NHS
West Leicestershire
Clinical Commissioning Group

Practice Appraisal Report
2016-17

Practice & Visiting Team Information			
Practice Name	**Charnwood Surgery**	**Practice Code:**	**C82097**
Appraisal Team:	**Dr Nil Sanganee, Ian Potter**	**Appraisal Date:**	**06.03.17**

Agenda	
Agenda Item	**Overview**
Practice Attendees	Four members of the PPG were present –magnificent! Apologies from the PPG chair. Practice Manager, Practice nurse, HCA and receptionist Federation Manager Helen Rose. Drs Hirani and Darji.
Brief summary of practice	This is a two partner practice where both partners work part-time. Dr Darji is also the chair of the South Charnwood Federation and Dr Hirani is the finance director. There has been a slight increase in the list size over the last twelve months. There is one HCA and two practice nurses. Funding is currently considerably higher than the CCG average but will be reducing over the next few years following the move to a GMS contract with the consequent loss of MPIG.
Practice Identified Areas for discussion	The practice highlighted its low antibiotic prescribing rate, high childhood vaccination of 100% and good access (appointments offered on the same day and in advance, online prescriptions and appointments, telephone answered very quickly and Dr available throughout the day every day (see later re Thursday afternoons). The patient survey supports all of the latter points but bizarrely, has low response to 'saw/spoke to GP on the same day.' The practice will look into this to investigate why the survey is consistently showing lower figures in this one area. There are monthly MDT meetings which are not attended by social care but are attended by the MHF which is working really well for the practice and the patients. Admissions and A&E attendances are analysed weekly via Gemima.

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	All staff report significant events and these are discussed at whole practice meetings once a month. Datix is being partially used. There is a strong PPG with good representation and regular attendance. The latest prevalence rates for the practice are AF 1.9%, COPD has increased to 1.4% with more screening and coding patients on inhalers without a diagnosis, cancer 2.6%, dementia 0.9%, mental health 0.4% and PAD 0.5%. We discussed the low prevalence on the palliative care register and ways to increase this including looking at adding patients with end-stage dementia, COPD and heart failure as well as other non-cancer diagnoses. The practice was frustrated it had applied to the GP resilience programme and had not received any response as to the next steps. A practice nurse has retired but has been replaced with a new member of the team. One of the receptionists has been trained to do phlebotomy and now also HCA roles too. There is a general theme of multiskilling staff and using the skills mix well. The practice has shared a 5 year business plan with its PPG to account for the concerns about sustainability over the next few years with a reduction in funding through the contract, a reduction in sessions from Dr Hirani and the ability of the practice to survive in the current NHS environment. The status quo, a merger and other options have all been considered and the practice is appraising all possibilities currently. The PPG and practice were concerned about long term affordability and sustainability if the list size does not increase any further but is hoping that many patients will join the practice if the positive reviews and feedback are shared more widely. There appears to be no section 106 money available currently despite there being plans for significant house building in the near future. There is also a plan for a care home and the practice is happy to look after patients in this home and provide continuity of care to the care home patients. The practice closes on a Thursday afternoon and there are no HCA or nurse appointments available and no access to the

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	premises. There is a doctor available on a mobile phone for urgent cases only. There has been no feedback declared that patients are unhappy with this arrangement and the GPs felt there was no impact on A&E attendances or admissions correlating with this practice closure. There are some extra appointments available on Thursday and Friday morning to compensate for this closure. The practice has a carer's lead and a PPG lead for carers too but is understandably upset about the loss of the VASL carers' service and the lack of communication from the local authority on the dissolution of this service. Other ways to increase the carer's register and support carers via the practice were discussed.
Actions Taken since Practice Appraisal in 2014/15	1. Minor injuries advertising – this is now on the website, facebook and a poster in the waiting room. We discussed how practice admin staff and clinicians could direct patients to use the service in-house by ensuring patients know what can be assessed in the practice vs. WIC/A&E. 2. Increase LTC prevalence –see above. This has occurred in the main but there is still room for improvement for the palliative care register. 3. Prescribing – antibiotic prescribing is low and the practice is working hard towards all of the prescribing schemes. The clinicians were concerned with patients becoming frustrated and not agreeing to de-prescribing or drug switches and we highlighted ways that the team could communicate and educate the patient population to warn them of such schemes.
Practice Profile Feedback	Overall, the profile was good in most areas and any elements which require more attention have been discussed within the rest of this report.

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Areas of Good Practice	Most good practice has been outlined above but the CCG thanked the GPs for their very active involvement and support with the Federation and support to develop the inter-practice referral process. The PPG were very supportive of the practice and there is some wonderful feedback on NHS choices and from the Friends and Family test as well as in the patient survey – well done!
Areas for Sharing Best Practice PLT event	The practice is now working with Charnwood Dementia Action Alliance to be a dementia friendly practice and has a lead within the practice team. The PM agreed to share the process of signing up to this with other practices as this was felt to be really beneficial.
Areas for Improvement and suggested areas for consideration	• The patient survey has a low response to 'saw/spoke to GP on the same day.' The practice will look into this to investigate why the survey is consistently showing lower figures in this one area. • We discussed the low prevalence for the palliative care register and ways to increase this including looking at adding patients with end-stage dementia, COPD and heart failure. • Consider a clear strategy for communicating messages to patients and providing education to the population on changes to the practice driven both internally and externally
QIPP	GP QIPP was not discussed in detail however the practice is on track to receive the second payment for this area of work.

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CCG Actions	The practice has not signed up to the PMS/FDR transition and is concerned that as it refers ECGs and spirometry to Glenfield, this will be affecting the referrals' budget for the Federation and impact on achieving QIPP targets. The team suggested an inter-practice referral process through the Federation which was agreed to be discussed further out of the meeting with the CCG and the Federation. Practice reported that they had not been able to access the Oberoi tool, CCG to follow this up for the practice.