NHS
West Leicestershire
Clinical Commissioning Group

Practice Appraisal Report
2015-2016

Practice & Visiting Team Information			
Practice Name	**Silverdale Medical Centre**	**Practice Code:**	**C82627**
Appraisal Team:	**Dr Kathryn Oliver, Jake Cooke**	**Appraisal Date:**	**05/11/15**

Agenda	
Agenda Item	**Overview**
Practice Attendees	Dr YB Shah, GP Partner Dr Asma Bukhari, GP Partner Dr Amit Chawla, GP Partner Caroline Roberts, Practice Manager Friends of Silverdale Medical Practice PPG – Mr Shantilal Valand and Mrs Dikshika Mistry.
Brief summary of practice	The overall list size is fairly static at 4,629, although further change in anticipated due to projected building over the next 10 years (Sustained Urban Expansion plan for the area). This has influenced the need to expand and develop the practice premises. It is projected that a further 1500 patients could be accommodated by the planned extension. COPD/Respiratory: prevalence's and recording have improved in these areas following the appointment of a new practice nurse with an interest in respiratory care, and a new Health Care Assistant has also been appointed. Despite being unable to recruit so that Dr Shah can consider reducing his surgery commitment, the partnership team has continued to embed and works cohesively together. The team is justifiably proud of the way challenges are faced together continuing to provide the best service possible to the patient population. This is supported by a very active PPG and evidenced by low numbers of patients moving practice, high QOF and QIPP attainments with low exception reporting. QOF responsibility is divided equally amongst the partners.

Practice Appraisal Report
2015-2016

Agenda	
Agenda Item	**Overview**
Practice Identified Areas for discussion	Practice premises: Funding was secured following the bid last February. Preparatory work is ongoing but it is hoped that this will now be going ahead later this month with a completion time of next March. Federations: The practice is keen to be involved but is currently struggling to see much tangible benefit at the moment. There is involvement in the medical student teaching plan which you are looking forward to with the first placement expected in Sept 16. You feel a sense of frustration with discussions going around in circles and a lack of "big" projects to get behind.
Actions Taken since Practice Appraisal in 2014/15	Last year's PrAAP has been completed. Upskilling of GPs has continued with participation in all areas –HF, Respiratory, Anticoagulation, and Eden Diabetes modules. This knowledge is being shared amongst the team and used to improve patient care. Recruitment: attempts have been made to recruit a further partner or salaried doctor, but so far no one suitable has been identified. The search continues, although in the interim cover is being provided internally. Improvement to premises: Funding was secured via the Primary Care Infrastructure Fund for the redevelopment of the practice premises and building is set to start later this month to extend into the rear of the garden providing meeting room and further office space. The project is expected to take 18 weeks. A planning consultant has been engaged to monitor and oversee the project. Prevalence figures: Further work is ongoing to monitor and maintain the figures. Debbie Oliver is due to visit the practice shortly to support with Impakt/CKD figures.
Practice Profile Feedback	In preparation for the practice appraisal the practice team must be congratulated for preparing a comprehensive presentation which detailed the practice progress against the practice profile. Prevalences: Some changes have occurred and work is ongoing to ensure correct coding of patients. Diabetes and dementia rates are high, whereas despite regular use of mini spirometry COPD rates are similar. We acknowledged that ongoing screening is required but that it is not possible to detect disease that isn't present. Dr Khalid (HF lead) has been into the practice which you found helpful. This reassured you that you are on the right track with your recording and treatment, and also gave you some further hints and tips. Use of Care Plans is going well, although it is felt

