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RESEARCH ARTICLE

Pressure on Appointments in General Practice: Relieved Through Joint Consultations

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ABSTRACT

Background: Obtaining appointments at a general practice was critical for reducing avoidable hospital admissions, and ultimately saving healthcare costs. In the United Kingdom (UK), problematic access of appointments at individual general practices persisted resulting from increasing health complexities in primary care, which were exacerbated by shortages of medical doctors as general practitioners (GP). The UK government pursued the employing of care-coordinators at primary care networks to allocate care to non-GP health professionals as a solution, but patient demand for GP appointments at individual practices continued to surge.

Aims: This paper reports on an investigation of the ideal way to address patient demand on GP appointments at individual practices. It aimed to report on the effects of two newly implemented joint consultations, one comprising a nursing team and another, a multi-disciplinary team comprising medical doctors and nursing personnel.

Methods: Three reviews were conducted in a 3500 patient-list-sized GP practice located in North-Eastern part of England. The aim was to analyse retrospective data of the telephony system to explore the effect of joint consultations on demand of GP appointments that were made through the telephony system. The number and lengths of incoming telephone calls to secure GP or nursing appointments at the practice were analysed descriptively. The periods of analysis were from January to August in the years 2021, 2022 and 2023.

Results: Since implementation of the two joint consultations, there was a 32% reduction in telephone calls for GP appointments. There was also a shortening of the duration of these telephone calls and decreasing trends of missed calls. The increased lengths of calls towards the tail end of the 3rd review period in 2023 demonstrated increased patient awareness and cooperation for in-depth discussions about their symptoms prior to securing appointments.

Conclusions: The joint consultations had significantly decreased patient demands for GP appointments via telephone. In addition, the joint consultations had not only allowed holistic care needs to be addressed, but also, they had permitted appropriate care to be delivered in a timely fashion. It is therefore important to ensure appropriate healthcare funding to support the implementation of joint consultations at individual GP practices.

Key learning points

1. GP appointment demands can be reduced through joint consultations which had every potential in offering a holistic care approach in a timely fashion.
2. Healthcare funding allocated to expanding the work force at primary care networks should be diverted to individual GP practices for staff retention in establishing joint consultations.

Introduction

General practice had always been regarded as the heart of the National Health Service (NHS)[1] where medical doctors as general practitioners (GPs) took the lead in primary care. Such views about general practice and the GPs have not changed in the slightest. Not only has general practice made NHS one of the world's most cost-effective health services, but also, it remains an important avenue for health promotion and disease prevention. Obtaining an appointment at a GP practice is therefore critical. However, problematic GP access with limited appointments persists. As time progressed, GP appointment shortages were exacerbated by the imbalance between an increasing rise in health complexities, and challenges in recruitment and retention of GPs. The NHS has published "The Modern General Practice Model" to explain how practices could provide a smooth, equitable experience of access to patients across telephone, online and walk-in routes[2]. More healthcare funding was subsequently allocated to recruit more non-GP healthcare professionals to meet the increasing demands through means of an 'Additional Roles Reimbursement Scheme' (ARRS)[2]. Whilst all GP practices were expected to embrace this vision, it was only recently that it was reported that each month, nearly five million patients were still waiting more than a fortnight to see a GP in England[3]. Apparently, the UK governmental efforts in allocating funding to supply additional non-GP healthcare professionals was not as ideal as it was first thought as a solution to address the increased GP appointment demand.

Background

The need to meet patient demand in GP practices is not new. In 2016, with the support of the Royal College of General Practitioners (RCGP), NHS England (NHSE) and Health Education England (HEE) published the General Practice Forward View. This was implemented with a 14% real-term increased funding to support general practice service area including, but not limited to, promoting patient self-caring behaviours, expanding and upskilling the workforce in primary care, improving estates and advancing technology, and enhancing collaboration between GP practices and the wider NHS system[1]. Five years on, little has changed with regards to GP appointment subscription. The status quo in GP appointment availability resulted in the birth of the Primary Care Networks (PCNs) in 2019[4]. The PCNs were established with an aim to coordinate role functions of GP practices. The emphasis of PCNs to improve primary care services had then swept across the entire UK primary care sector. Many so called innovative and creative ways crept into the system, all with a common goal to 'relieve' the GPs to meet increasing patient demands. It was clear that the ultimate aim of the PCN was to increase GP appointments for GPs to fulfil the General Medical Service (GMS) contractual agreement in providing timely, equitable and appropriate GP access[5]. The urge for PCNs to 'help' GP practices to fulfil this contractual agreement also led to the introduction of 'Single Point of Contact' (SPOC) where many PCNs would employ care-coordinators with dedicated time to explore concerns with the NHS service users[6]. The aim was for each and every encounter, patients' health and social concerns were screened and filtered, and where appropriate redirected to non-GP care, for example, that from a physiotherapist, a mental health coach or a community pharmacist. Even social prescribers were included in the list of professionals to provide non-GP care services[7]. In this way, the 'ARRS'[2] was justified because, every individual, whether residing at one's own home or residential and care homes, who had requested for a GP appointment, and not obtained one, would now, have their health and social care issues attended in whatever shape or form.

