

Economies of scale

*'A radical restructuring with bigger and better organised practices, and units of 30 000–50 000 patients, is needed. This will afford economies of scale, diversification in careers, standardisation, and less chaotic working.'*¹ I applaud the sentiment, but there are some assumptions that worry me:

The pain of repeated radical restructuring is possibly the worst part of being a doctor in the UK, however well motivated the orchestrator and however good the ideology.

'[B]igger and better organised.' I presume a causal relationship is suggested.

I hear this over and over again from colleagues at locality and PCO level. I fear the hand of McKinsey and the like. We have all worked for bigger NHS organisations. The experience is often what drives a doctor away from hospital medicine. My personal and ongoing proxy experience of bigger NHS organisations throughout the service is chaos, waste, poor management, miserable workforces, a bullying culture, and the institutional inability to understand professional autonomy. Quite awful reliance on over-sold IT systems and the use of 'Information' (the illegitimate child of fundamental data and communication). I have only ever seen one genuine example of 'economies of scale': paper is a little cheaper when bought in bulk.

Diversification in careers: doesn't this presuppose that general practice is, in fact, a non-career; a second class specialty? Just what the article seeks to reverse. Standardisation and less chaotic working can surely only happen where the patients only have one illness?

Andrew Polkinghorn,

GP Partner, Verwood Surgery, Dorset.

E-mail: andrew.polk@nhs.net

REFERENCE

1. Spence D. General practice in meltdown. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685021. <http://bjgp.org/content/66/646/259>.

DOI: 10.3399/bjgp16X685837

The Roundhouse model

There is a lot of discussion about 'new' models of general practice and primary care.¹ I am currently in the US where health service reform is moving apace to improve the patient experience and outcomes, and

reduce costs. What is frequently forgotten in a lot of these discussions is that primary care providers, including GPs, advanced nurse practitioners, physician assistants, and other members of the co-located team, will not necessarily have the skills to work collaboratively together. Although interprofessional education is a feature of many undergraduate health professional programmes in the UK, Australia, and elsewhere, the majority of graduates are not 'collaborative-ready', are unused to working in teams with other professionals, and are frequently unaware of the roles and responsibilities of their colleagues. Once qualified, interprofessional development is also less common. New models of care require changes to education and training. Interprofessional collaborative practice is the way forward, but there will need to be investment in preparing the workforce for this way of interacting.

Also, I understand from architects that round buildings are very expensive to build.

Jill E Thistlethwaite,

GP and Academic, University Health Service, Sydney.

E-mail: jill.thistlethwaite@uts.edu.au

REFERENCE

1. Lewis DM, Naidoo C, Perry J, Watkins J. The Roundhouse: an alternative model for primary care. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685129. <http://bjgp.org/content/66/646/e362>.

DOI: 10.3399/bjgp16X685849

Learning disability registers in primary care

We thank Russell and House for raising an important issue that we lacked space to discuss in our paper.¹ Although we noted that 'practices may not identify all [intellectual disability] ID individuals, especially those with mild ID', it was not our intention to underestimate this difficult task.

Adults with ID not known to primary care in England have been described as a 'hidden majority', due to administrative health systems failing to detect a large proportion of mild and moderate ID.² Large discrepancies have been seen between the administrative prevalence of mild or moderate ID identified in school-

age children compared with adults from primary care registers (the 'transition cliff'²), and Public Health England has estimated that 2.17% of the English adult population may have ID.³

A meta-analysis estimated global ID prevalence at 1.0%,⁴ falling to 0.5% when only adults were considered. Our study of adults in England estimated a prevalence of 0.54%,¹ similar to a recent Scottish study (0.56%).⁵ Prevalence rates in adults calculated using QOF registers have stabilised around 0.5%,⁶ so a true prevalence of 2.0%, implies 3/4 patients with ID are not on QOF registers. In our data, only 8% of practices had a prevalence >1.0%, so although ID coding is highly variable across practices, any potential under-recording of ID must be consistent across them.

In our data, among those with severity recorded, about 1 in 4 adults were classified as severe/profound, compared with 1 in 5 estimated known to schools in 2013.³ Assuming all severe/profound patients have been identified, and the under-recording is only of mild/moderate ID, then 2% prevalence would result in only 7% (1 in 15) of our patients having severe/profound ID, much lower than 1 in 5.

Finally, the implications for any under-recording in our study would be that our comparisons with the general population are exaggerated, as we assume that ID patients with chronic comorbidities are more likely to be known to primary care, presumably having their ID recorded as a result. However, our central message of improving continuity of care and offering longer appointment times is not changed. Nor should it detract from efforts to better collect and identify ID among adults.⁷

Iain M Carey,

Lecturer in Epidemiology and Medical Statistics, St George's, University of London.

E-mail: i.carey@sgul.ac.uk

Fay J Hosking,

Research Fellow, St George's, University of London.

Stephen DeWilde,

GP and Senior Lecturer in Primary Care Epidemiology, St George's, University of London.

Tess Harris,

GP and Reader in Primary Care, St George's, University of London.