Dr Allison Reid, Dr Lynsay Crawford & Dr Alyson Hee
Balmore Surgery
Possilpark Health and Care Centre
99 Saracen Street
Glasgow
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Mr David Williams
Chief Executive Officer
Glasgow City Health and Social Care Partnership

24 July 2015

Dear David Williams

We are submitting a request for extra resources to be allocated to Balmore Surgery to cope with escalating levels of workload which are creating a challenging and stressful environment for both patients and staff; without this the practice cannot survive and the GPs will be forced to resign.

There is no denying a crisis in general practice in the UK with multiple reasons behind this – increasing patient demand, more elderly patients with long-term ill health, increasing numbers of asylum seekers, tight budgets, poor GP morale and a recruitment crisis with fewer new GPs and the early retirement of older GPs due to stress. This is all creating a perfect storm for the profession in general but is having an even greater impact in deprived areas and the GPs who serve them.

Balmore Surgery is a Deep End practice and the 3rd most deprived surgery in Scotland. As we will detail later, this results in all the challenges that health inequalities bring, yet we have consistently provided high quality medical care to our patients (evident in our QOF achievements and prescribing data) and have excellent patient feedback in our patient surveys. We are exactly the sort of practice that the Government promotes, working in a difficult environment while delivering good quality personal medical care but we need help to continue providing the service our patients deserve to the high standards we feel are important in conscientious professionals. It is a measure of the pressure we are under that we have swallowed our stoic pride and asked for help. Simply put, we cannot continue without help.

The press is full of failing/struggling practices and health boards having to take them over – Forth Valley has been particularly hard hit – yet GGHB is unique in not being in that predicament. However, without additional support Balmore Surgery may become the first.

Since we approached GGHB a few months ago the situation has deteriorated. Our initial request to close our list resulted in a meeting with health board colleagues. It was clear that the situation was more complex than merely closing our list and we warned that all the Balmore Surgery GPs were close to resigning due to intolerable stress. Sadly, that prediction

has come partially true. Dr H announced at the beginning of July that she is resigning due to work-related stress and an impossible workload. She has 3 months notice to work before leaving. The prospect of finding a locum to cover her 7 sessions is daunting and impossible; never mind finding a new partner. The situation was desperate with all 3 partners working but if we cannot find a locum or new partner, then the practice will fail and terminate its contract with the board.

We are now in the position of needing to provide background information to support our initial request for additional resources, with the added complication of an impending resignation.

Allison Reid and Lynsay Crawford (GPs) have been in post since 1997 and 1998 respectively; this is the 3rd partner we have lost due to workload. Dr C joined us in 2000 and left in early 2007 – she emigrated to Australia (as have so many GPs) for a better work/life balance; Dr M replaced her in 2007 and lasted until March 2012 – she also struggled with workload, and in addition to taking extending maternity leave twice she also reduced her sessional commitment as a way of coping but to no avail – she left; Dr H then joined on 1st April 2012. She has now resigned. Three excellent doctors and fine colleagues – what a loss to the NHS and the people of Possil.

Having set the scene and provided background on our current situation we would like to explore the issues in more detail.

WORKLOAD

What have we done to help ourselves?

Our actual list size is 3,500 but our patients generate a higher level of demand due increased morbidity and higher disease prevalence (see data later in the letter). We have 3 partners who work as follows; Allison Reid = 7 sessions, Dr H = 7 sessions and Lynsay Crawford = 5. Although all 3 partners are classed as 'part time' the hours we work would contradict that; Lynsay Crawford works 5 sessions which equates to 24 hours while Allison Reid and Dr H work 7 sessions which equates to 36 hours spent physically in the surgery and several more hours per week working remotely from home e.g. Docman and referrals (completing work that could not be done during surgery hours). In the UK working full time is classed as anyone working over 35 hours per week – Allison Reid and Dr H would fall into that category.

For clarity a session= a half day. In theory, this would be 8am-1pm, 9am-2pm or 1pm-6pm; the reality is longer.