At surface value, the approach adopted by many PCNs appeared to provide a good solution to GP appointment oversubscription. Justifying the 'ARRS' was the assumption that many NHS service users who desired a GP appointment may not necessarily need one. Whist we endorsed this assumption and recognised the attributing causes for unnecessary demands of GP appointments might be inappropriate requests for GP appointments by NHS service users, we maintained that quality patient care must remain as the relentless focus in general practice. Keeping this attitude in mind, instead of relying on the PCN's conventional ways to reduce GP appointment demands, a GP surgery located in North-Eastern part of England explored joint consultations and implemented them on 1st January 2022. Three reviews were conducted between January and August in year 2021, 2022 and 2023 to evaluate the impact of these joint consultations on patient demands of GP appointments.

Joint Consultations

Based on the skill sets and knowledge mix within the GP practice, these joint consultations took two forms, namely, nursing and multidisciplinary. The former comprised two nursing personnel and the latter was two nursing personnel and a GP. The nursing consultations were delivered jointly by a healthcare assistant (HCA) and a registered nurse practising as an Advanced Nurse Practitioner (ANP). To support

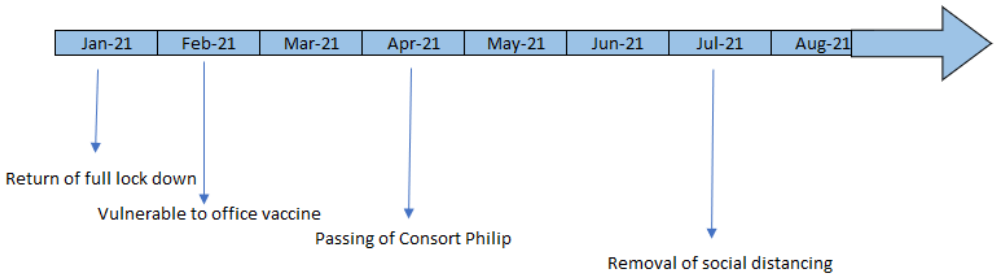
this approach, the HCA was trained to conduct several nursing procedures including, but not limited to fundamental health checks, phlebotomies, electrocardiograms, peak flow tests, simple spirometry and artery-brachial pressure index measuring. The ANP was an independent non-medical prescriber who was trained to perform physical assessments using inspection, palpation and auscultation[8]. All of which were commonly done by medical doctors rather than nurses to arrive at the correct medical diagnoses. The ANP also possessed good general clinical knowledge and assessment skills, that she could independently provide patient advice and treatment plans to address acute health problems and long-term health issues. In other words, the ANP working at this advanced level was also able to make referrals to specialists for further care and tests. In line with the nursing workforce reform for primary care[9], the ANP was authorised to certify fit notes[10]. The only difference in the role of this ANP from ANPs in other GP practices was that her responsibilities included treatment room or practice nurses' job description. Hence, any service users requiring routine long term health condition reviews, immunisations, cervical screening tests, injections, or contraceptive pill checks, were able to have all done within one nursing consultation jointly delivered by an HCA and an ANP. The reason for having an ANP who would not give up any fundamental nursing procedures when having assumed more complex and advanced nursing practice, was to ensure a holistic approach to care in one single patient encounter was not missed.