Practice Appraisal Report
2015-2016

Agenda	
Agenda Item	**Overview**
	that this is quite time consuming to do well. This has improved with the newer version of the plan, although you feel this is still not succinct enough. Stroke prevalence has increased and you put this down to increased retrospective coding of previous TIAs. The practice has devised its own QIPP review template which easily gives real time information on the position relating to QIPP targets. QOF work is targeted, but work is also captured opportunistically by responding to alerts. Screening: Figures are all good, with regular follow-up of non-responders. A suggestion was made to try to streamline the alert process here, so that the doctors file the result as requiring a follow-up letter, but that this is then searched regularly by an admin team member rather than as a further task generated by the doctor. Influenza Campaign: there has been little administration of vaccinations by the local pharmacy, and the majority are done in house. There have been some concerns about patients being given them at their place of work and the difficulty in recording this information. We could not come up with a solution for this, although it was felt that there would be no responsibility on the doctors should there be an issue as the vaccination had not been administered by the surgery team. NHS healthchecks: you continue to perform well, and use this as an opportunity to check pulse, spirometry and other screening. Gemima: you feel that this is a good system, but does have its glitches. The password only lasts for 4 hours, so it can create problems with maintaining log in. LD checks have all been completed, and immunisation rates are good despite concern last year regarding uptake by some of the immigrant population. Out of Hospital: The practice makes good use of the OPU and has found this beneficial. There are frustrations with AVS as they do not seem to have the capacity to pick up visits coming in around lunchtime or later. UCC usage is very low which you feel is attributable to the open door policy of always seeing patients should they need to be seen. You have a good working relationship with the Virtual Ward manager and find this service beneficial. The practice has some use of Sound Doctor although is not promoting this hugely. First Contact has been used more since

Practice Appraisal Report
2015-2016

Agenda	
Agenda Item	**Overview**
	hearing about it at a recent PLT event. The presence of a self populating form helps stream line the referral process. The practice has developed a Reconciliation template to code and record all changes to medication and care following hospital or other review. This has helped with patient management and has been time saving. Secondary care: You have some concerns about the recording of attendances which you feel adversely affects your figures (eg patients reviewed in eye casualty are then coded as a new ED attendance), UCC patients having onward referral to A&E, and day cases longer than 8 hours becoming an admission (eg RACPC with patients awaiting repeat troponins). You do not cover a nursing or care home although you have one patient resident in one. You are confused by the high number of acute ED admissions not deemed to require admission and take issue with the figures. You offer good access, routinely seeing >65 and <5 year olds on the same day. This is supported by your low UCC use. Prescribing: QIPP prescribing audits have already been undertaken. You continue to monitor your prescribing budget and expect this to be below target with the recent changes. Your specials prescribing is quite high. You have looked into this and shown that it relates to two bypass patients receiving special formulations. Some concern was raised about the possible impact of out of hours prescriptions being attributed to the practice, although this seems unlikely. Patient Experience: no recent survey has been completed by the PRG, and the results of the IPSOS Mori survey were discussed. These show good overall responses with a low number of patients seeing the Dr on the same day. We discussed why this may be happening, but the result is surprising based on the low use of UCC and the open access approach by the practice. The lowest result for support to manage LTC may represent feeling prior to the appointment of the new PN who is trained in respiratory support. The practice phone number has now been changed to a local cost number which has gone down well with patients. NHS Choices comments are received and responded on in a timely fashion. 16 positive and 3 negative comments have been received. The PPG feel very happy about the level and quality of service received and hasn't presented any concerns.

Practice Appraisal Report
2015-2016

Agenda	
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Areas of Good Practice	Reconciliation template. Good PPG involvement. High QOF scores with low exception reporting. High diabetes prevalence with identification of at risk patients and maintenance of register. Good team cohesion despite the ongoing challenges of current general practice.
Areas for Sharing Best Practice PLT event	Reconciliation Template: devised to easily record any changes to medications and care following hospital appointments. Allows an easily readable audit trail so that reasons for change can be found easily. QIPP data template: provides real time data on attainment in relation to QIPP targets. Developed and used within practice but could be rolled out for use by other teams.
Areas for Improvement and suggested areas for consideration	Bowel screening non responder follow-up: suggest you try to streamline the current alert system by filing the result as "non responder, requires letter" and then tasking an admin member to search on these on a regular basis so that letters can be sent out in batches (better time use, less doctor time used per case). Further HISS EMIS web training for Dr Bukhari. Recruitment: further advertising and exploration to try to recruit further sessions either partner or salaried. Premises: undertake extension with supervision provided by planning consultant. Support for PM: appoint additional hours of support for PM. Specials meds: ensure that all meds have been reviewed to check that a licensed cheaper formulation could not be used (check "medicines that may be crushed" information on LMSG website).

Practice Appraisal Report
2015-2016

Agenda	
Agenda Item	**Overview**
QIPP	At this stage of the QIPP year you appear to be on target for payment.