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 teamworking 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’ — 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.\(^1\) 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 has naturally morphed into a more flexible system 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.

REFERENCES