The second type of joint consultations included a GP. Hence, these joint consultations took the form of a multidisciplinary approach. These GP-Nursing joint consultations were implemented with a further aim to provide holistic care, in the same way as desired in the joint nursing consultations. Similar to the joint nursing consultations, these multidisciplinary based joint consultations could be pre-planned and offered within a 2-week period. They could also be unplanned and be offered as 'same-day' appointments by staff on reception. The unplanned GP-Nursing consultations could also be a result from any joint nursing consultations based on an internal referral by the ANP and/or the HCA who were given the authority to escalate the care to the GP, for patients to be seen on the same day as needed. In other words, for any NHS service users who were attending the surgery to see the HCA or ANP for a nursing procedure, both nursing personnel were in position to escalate the care to a GP as needed. Whichever form these joint consultations might be, any NHS service users who attended the surgery would first have their fundamental health checks of height, weight and blood pressure by the HCA before seeing the ANP or GP. By the time they saw the ANP or GP, any social items that might affect health, such as smoking status, alcoholic drink consumption or carer status would all have been explored by the HCA. This new approach to assigning appointments which seemed straight forward, required a high level of clinical acumen amongst the non-GP colleagues for triaging care. This is because appropriateness of appointment allocation relied heavily on patients' potential problems being detected efficiently, and actual problems being identified effectively.

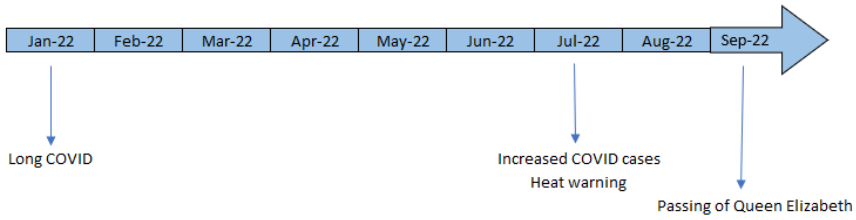
Context of Study

The review was conducted in a 3500 patient-list-sized GP practice located in North-Eastern part of England. There were many ways individuals contacted this practice for GP appointments, and despite the introduction of online access, 99% of the appointments were still made via the cloud-based telephony system. In view of the preference in securing GP appointments, the reviews involved data analysis of the information obtained retrospectively from the digital telephony system. The selected periods for the reviews were from 1st January to 31st August in the years 2021, 2022 and 2023 as follows:

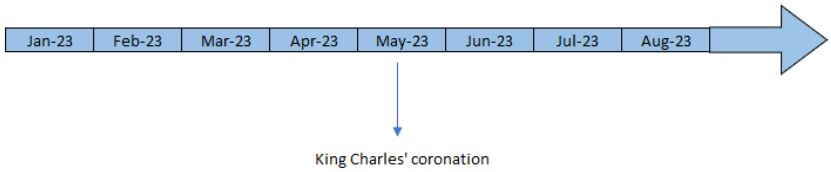
1. 1st January 2021 to 31st August 2021 (Baseline);



2. 1st January 2022 to 31st August 2022 (First phase of new approaches);



3. 1st January 2023 to 31st August 2023 (Second phase of new approaches).



Methods

DESIGN

This study involved retrospective data analysis which did not include any identifiable individuals but cloud-based quantitative telephony data. The quantitative data were the counts of telephone calls made by individuals on the 'GP appointment request line'. Data were collected from the digital telephony system at the Practice where the records of calls were stored in the cloud. For the purpose of the reviews, these stored data were retrieved in the form of a management report in 2023. The contents of calls were not of interest in this analysis. Therefore, no personal data nor qualitative data such as call contents were extracted for this report. Following analysis, the data which were downloaded was destroyed as confidential waste.

Statistics

Simple descriptive statistics based on total counts of missed calls and incoming calls as well as the lengths of incoming calls were used to provide insight to the effects of the newly implemented joint consultations.

Results

For the baseline period between 1st January 2021 and 31st August 2021, the lockdown of the pandemic had come to an end. Many patients were likely to call for appointments due to the long absence of face-to-face contact with their GPs. As demonstrated in Table 1i, the demand was particularly high in July 2021, and this coincided with the removal of social distancing protocols at GP practices, that many patients were seizing the opportunity to secure face-to-face appointments at the Practice.

For the first phase of the review between 1st January 2022 and 31st August 2022, the factors which possibly had influenced GP appointment demand were the effects of the pandemic and the rise of COVID incidents in July 2022. As shown in Table 1i, increased demand was seen in March 2022, and this gradually tapered towards the end of July 2022 but with a turn of events, that there was a rise of in-coming calls seen in August 2022. This turn of event coincided with the period where many patients, especially the older ones, who had started the grieving process of the impending death of Queen Elizabeth II.

