. X. L., Bentley, S. V., Haslam, S. A., Dingle, G. A., & Jetten, J. (2019). [GROUPS 4 HEALTH reduces loneliness and social anxiety in adults with psychological distress: Findings from a randomized controlled trial](#). *Journal of consulting and clinical psychology*, 87(9), 787.

Specifically, there was evidence that compared to TAU, G4H was associated with a greater reduction in symptoms of loneliness(H1) and social anxiety(H4).

Telemedicine and electronic consultation systems:

Virtanen, L., Kaihlanen, A. M., Kainiemi, E., Saukkonen, P., & Heponiemi, T. (2023). [Patterns of acceptance and use of digital health services among the persistent frequent attenders of outpatient care: A qualitatively driven multimethod analysis.](#) *Digital Health*, 9, 20552076231178422.

The FAs were grouped by their acceptance and use of services for digital self-management of health into Self-Managers, Supported Self-Managers, and Non-Self-Managers. Based on their acceptance and use of telemedicine services, we found Telemedicine Users, Doubtful Telemedicine Users, and Telemedicine Refusers.

Leung, K., & Qureshi, S. (2021). [Managing high frequency users of an electronic consultation system in primary care: a quality improvement project.](#) *BMJ Open Quality*, 10(2).

Users were first informed of the number of online consultations they had submitted the previous month, then their views of the consultation platform were assessed. Topics covered included whether the patient felt their health needs were being met by Dr iQ and their perceived advantages and disadvantages of the service. Finally, if appropriate, a suggestion to convert to regular telephone or face-to-face appointments with a single named clinician rather than using the online consultation platform was made.

Themes which emerged from Telephone interviews:

- Patients who felt needs were being met by Dr. iQ and favoured the ease of access and speed of response from clinicians. Felt this decreased their health anxiety and prevented googling.
- unmet expectations (educational opportunity for this group of patients) such as someone recently diagnosed with a chronic health condition who is struggling.
- some patients decreased usage after the telephone interview. Theories from authors as to why:
 - a positive result from the human interaction and listening through the interview
 - users being made aware of the amount of times they'd used the service.

Users were then contacted again for a second round of interviews. The second round of interviews focused more on proposing to convert patients to a regular telephone or face to face consultation.

Further, persistent high frequency users were educated on more suitable methods to use Dr iQ going forward

They were advised Dr iQ would be appropriate for administrative tasks such as medication requests and sick notes

Whole System approaches

Hudon C., Chouinard M.-C., Dumont-Samson O., Gobeil-Lavoie A.-P., Morneau J., Paradis M., Lambert M. (2023). [Integrated case management between primary care clinics and hospitals for people with complex needs who frequently use healthcare services: A multiple-case embedded study.](#) *Health Policy*, 132 no pagination.

Integrated CM between primary care clinics and hospitals is a promising innovation to improve care integration for people with complex needs who frequently use healthcare services

The Strategy Unit, Qualitative Evaluation of the high intensity use service, 2022.

What are the recommendations and key success factors of a high intensity use service.

Health Equity Evidence Centre, [What works: Finding ways to better support people who frequently attend emergency departments, 2024](#)

1. Screening tools combined with clinical judgement to identify patients at risk.
2. Good primary care access and continuity.
3. Integrated multidisciplinary services.
4. A whole-person approach.

British red cross, [Nowhere else to turn, 2021](#)

Top 3 recommendations:

Putting in place appropriate non-clinical, specialist support (Integrated Care Systems to develop strategies for addressing high intensity use across their areas)

Improving access to community based support – they recommend VCSE initiatives like social prescribing.

Addressing health inequalities

British Red Cross, [Seen and heard | British Red Cross, 2024](#)

Looked at linked data in Dorset

Further develop multidisciplinary proactive care in primary care for people with long-term conditions, prioritising those most at risk of experiencing poor health outcomes due to other risk factors.