In addition we have a 3 session retainer – who joined us in January 2015, replacing our previous retainer who had been with us for 4 years. We embarked on the retainer scheme while Dr M was with us. Workload was already increasing then and we hoped that employing a retainer, while costing us money, would reduce our work/stress – it has not. Having a retainer is not like having another partner; they function at a significantly lower level and have a very protected contract. In theory, we were offering more GP appointments and had blocked off protected time for the 3 partners to complete onerous admin/referrals etc, but the protected time has always been 'unblocked' and used to see patients as demand has inexorably increased. Employing a retainer has not reduced

workload but has reduced our drawings – it feels very much as if we are personally funding the NHS but it is an example of how we have tried to resolve our difficulties ourselves.

As part of QOF we undertook an analysis of how we work – right person, right time. It looked at each appointment for both GPs and nurses and we completed data about whether the consultation was necessary or could it have been dealt with by someone else. The results were clear – 99% of the GPs consultations needed a face-to-face GP appointment and could not have been dealt with by another health professional or over the phone; the nurses' results were similar, in fact some of the nurses' appointments should have been GP appointments. It is true that the nurses often have to ask us to review patients in their rooms who need to see a GP – these appointments will not show up on the EMIS appointment book as GP consultations because they are booked in a nurse slot – so will give a false result on how many people we see (we should add them as extras at the end of our surgery for data purposes but, guess what, there is no time). The conclusion from this data collection exercise is that the patients needed to see a GP and we could not 'off load' the demand appropriately, or safely, onto anyone else.

We have increased our nurses' hours to combat workload and help with chronic disease management (CDM). Apparently, having 2 full time nurses in a practice of our size is unusual; perhaps that speaks volumes about practice demand. Again, this is an example of us paying to support the population's demands from our own pockets. Our 2 nurses, R and L, are magnificent, both clinically and as colleagues, but they too are feeling the strain. R is our senior practice nurse and almost single-handedly runs our CDM and sees patients. L was initially appointed in a treatment room capacity but her role has expanded and she too does CDM and sexual health e.g. implants. We increased L's hours this year to full time to help with CDM, recall of patients and notes summarising; the latter because there is no time for the partners to summarise notes.

Other steps we have taken to combat workload;

- **i)** We have an excellent pharmacist – AF – who is in the practice weekly. She completes most of our prescribing audits and has been doing some CDM clinics for us e.g. Asthma reviews/inhaler checks; analgesia reviews; Polypharmacy reviews; and most recently Chronic Pain reviews. She has found it challenging to get patients to engage or attend, as has even visited them at home to increase uptake.
- **ii)** In the last few months the Financial Inclusion service has come to Possilpark Health Centre via Citizen's Advice. Despite posters, leaflets and the GPs actively referring patients – they have failed to engage. We had hoped this would reduce the number of appointments related to benefits issues but there has been no obvious reduction so far.
- **iii)** We are always open to initiatives that may help patients while also reducing workload. Last week we signed up to the new Alcohol Initiative that will see a named Alcohol Addictions worker being attached to the practice. We are optimistic this will help with the significant alcohol problems in Possil and, hopefully, increase patient participation and ultimately, reduce the burden of alcohol-related morbidity in our patients.
- **iv)** We introduced a 'drop in' clinic on Monday mornings rather than appointments. This was to 'mop up' demand created over the weekend or for people who have not

contacted OOH and waited for us to open to get medical help. This started in January 2015 and we hoped by offering this facility on the busiest day of the week it might take pressure off demand for appointments later in the week – we are not convinced it has – maybe demand was just going to increase anyway or this was previously unmet need.

What are the workload issues?

1) **Disease burden/prevalence**; the population we serve have above average levels of ill-health and these stats, collated from EMIS population manager and from www.isdscotland.co.uk . We have picked a few of the key disease areas rather than go over them all.