The final phase between 1st January 2023 and 31st August 2023, was an uneventful period that the peak of demand in January 2023 and March 2023 was a result of patients responding to the surgery's invitations for long term health reviews and vaccinations.

Table 1i: The trends Inbound calls in the 3 phases by months.

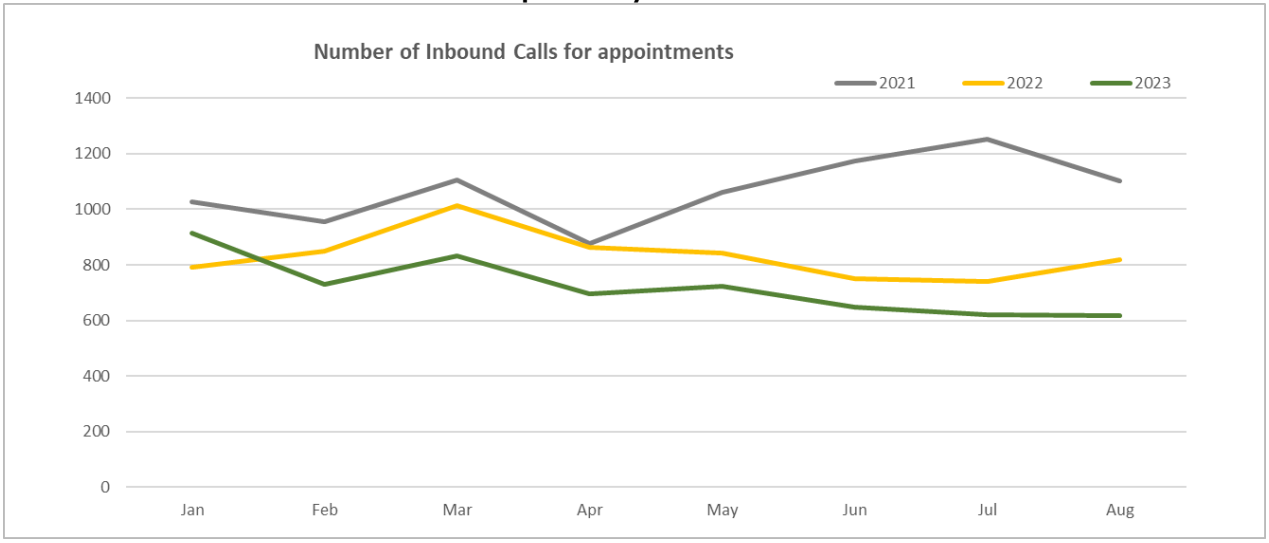
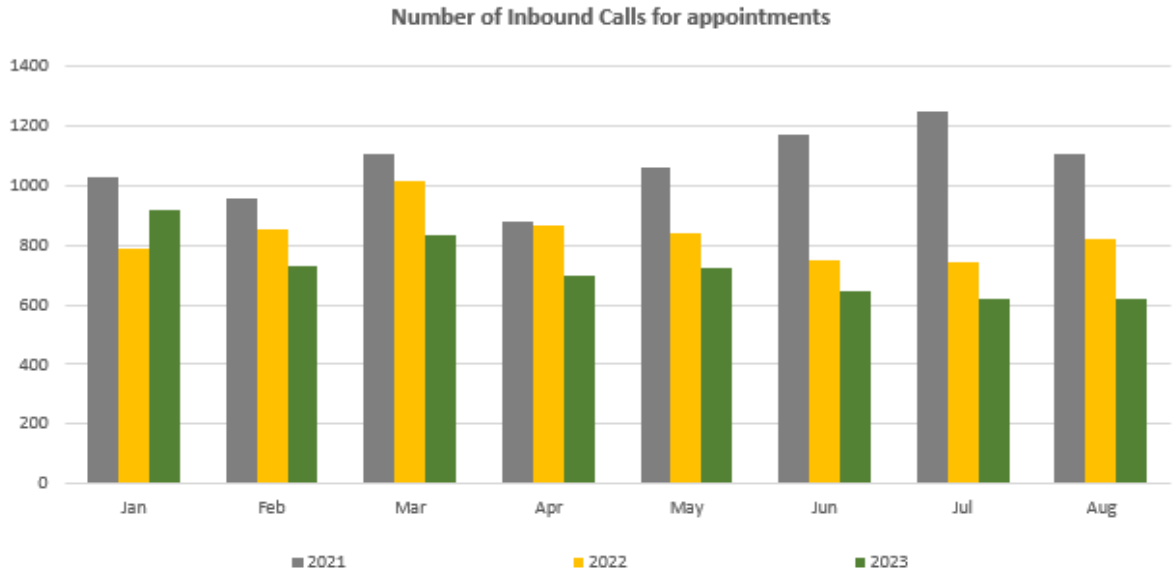
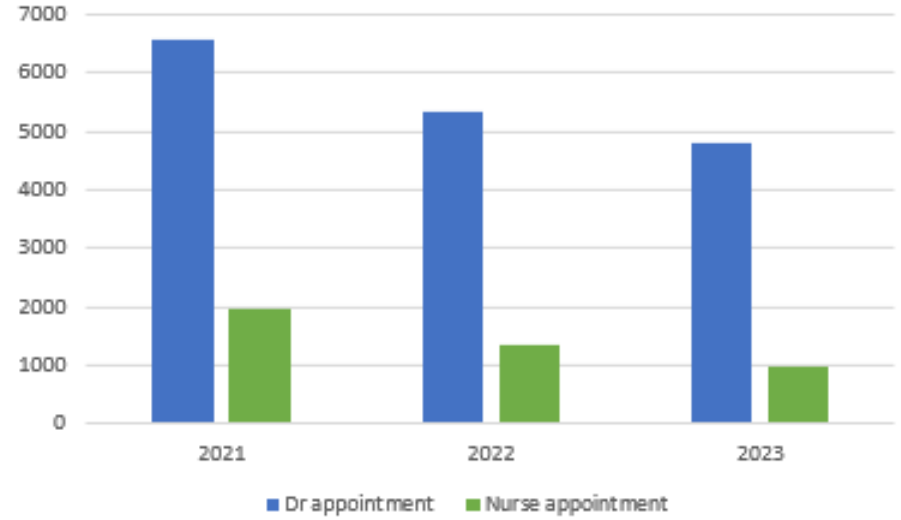


