

Debate & Analysis

The Roundhouse:

an alternative model for primary care

INTRODUCTION

The challenges facing health care are well known. They include an ageing population, increasing expectations, and shrinking budgets.¹

GPs remain key in the provision of primary care in the current model and report that they are failing to cope with rising demand.¹ Increasing concern that the 10-minute GP appointment is obsolete² in the face of increasing comorbidity adds to these pressures.

NHS England's *Five Year Forward View* nevertheless emphasises that 'The foundation of NHS care will remain list-based primary care.'³ It also reiterates the concept of redeploying care from secondary to primary, so-called 'shift left'.

This article presents an alternative model for delivering GP services. No single element of the model is new but the overall concept is revolutionary. The model's integrity is key. It seeks to improve productivity through using the skills and knowledge of the GP to maximum effect while introducing a range of healthcare professionals to relieve the pressure of less complex care.

THE GP

The daily tasks of a modern GP would be instantly recognisable to their predecessor at the inception of the NHS in 1948. They are booked for most of the working day for face-to-face consultations with patients who 'believe themselves to be ill'.

What is different is the GP's training and remuneration. In 1948 a GP's training would have comprised 6 years. The modern GP has up to 11 years of training. Despite this, modern GPs continue to see 'undifferentiated illness'. In addition, most personally type up patient notes (probably 2 hours of a GP's day is spent typing [D Lewis, unpublished data, 2014]), and address all clinical decision making (100–200 laboratory results, 150–200 prescribing queries, 50–100 incoming hospital letters, per GP per day.)

The modern GP is relatively more highly paid than their 1948 counterpart. In England GPs earn £80–120K per annum.⁴ In view of the burgeoning workload, and oppressively long hours, many GPs feel they earn their money and would naturally be very reluctant to countenance a reduction.

Are the tasks listed above an appropriate use of such a highly paid, highly trained healthcare professional?

SKILL-MIX

General practice has experimented tentatively with 'skill-mix'. As long ago as 1991 Dr GN Marsh was providing care for a list of 4000 patients by delegating clinical responsibility to other healthcare professionals, mostly nurse practitioners.⁵ More recently, healthcare assistants have been introduced to perform basic clinical duties and to take pressure off practice nurses. In turn, practice nurses have taken over most chronic disease management, usually working to agreed guidelines. Practice pharmacists are occasionally found in larger practices tackling the growing medicines management task. Some pharmacists are also prescribers and have relieved GPs of medicine reviews, prescribing optimisation, and the audit task around prescribing/medicines management. There are a number of advanced nurse practitioners (ANPs) whose scope of practice varies.⁶

PHYSICIAN ASSISTANTS/ASSOCIATES

The physician associate (PA) (previously known as physician assistant in the UK) is a new healthcare professional that can significantly contribute to the primary care multidisciplinary team.⁷ PAs have been practising successfully in the US for almost five decades. In the US as at December 2013 there were 95 500 certified PAs.⁸ The model has been adopted in the UK and in 2006 the Department of Health in conjunction with the Royal College of Physicians and the Royal College of General Practitioners, following wide consultation, produced a *Competence and Curriculum Framework* advising on standards for the education of PAs in the UK.⁹ It defines a PA as:

*'... a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.'*⁹

Several universities in the UK have been training PAs since 2004 (pilots initially with established programmes beginning in 2008). Momentum is gathering and more universities are looking to open PA programmes across the country, significantly increasing the supply of PAs in the future.

Students are mainly life science

graduates with some graduates from professions allied to medicine. PA students undergo a 2-year intensive medical training programme and then have to pass a PA national exam.

According to the UK Association of Physician Associates (UKAPA) census (2015) (now the Faculty of Physician Associates at the Royal College of Physicians [FPA]) there are 223 PAs and 191 PA students in the UK. Most PAs are currently employed in secondary care but there are many examples of PAs working successfully in primary care.

Recent studies have reported high levels of patient satisfaction with PAs and other studies examining the attitudes of other healthcare professionals to PA team members have been positive.^{10,11}

Mean pay for all PAs who work more than 30 hours per week is £35 620 per annum.

There are examples of how PAs can be integrated into a primary care organisation. Midlands Health Network New Zealand,¹² who were charged with investigating alternative models of primary care, wrote a detailed report on how the company Group Health in Seattle significantly changed the way patients interacted with their GP. In this model the GP leads a multiprofessional team containing nurses, pharmacists, and PAs.¹²

THE 'ROUNDHOUSE' MODEL

The Roundhouse model relies on a particular skill-mix, supported by an innovative building that defines patient flow and facilitates appropriate support for non-doctor clinicians. The Roundhouse building is shown in Figure 1.