   The % lists below are from **2015** EMIS Population manager

   Obesity = 11% of the practice list has a BMI>30
   Mental Health (psychosis etc not simple depression) = 1% (42 people)
   Hypertension = 13% (467 people)
   Diabetes = 7% (231 people)
   COPD=4% (153 people)
   Cancer 3% (90 people)
   Ischaemic Heart Disease = 5% (193)

   Standardised mortality ratio per 100,000 (from **2013**)

	Scotland	Hyndland	Balmore
All deaths	787	718	1412
Alcohol-related	27.1	24.5	72.1

   QOF/Prevalence (from **2013**)

	Balmore	Hyndland
Cancer	77 (2.25/100)	47 (1.86/100)
IHD	206 (6.02/100)	44 (1.74/100)
COPD	143 (4.18/100)	16 (0.63/100)
Obesity	331 (9.68/100)	54 (2.13/100)

   We have compared our data with a more affluent area of Glasgow (Hyndland) to show the stark reality of Health Inequalities; Possil and Hyndland are only a few miles apart geographically but clearly worlds apart in health terms. There are small differences in the % above as they are from different years; some of the sources did not have 2015 data yet.
   More data
   Raw prevalence per 100 patients; this is from **2013**

	Scotland	GGHB	CHP	Hyndland	Balmore
Cancer	2.18	2.99	1.77	1.86	2.25

IHD	4.29	4.18	3.95	1.74	6.02
COPD	2.21	2.42	2.79	0.63	4.18
Diabetes	4.81	4.58	4.51	2.57	6.40
Mental	0.88	0.99	1.09	0.51	1.14
Smoking*	24.87	23.65	22.46	13.16	29.17

*(Relates to smoking related ill-health)

It is clear looking at the raw data that our patients have greatly increased rates of disease prevalence no matter how you look at it – CHP wide, within GGHB and in comparison to Scotland as a whole.

What those bold figures do not show is the increased workload they generate. To achieve the 90% targets rates for QOF payments we, and our nurses, have to work much harder to achieve coverage of many more patients; it is well documented that patient from deprived areas are much harder to engage with CDM and follow up.

If we look at COPD as one example; our 2014 EMIS database shows we have 153 patients with COPD = 4% of the list size. That is 153 people to see annually just for their QOF COPD assessment – they also need the COPD LES template completed too. That is just the basic nGMS box ticking completed. They will also need seen for their flu-jags and will have, on average 3 exacerbations per year of their COPD; many of our patients have severe COPD and are housebound or on home oxygen. That means ~450 appointments or house calls on top of the 150 appointments for their QOF COPD reviews and further appointments for their flu-jags.

These figures do not count the return appointments following their acute exacerbations or the fact that this group often have other co-morbidities they are attending for. Furthermore, we look after our COPD patients in the community rather than admit them, despite the increased workload for us. This is confirmed in our **Practice Activity Report of 18/7/2014**. This shows that, based on our CHP data, we are at the lower end of the COPD emergency admission graph – despite our much larger COPD prevalence overall.

Diabetes is even worse. We have 231 diabetics = 7% of the list size. A considerably higher percentage than the general population. They are each seen at least twice per year for a diabetic check, more if their control is poor. This involves a huge amount of nurse and GP time with reviewing of blood results and follow up. This is work previously conducted in secondary care. While we appreciate that primary care is more than capable of treating these patients the time and remuneration have not followed the exodus from the hospital clinics. Again, this is not all about QOF assessments and diabetic patients invariably have other chronic diseases too that need addressed – IHD, stroke, CKD, painful peripheral neuropathy. The workload implications are huge.

2) **Multimorbidity;** There are increasing levels of multimorbidity globally as people live longer, and no longer die from conditions which can now be treated. This disease burden is felt most acutely in deprived areas**; Lancet 2012; 380: 37-43**. Research shows that the onset of multimorbidity occurs 10-15 years earlier in people living in the most deprived areas compared with the most affluent; with socioeconomic

deprivation particularly associated with multimorbidity that included mental health disorders. Balmore Surgery is the 3rd most deprived practice in Scotland. The data we have provided on our disease prevalence reflects the research findings. Following the publication of this paper there were calls for GPS in deprived areas to have smaller caseloads because of the increased complexity of their patients' medical needs and the greater number of such patients.