Table 1ii: The number of inbound calls in the 3 phases by months.



Whilst there were events to explain the different level of demand in different months, overall, there was a fall in demand from 2021 to 2022 (Table 1ii). The total number of calls in for appointments were 8553 in the year 2021 and 6670 in the year 2022. The demand had further decreased in the year 2023 where there were only 5784 calls in the 8-month period. Table 2 showed the decline in calls over the selected 3-year period, and a 32% drop in calls from 2021 to 2023.

Table 2 Total inbound calls for doctors and nurses' appointments in the three phases.



Other than a reduction of telephone calls for GP appointments, the analysis evidenced a shortened length of calls since the implementation of joint consultations (Table 3). The average call time in 2021 was 3.01 minute and 2.9 minutes in 2022 and 2023. This pattern suggested effective joint consultations, that when patients called in for appointments, they only had to refer the staff to the last joint consultation where many of the outstanding issues would have been addressed to a large extent, if not completely resolved. In this context, patients did not have to explain as much as before. Clearly, the joint consultations had alleviated the need for in-depth exploration of concerns when patients called in. When each call was shortened, time was freed up at reception for staff to take more incoming calls. This also resulted in fewer missed calls (Table 4). Notice in 2021, the practice experienced a large volume of missed calls but the least missed calls in 2023 (Table 4).

The alleviated telephone traffic could be translated to increased equitable access to GP services via telephone. However, we noticed from May 2023 onwards, telephone conversations were becoming lengthier. This observation could be explained by the fact that staff on reception were no longer simply providing appointments based on desire, but on health needs. The longer telephone conversations were a reflection on staff taking time to obtain more in-depth information from the callers. This is because staff knew they could do so without a backlog of queues; by giving time to each call, appointments could be better assigned fairly and more equitably based on care needs, rather than on NHS service users' desire.

Table 3 Lengths of inbound calls for doctors and nurses' appointments in the three phases.