Two cohorts make up around 70 per cent of the frequently attending population in Dorset:

- Cohort One is aged 70+; 98.2 per cent of the cohort have two or more long-term conditions; and 44.5 per cent are recorded as being on a palliative care register.
- Cohort Two is aged 20-49 with slightly more females; there is a significant link with deprivation; depression, seizure, self-injury and substance misuse are particularly prevalent presentation reasons; and they are more than twice as likely as the control group to have two or more long-term conditions

King's Fund, [Realising the three shifts: preventing more people from reaching crisis point will be one measure of success, 2019.](#)

“Patients attribute much of the value of the services to the non-judgemental and relational nature of the support.”

Case study, Transformation partners, [A High Intensity User service for individuals with complex needs in NCL, 2023](#)

Non-clinical care coordinators

Team based in North Middlesex University Hospital receive report of patients over attendance threshold (120 top high intensity users of A&E identified utilising A&E data systems) then triage to identify patients who would benefit from support. Personalised person-centred approach focusing on the individual's issues, identifying, de-medicalising, de-criminalising and humanising their needs to uncover the core reasons for attending A&E or an admission. Where beneficial to patients, they are linked with a CC who meets with patients to identify unmet needs. Use Urgent Care Plan (UPC), a system to create bespoke care plans for the HIU cohort that can be shared with NHS professionals for continuity of care. After 12 weeks on the programme, patients are discharged into community or voluntary support services. CC come into hospital one day per week to engage with hospital staff & raise awareness of the role. They also hold an HIU day once per month taking a multidisciplinary approach to promote the service including a stall in the hospital foyer. CC are directly employed by Mind but line

managed by a Project Manager on the pilot, and meet fortnightly. Training in UPC, basic training and induction are led at the hospital.

NHS Confederation, [The future of primary care | NHS Confederation, 2025](#)

High-intensity users comprise a small proportion of the population but use up to ten or 20 times as many resources as other citizens. Yet, despite all that activity, the system often fails to help them improve their lives. We therefore need a new model which complements the NHS's bio-medical model with a psycho-social approach. The emphasis is on seeing the patient in the round, helping them solve whatever problems are most standing in their way and empowering them to take greater control of their lives and their health. While these non-health interventions can be seen as a marginal to core NHS business, this kind of approach is not only more effective and more compassionate but saves money by reducing demand and unnecessary activity.

NHS England, [Supporting High Frequency Users \(HFU\) through proactive personalised care, delivered by Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators, 2022](#)

This guidance note sets out the principles and recommended approach for offering proactive, personalised care for those at higher risk of hospital admissions due to psychosocial needs, as part of a broader strategy for ICBs and PCNs to tackle winter pressures and reduce unplanned admissions. These are patients who use services more frequently than usual, including A&E attendances or unplanned hospital admissions and may be identified as being vulnerable, where lifestyle, behavioural or social risk factors are impacting on primary and secondary care service usage. Through the offer of proactive, personalised care, and in particular maximising the support offered through social prescribing link workers, health and wellbeing coaches, and care coordinators, they can be supported to uncover and address psychosocial support needs, improve their symptom and condition management, and to access a broader range of support options in their communities, resulting in reduced unscheduled use of primary and emergency care.

Contacts (Roxanne can provide emails)


Neil Thomas (SFT) High intensity lead

Jessica Martina (ICB) Urgent care team lead for High intensity users

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Keywords/search strategy	Limits used
Persistent Long term high attend* high utilizer high user high consult* high consumer frequent user heavy user constant* attend* frequen* attend* increased attend* persistent multiyear frequent frequent flyers high impact users	

Databases/sources used		
<input type="checkbox"/> Pubmed	<input type="checkbox"/> HMIC	<input type="checkbox"/> BMJ Best Practice
<input checked="" type="checkbox"/> MEDLINE	<input type="checkbox"/> Social Policy & Practice	<input type="checkbox"/> UpToDate
<input type="checkbox"/> Emcare	<input type="checkbox"/> CINAHL	<input type="checkbox"/> Trip Pro
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