3) **Social problems**; the population of Possilpark has well documented social problems compounded by the recent recession and the Government's overhaul of the benefits system. Lack of job opportunities creates a depressing environment that has seen addictions increase – drugs but particularly alcohol. Levels of depression increase due to job losses and consequent high levels of debt. With the reduction in benefits and the issues with ATOS medical assessments on behalf of the DWP, this has had the effect of increasing patient demand and increasing paperwork (benefits reports and then a merry-go-round of benefits appeals and requests for reports and letters of support). Appointments are used up increasingly for these issues.

   The situation is also exacerbated by the high levels of illiteracy amongst our patients who need help completing their benefits forms and have no-one else (cost free and accessible) to turn to; even the Citizen's Advice Bureau has a 12 week wait so where can patients be seen sooner?.....at their GP surgery, so once again we have to mop up demand. A lot of this information has been covered in reports from The Deep End project.

4) **Asylum seekers**; we have had an unprecedented increase in the number of foreign national/asylum seekers registering with the practice with enormous workload implications and no extra resources to help. There appears to have been 3 obvious reasons for this **1)** moving to the new Health Centre has increased our 'visibility' **2)** the sheer volume of asylum seekers being housed in this deprived community. Why were they not housed in more affluent and less-resource poor areas? A case of NIMBY no doubt**. 3)** the dissolution of the Asylum Seekers practice and the subsequent abandonment of the Asylum seekers LES – both of which resulted in all practices being forced to accept Asylum Seekers as 'routine' patients with no extra resources. We note that this point has been raised repeatedly by the LMC and was being raised again with Paul Ryan only last month.

   We have collated data to support our claims. In the year before we moved to the Health Centre we have **15** Asylum Seekers register with the practice. In the 16 months after we moved we had **123**! An enormous increase both in our list size, which is usually fairly static, and in workload. The Asylum Seekers are high users of the NHS for multiple reasons (background health conditions, mental health conditions related to fleeing war zones/torture etc, higher birth rates and more young children) and each of those consultations is complex and long. We require translators who have to be booked in advance – an increasing use of reception staff time in organising this – and they require double appointments which reduces the number of available appointments for other patients. Often either the translator or the patient does not turn up and the double appointment is wasted. We are unable

to use the translation phone line as the telephones in the new Health centre are not compatible.

A vast amount of reception time is taken up registering these patients due to communication difficulties and different cultural expectations of the service. We have tried to reduce the amount of time our reception staff have to spend on this but producing a laminated sheet, printed in many languages that says ' here are the forms to register with this practice; please take them away and return with them completed, your residency documents and with a translator so we can book you an appointment. We cannot safely see you without a translator'. We think this has helped a little but there are still huge queues at the reception desk as our staff try to deal with this problem.

The situation is equally challenging for clinical staff. We cannot safely see patients with whom we cannot communicate but they still do turn up without translators and demand to be seen; we have had to say no. There is a notice in the waiting room about this in several languages. We have had the following scenarios; a patient typing their problem into their Smartphone and using 'Google translate' and expecting the GP to do the same; another patient phoning a friend on her mobile to translate over the phone. This is dangerous for both patient and clinician; any mistake will have lasting effects on both parties.

Further analysis of all the Asylum seekers has shown that 44 are recording as needing translators; the true number may be slightly higher as many of those who say the speak English have poor language skills which make for challenging consultations. Nonetheless, if we focus on the 44 patients that are confirmed as needing translators our data shows they attended **451** times since registering in the last year. Each of these consultations will have required a booked translator and will have needed a double appointment (20 minutes instead of 10); that means the actual amount of consultation time needed equates to **902** routine appointments for just 44 people.

We cannot be expected to absorb this huge number of challenging, and deserving, patients without extra resources. To expect us to do so is not fair on the Asylum Seekers, the indigenous Possil population or any of the staff in Balmore Surgery.