The Roundhouse building

The Roundhouse consulting suite comprises a circular arrangement of consulting rooms, each with two doors. Patients enter through the doors on the larger circumference. The inner doors give access to the 'Roundroom': the hub of the complex.

THE ROUNDHOUSE STAFF

The clinicians

The clinicians are responsible for face-to-face patient contact and occupy the circle of consulting rooms. They would comprise a multidisciplinary team drawn from various skill levels and specialties. The team on any particular day could include the following:

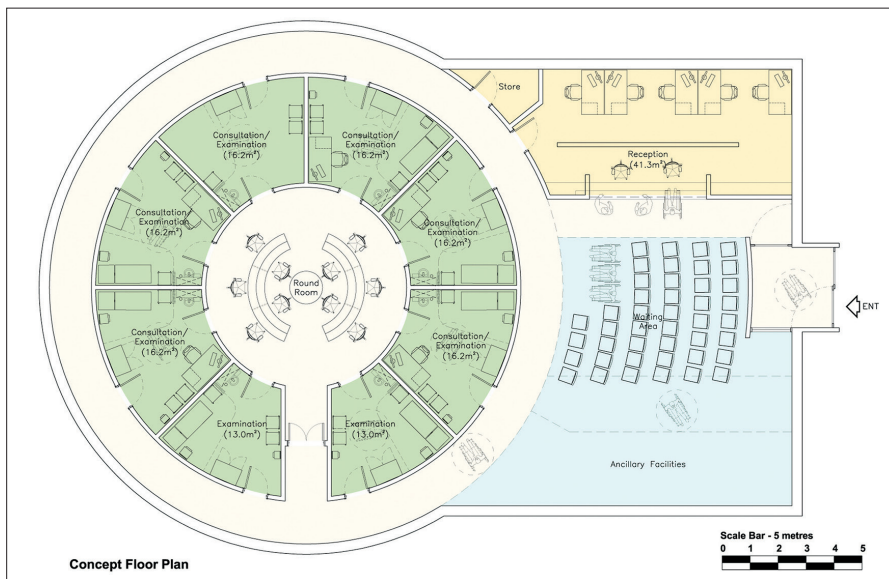


Figure 1. The Roundhouse building.

- physician associates;
- advanced nurse practitioners;
- practice nurses;
- community pharmacist;
- orthopaedic practitioner;
- community psychiatric nurse;
- GP trainee; and
- GP returner.

This team would be the first face-to-face contact for patients using the Roundhouse service. Before the consultation, patients would have been triaged and allocated to an appropriate professional by the triage team in the Roundroom.

Triage team (in Roundroom)

The triage team would occupy the Roundroom and consist of triage nurses supported by GPs. In this context GPs are rebranded as consultant primary care physicians (CPCPs). Initial triage would be by telephone only.

All requests for appointments would be routed to the triage team of experienced triage nurses supported by CPCPs 'looking over their shoulders'. The majority of patients would be booked with their usual PA, although some patients might be diverted to a more appropriate healthcare professional, such as an orthopaedic practitioner or a community psychiatric nurse. The option of seeing a CPCP directly would not be offered.

Consultant primary care physicians

In the new model, GPs, re-titled as CPCPs, would staff the Roundroom in shifts. Their role would include:

- overarching clinical responsibility for the Roundhouse;
- immediate support for any of the clinicians requiring higher-level advice;
- advice to nurse triage team colocated in the Roundroom;
- telephone consultations;
- telephone triage;
- email consultations;
- checking online resources for up-to-date advice on management of complex clinical problems; and
- advice to home-visiting PAs, paramedics, emergency care technicians, and community nurses via video-links and headcams, with images relayed onto large screens in the Roundroom.

The ratio of CPCPs to primary clinicians would allow immediate availability of a CPCP to be called into a consulting room to advise on a patient with complex problems. In this model, GPs with a modern training (rebranded as CPCPs) are used in the role for which they have been trained: high-level clinical decision making and management of particularly complex patients.

Patient experience

Patient experience would be at the centre of this model. We know that continuity of care is important to patients and this would be achieved by a long-serving team of PAs and ANPs. However, from a patient's perspective 'my doctor' would not be a doctor, which would involve a significant cultural change. Dramatically reduced staff costs would result in a larger team.

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Access would be significantly improved. Safety would not be compromised as an experienced medical opinion would be instantly available, preventing the need for patients to book further appointments on another day.

CONCLUSION

The future of primary care is likely to involve a radically different way of working and the Roundhouse is a suggested option. The skill-mix will become more complex. It would involve a cultural shift for primary care professionals and for patients.

Currently GPs and their teams are caught on a treadmill trying to meet escalating demand while lacking time to reflect on how to provide and organise care for the future. They are aware that more of the same is not the answer.

A Roundhouse pilot would test the concept and provide data for details such as the best ratio for CPCPs:primary care patients.

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Provenance

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