Life & Times

Seeing double:

expanding GP capacity through teamwork and redesign

UNDER PRESSURE

Like many practices, we've felt the pinch from a shrinking GP workforce. Over a period of some years we've suffered from GP turnover: younger GPs emigrating to Australia or Canada, with the more senior among us contemplating approaching retirements. Recruitment has faltered and failed.

We responded with some radical ideas and embraced change. This year we merged with a 'super practice' to ensure our future viability and we also decided to recruit two advanced nurse practitioners to spread our workload. But we also came up with a novel idea to redesign the GP consultation involving our practice nurses, effectively expanding GP capacity.

CONSECUTIVE CONSULTATION

The idea was simple but challenging. For suitable patients, might it be possible to split the consultation such that history taking and basic observations or examination could be done by the nurse, with the GP then completing the consultation after a brief handover? The nurse then starts a new consultation in the next room — and so on.

Would our nurses support this? Well, it turned out that the nurses saw an opportunity for improving their minor illness and assessment skills through close teamwork with GPs. So a trial session was booked in May 2016. Patients were booked at 5-minute intervals, but each patient experienced a 10-minute consultation between two clinicians consecutively, with the nurse and GP alternating rooms. We scheduled two blocks of 18 patients with a half-hour break between. It was fully booked yet we ran to time and informal patient feedback was encouraging. The GP's appointment capacity had effectively been doubled.

CLINIC ROLLOUT

To benefit the practice and expand capacity, we needed to deploy these sessions throughout the week. We coined it '1-Clinic' to emphasise its suitability for one problem. To simplify patient booking, we wanted to exclude only the severely ill (physical or mental) or frail. The direct GP input helps support a much wider range of presentations than just 'minor illness'. Patients are told at the time of booking how the appointment will work and asked whether this is acceptable.

Rollout required our other nurses and GPs to support the clinic and we invited this initially on a voluntary and trial basis. Adaptation of GP consultation style is required, yet only one GP opted out. Far from being a minor illness clinic, we routinely make hospital referrals and sometimes admissions, and have achieved major diagnoses. We have also found the system suitable for follow-ups, medication reviews, and some chronic disease management. We work as a two-person team handling one complex patient stream and, effectively, we have achieved the appointment capacity of an additional GP for the cost of a practice nurse, assuming consulting room availability. Yet the nurse is also available to chaperone, take ECGs, or monitor patients before admission.

IMPACT ON CAPACITY AND CONTINUITY

Like others, we have previously implemented 'Advanced Access'[1] — meaning brought forward or same-day access — to improve patient access to us. However, this created problems with continuity and forward booking, and some patients were certainly unhappy with phoning day after day, trying to get an appointment. This fits to a degree with a controlled study of Advanced Access in the UK, which found only slightly shorter waits and no improvement in workload or continuity.[2] We also tried 'Open Access' each weekday morning, but this similarly impaired continuity and forward booking through 'carve-out' of the schedules.

But isn't capacity the real problem here, rather than how you engineer your appointment system? Ultimately, you can't squeeze a quart into a pint pot! So, alongside our rollout of 1-Clinic, we counted unused GP appointments in the previous week — to reflect ease of access; and the number of forward bookable appointments each week — which supports continuity.

We found that the pre-bookable appointment count is strongly correlated to the number of 1-Clinic sessions ($r^s = 0.70$, $P<0.001$). Similarly, unused GP appointments are also strongly correlated with 1-Clinic session counts ($r^s = 0.64$, $P<0.001$). The increased capacity allows the schedules to be more open. Ideally, capacity would approximate peaks in demand, meaning that unused appointments would be the norm.

The initial clinic configuration of 18 + 18 patients at 5-minute intervals did prove to be daunting for clinicians. Timings were therefore relaxed to 6 minutes and fewer patients, but still providing 130 'new' GP appointments weekly. Reassuringly, 100% of a small sample of 49 patients were willing to reuse the clinic, showing it to be acceptable.

ONE YEAR LATER

From day 1, we found that the nurse could often complete a consultation and perhaps just need a prescription signed, particularly if trained in minor illness. This releases the GP to call another patient, and in fact the clinic has naturally morphed into a more flexible operation where consecutive consultation is employed when needed. 1-Clinic continues to remain an essential element of our capacity management.

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