5) **List size/GP ratio**; Our practice list size is 3,500 but the workload generated is that of a greater list size due to disease prevalence as outlined in point **1.** The weighted list size given in our Prescribing report is actually 5,080. As the 3 partners are all varying degrees of part-time we have calculated what the WTE for our surgery is, including the sessions provided by our retainer. We have a WTE of 2. If we then look at some historical figures, namely the Scottish 'average' list size per WTE GP which was ~1,500 (we have been unable to get more recent figures for list size per WTE as patients are now registered with the practice as a whole).

Using that figure our list size should be 3,000 for a WTE of 2; our list size is significantly greater than that and we are not an 'average' practice, as we have above average disease prevalence. It is clear we are 'under doctored' in our practice

workforce and that the practice needs more GP time than can be reasonably expected from the income.

That is just looking at the raw data. There is more to it than just list sizes. As the BMA has reported, the average person sees their GP 6 times per year; that is double what it was 10 years ago. Although our list size has been 3,300-3,500 over the last 10 years, that hides the fact that the consultation rate has doubled.

In fact, further analysis of our patients shows considerably higher levels of consultation. We attach data showing that 26% of our patients attended between **7-20** times and 2.2% attended more than 20 times – one outstanding character managed an impressive 86 consultations!

The recommended number of appointments that should be offered in a GP practice is 70-100 appointments per 1,000 patients per week. Having analysed our data we offer **147; 92 GP appointments and 55 nurse appointments.** That is more than double the lower figure quoted of 70 per 1,000 and well above the higher figure of 100. Obviously we are providing plenty of appointments but demand still exceeds what we offer, due to all the reasons we are delineating in this document.

Poverty= higher levels of morbidity =greater need for health care.

6) **Elderly**; people are living longer, even in Possil! There has been a rise in the number of elderly patients – particularly age 85+. Longevity is not equating with good health however and this cohort of patients has frequent medical contact with the practice; they are the main recipients of house calls and, as their numbers rise, so do the house calls. Juggling their complex co-morbidities and polypharmacy is demanding and time-consuming. Increasingly, elderly patients do not want admitted to hospital (for many valid reasons) even when very ill and are keen to stay at home; while beneficial for the patient and helping strain on secondary care, the knock-on effect is increased work for us and more house calls as we follow up/review them. This leads on nicely to our next point.

7) **Expanding role of primary care** – doing the work that secondary care did. The role of a GP has changed immeasurably in the years that Dr Reid and Dr Crawford have been at Balmore surgery; something that all GPs will have noted. Huge amounts of work, that was historically dealt with in secondary care, has been transferred to GPs e.g. routine care of the majority of type 2 diabetes; DMARDS monitoring; follow up of discharged patients as they no longer seem to get routine clinic follow up following admission. Add in to this shorter admission length for patients and 'early' discharge of patients with multi-morbidity and this all equals to more GP time and resources. It has been professionally demoralising and frustrating to note the emphasis on protecting secondary care over the last few years – at the expense of primary care. Note all the QOF and QUIPP meetings and reports where we have had to analyse our activity and try to reduce clinic referrals and emergency admissions – it is clear that if these patients are not referred on to secondary care then they are remaining in the community with consequent increased levels of GP involvement. There has been no similar exercise to try and protect General Practice.

8) **Bureaucracy**; the effects of the nGMS contract and QOF have been well documented elsewhere. The 'tick box' culture shows no significant sign of abating; the increased QOF-driven patient contact reduces appointment availability for both Practice Nurses and GPs. The evidence for the effectiveness of the QOF in altering outcomes in long-term conditions remains unclear. An article in this year's BMJ; **BMJ 2015; 350:h904 2/3/15**, added to the debate. It showed that there was a small improvement between 2004-2006, when QOF was new and practices were setting up databases/disease registers, but since then there has been no significant effect on mortality. There was NO evidence that QOF improved outcomes and, interestingly, the strongest predictor of mortality was **deprivation.**

