

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?

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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.

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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

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Poor adherence to gonorrhoea treatment guidelines in general practice in England

Gonorrhoea diagnoses are on the increase in England and a cluster of high-level azithromycin resistance was detected in 2015.^{1,2} Treatment options are limited and, in response to emerging antimicrobial resistance, treatment guidelines have changed twice since 2004.^{3,4} Current recommended treatment for gonorrhoea is dual therapy with 500 mg ceftriaxone (intramuscularly) and 1 g azithromycin

(orally).³ Following a diagnosis of gonorrhoea in general practice, referral to specialist sexual health services for treatment, test of cure, partner notification, further STI testing and culture for antimicrobial susceptibility testing is recommended.⁵

Here, we report the results of an analysis of data from GPs in England from the Clinical Practice Research Datalink, an anonymised extract of visits to a sample of GPs whose patients are representative of the UK population.⁶ As the treatment guidelines were last updated in 2011,³ we focus on the gonorrhoea diagnoses reported from 2011–2014. During this time, an estimated 4150 gonorrhoea diagnoses were made by GPs in England, representing 4% of the total number of diagnoses made in all clinical settings reporting data (GPs and specialist sexual health clinics).

The proportion of cases treated each year by GPs fluctuated between 50–52% ($P=0.729$). Among those treated, the proportion given the recommended dual therapy ranged from 11–5% (2011–2014; $P=0.488$). Most cases were prescribed antibiotics no longer recommended for the treatment of gonorrhoea. From 2011–2014, the proportion of gonorrhoea diagnoses for which penicillins were prescribed fluctuated between 15–20% ($P=0.729$), whereas that of ciprofloxacin and azithromycin monotherapy ranged from 15–5% ($P=0.166$) and 7–30% ($P=0.166$), respectively.

These findings are consistent with trends reported prior to the most recent change in treatment guideline in 2011.⁷ Although GPs diagnose fewer cases of gonorrhoea than specialist clinics, they make an important contribution to the management of this infection and there is a need to raise awareness of current treatment guidelines among them; this has recently been highlighted in a letter from England's Chief Medical Officer to GPs.⁸ Prompt and correct treatment of gonorrhoea is required to prevent treatment failure, onward transmission, and the further emergence of antimicrobial resistance.

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Correction

In the February 2016 article by Elsey H *et al*. Green fingers and clear minds: prescribing 'care farming' for mental illness. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X683749, the third author's name was incorrectly spelled with a 'y'. Her name is 'Rachel Bragg'. This has been corrected in the online version.

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