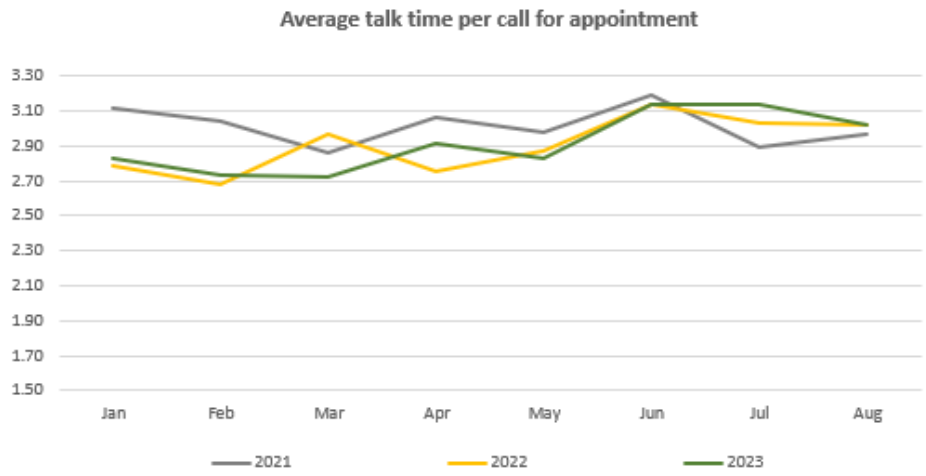
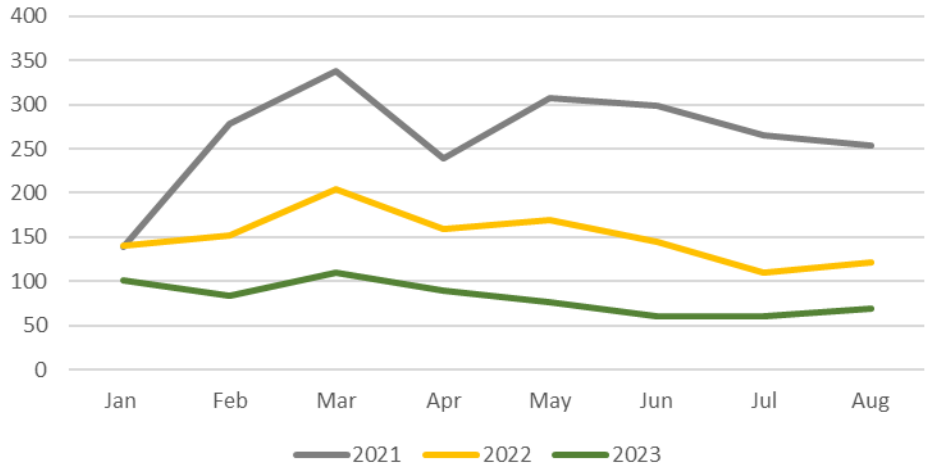


Table 4: Number of missed calls



Discussion

The reason for selecting these three periods for analysis was due to the fact that these 3 periods shared very similar contexts and comprises lesser external variables on GP appointment demands. The periods reviewed excluded the October school holiday and Christmas celebrations both of which had significant impact on incoming calls in the period of September through to December. However, it was important to note that the selected review period in the 8 months within the three phases comprised some degree of differences, this was particularly pronounced in 2021. There was a rise in calls when lockdown came to an end in March 2021 and again in July 2021when social distancing was no longer imposed at GP practices. Many NHS service users who had not seen their GPs in a face-to-face context for almost two years, were anxious about their health and so they would start calling to obtain GP appointments at the first opportunity. The high number of telephone calls in that period could therefore be explained as a result of the end of the pandemic lockdown. Other significant events that had an impact on patient demand and produced the variances in this review included the re-emerging COVID threats in July 2022 and the King's coronation in May 2023. These significant events would have in one way or another, contributed to the various demands in GP appointments differently. That said, the proportionately reduced number of missed calls from the 2021 to 2023 demonstrated that these variances did not have a significant impact. However, it is important to acknowledge that without a prospective research study to control or measure the variabilities, we cannot be one hundred percent confident that the patient demand in GP appointment was a direct consequential outcome of the joint consultations.