   The effects of the recession have been greatly felt in our deprived community with huge levels of DWP reports and legal reports for DWP appeals all adding to the bureaucracy. As a deprived practice our patients are more likely to be on benefits than more affluent areas and we have, therefore, felt more of the effects of the Government's review of the benefit system. To try to stem demand we have stopped all letters of support for DWP appeals, including those from Citizen's Advice, and put posters in the waiting room to this effect. We still receive large volumes of requests from legal firms representing patients for their appeals and were refusing those too, despite the financial rewards, as we simply did not have the time. However, the LMC gave mixed opinions on whether this was legal and we felt obligated to start doing them again.

9) **Small practice**; Balmore Surgery is a small practice with only 3 partners, all working varying degrees of part-time, as documented earlier in the report. Studies have shown that this small practice model of General Practice is the one most patients prefer; a small number of GPs who know their patients well. For the practice it poses several problems.

   There are multiple compulsory QOF meetings which at least one partner has to attend – the practice has to bear the costs of locum cover for these meetings, if a locum can be found. In the last 18 months that has proven impossible on many occasions leaving one partner having to cover all the work while the second partner attends a compulsory meeting.

   The locum issue has deteriorated even more this year. The lack of junior doctors choosing general practice as a career, and the subsequent large volume emigration of the few that do complete training, means there is a shortage of new GPs. This affects locum availability and the pool of prospective candidates for any partnerships. We have not been able to take all our annual leave for the last few years because we have been unable to get locum cover; conferences and study days have had to be cancelled due to the lack of locum cover; as a last resort we have had to have no locum cover which leaves one GP in the practice on their own all day dealing with huge volumes of patients and data – that is not sustainable nor safe.

10) **Income**; since 2008 GP income has reduced by 11% while costs have increased by 2.3% (data from BMA). Workload has increased and we are working harder and harder for less and less. As we have already stated, our income has probably fallen further as we have paid for increased nursing hours and a retainer, from our profits,

to help with increasing demand. In point **5** we showed that we are 'under doctored' based on list size alone but we simply do not have enough income to take on another partner/salaried GP. The clinical need is there but not the cash!

Our financial information shows that we earn a good amount per patient in NHS fees but this is offset by increased staff costs (due to higher nursing costs and our retainer). As we have stated on several occasions already, we had to provide more nurse time and have a retainer to cope with workload with resultant detrimental financial implications for the partners at a time of dwindling profits and increased expenses in General Practice as a whole; a double dip effect.

In conclusion, Balmore Surgery is in urgent need of support. In a challenging environment we have worked hard to continue to provide high quality medical care to a very deprived population with all the problems associated with Health Inequalities. We have shown, in this document, that we have done everything we can to meet the needs of our patients and yet we are facing an unsustainable situation.

The situation needs urgent action as Dr H's recent resignation means she will leave at the end of September. We hope to appoint a 7 session locum in the interim to cover her sessions; it will not cover her workload as a considerable amount will inevitably pass to Drs Reid and Crawford, thus exacerbating the precarious situation further. We cannot advertise for a new partner until the concerns raised in this document are addressed. If extra resources were provided we may look for a 9 session partner or 2 partners working 4 or 5 session and the retainer situation will need reviewed. All of these variables cannot be fully resolved until the outcome of this process is known. We are open to all offers of support and are willing to work with the Board to find solutions.

Do not let Balmore Surgery be another example of the Inverse Care Law.

Yours sincerely,

Drs Allison Reid, Lynsay Crawford & Alyson Hee

Number of Appointments	Number of Patients
0	695
1	461
2	371
3	320
4	245
5	240
6	201
7	164
8	141
9	127
10	78
11	85
12	58
13	62
14	58
15	38
16	37
17	16
18	22
19	25
20	17
21	10
22	5
23	10
24	10
25	3
26	1
27	4
28	3
29	3
30	3
31	2
32	2
33	1
34	1
38	1
40	1
42	1
86	1