Nevertheless, the reviews provided a good insight to the trends of GP appointment demands. The fact that consultations were the core activities in a GP practice that they were very likely to have a direct impact on patient demand for appointments. Hence, this review was able to explain the patterns of incoming telephone calls as consequential outcome of the joint consultation provisions. As demonstrated by this review, between 2021 and 2023 there was a 32% drop in numbers of telephone calls made to the surgery for GP appointments. Time was freed up on reception to allow staff to take more incoming calls. In this regard, we should see an increased in the number of telephone calls. Yet, this was not observed. In addition, in the same period, each call was shortened, this meant, that the alleviated telephone traffic with lines being free up, strongly suggested increased equitable access by the NHS service users. It also meant, staff on reception, on receiving an incoming call, were able to take time to ask more in-depth questions regarding the purpose of call. Due to the fact that more information could be gathered, a safer disposition of care can be rendered at reception level. This observation was obvious towards the tail end of the final review when staff were better trained in care-navigation.

The same observation also highlighted one other important point; the joint consultations which aid with reduction of calls and promoted staff choice to engage in a longer conversation as needed, had allowed reception staff at individual practice to employ the same techniques as expected of care coordinators at PCN level[6]. This raised the question if funds allocation for employing care coordinators at PCN level was the right choice. Based on the findings of the review, investing in existing staff at practice level may be more sensible, more so when

recruitment costs are always higher[11]. Also, given the fact that care coordinators at PCN level will not have the same level of rapport with patients, care-coordinators may hinder the care navigation process. In this regard, more energy should be focussed on retraining and retaining existing core practice staff.

Coming back to these joint consultations, when we first introduced the joint nursing ones, where NHS service users ended their encounter with the ANP, patient dissatisfaction rate was significantly raised. The heightened patient dissatisfaction rate was reflected in the UK GP patient survey[12]. It took the GP practice three long years to change the culture and to successfully instil in individuals the concept of self-caring behaviours, that ending their GP practice encounter with a non-GP health professional had become less problematic. Nevertheless, until now, not every NHS service user was receptive to the idea of not seeing a GP when they so desired. That said, more individuals were beginning to experience the usefulness of our joint nursing consultations. This was demonstrated by the reduction of telephone calls. Our in-house surveys also showed that individuals having had the experience of joint nursing consultations appreciated the benefits. Those who had experienced the escalation of care to a GP via the joint nursing consultations, were receptive about the idea and identified with us the importance of first receiving a health screen by the HCA prior to seeing an ANP or a GP. In essence, only those who experienced the holistic management of care were able to appreciate the rationale for triaging right at the start of any joint consultations.

Our review demonstrated that the overhaul of consultations which cost the surgery a significant investment in time and effort in the last three years, had resulted in a small incremental improvement in our telephony system. Drawing parallels, achieving equitable and fair access within a "Modern General Practice Model" was likely to remain a steep climbing curve. Despite the foreseeable challenges, our review demonstrated that these joint consultations had negated the need for a layer of middlemen of SPOC. It has clearly demonstrated the need for reallocation of healthcare fundings so that it is diverted to individual practices for training and upskilling the core team for establishing joint consultations. Only then, can GP access be truly equitable and regarded as fair for all NHS service users.

Conclusions

In view of the fact that many GP practices have already implemented Modern General Practice Access model as prescribed by the general practice recovery plan but were still, finding it challenging to improve GP access for their NHS service users[13], the results of our review should hopefully serve as an encouragement. As advised by Madan et. al turning tides for palpable changes in consulting rooms takes time[1]. Our study supported Madan's view. It demonstrated that significant improvements were the consequential outcomes of our joint consultations, all of which had happened within a GP practice at a slow but steady rate. Despite attributable factors of the substantial variability in the incoming telephone calls for GP appointments in the three different phases, the variability which reflected the improvements to our telephone demand for GP appointments was a consequential outcome of the well thought out amendments we made to our consultations. Clearly, there was a reduction in the number of telephone calls for GP appointments after implementing the new approach to consultations. As a result, this allowed the calls from each and every NHS service user to be handled with better care, achieving more efficient triaging at reception level, and overall shortening each telephone encounter. As discussed, the improvement was not simply about shifting these GP appointment demands to other healthcare colleagues using care co-ordinators through SPOC, but was based on our modified consultations, which harnessed the important concept of holistic care which effectively addressed the concerns of the NHS service users. Our results highlighted one very important shared lesson; if one was willing to take the risk in turning tides, one would enjoy the positive process that could fetch good outcomes that must be well supported by appropriate reallocation of governmental fundings to individual general practices.

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