William Fisher Medical Centre

Quality Report

High Street
Southminster
Essex
CM0 7AY
Tel: 01621772360
Website: williamfishermedicalcentre.nhs.uk

Date of inspection visit: 2 August 2016
Date of publication: 16/09/2016

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at William Fisher Medical Centre on 2 August 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- The practice demonstrated to us a safely run service over time.
- We found there was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- There were robust processes in place for managing medicines.
- Effective standards of cleanliness and hygiene were maintained throughout the practice.
- The practice had a system in place to ensure enough staff with the right skill mix were on duty to ensure safe care delivery.
- Staff had received appropriate training to undertake their roles and responsibilities.
- The practice recognised the importance of the continuing development of staff skills, competence and knowledge to ensure high-quality care.
- The practice held several different meetings with health care professionals to share and coordinate services for patients.
- Staff understood the relevant consent and decision making requirements of legislation and guidance.
- Staff used every contact as an opportunity to identify potential risks to patients health and signposted them to support to live healthier lives.
- There was a strong, visible, person-centred culture within the practice. Staff were highly motivated to offer care that was kind and promoted patient's dignity.
- Information about services and how to complain was available and easy to understand. We found improvements had been made to the quality of care as a result of complaints and concerns.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had a clear vision and a set of values, with patient's wellbeing as a priority.
- There was a clear leadership structure and staff felt supported by management.
- The practice actively sought the views from a wide range of stakeholder, including patients, staff, visiting professionals and commissioners about their experience of and quality of care and treatment delivered.

We saw an area of outstanding practice that ensured that patients with long term conditions;

- The practice adopted a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met these needs. The practice had employed a practice matron to provide a bespoke service for these patients at the practice. This ensured joined up care delivery to patients.
- The matron visited care homes weekly to review patients and to support staff in understanding and managing patient's medical conditions. Home visits were arranged in conjunction with a GP, for the review of patients with long term conditions that were unable to attend the surgery.
- The matron conducted reviews of all A&E attendances, hospital admissions and discharges. Where relevant the practice arranged a telephone call or home visit to identify if any support was required.
- The practice had identified a delay in receiving discharge information. The practice matron liaises with the hospitals and follows up the patient on discharge to ensure the patient's health and wellbeing needs had been meet
- The practice matron reviewed and promoted the carers register ensuring this group of patients received support, advice and checks for their wellbeing so that they were able to provide the care required.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- There were robust processes in place for ensuring the safe management of medicines.
- Effective standards of cleanliness and hygiene were maintained throughout the practice.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The practice ensured there was enough staff on duty with an appropriate skill mix to ensure safe care for patients.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed the practice were high achievers with 98% for clinical indicators within QOF. This was higher than the local average of 92% and national average of 94%.
- Staff assessed needs and delivered care in line with current evidence based guidance such as NICE.
- Clinical audits demonstrated quality improvement.
- The practice invested in the training and development of staff skills, competence and knowledge as it was recognised as integral to ensuring high-quality care delivery.
- The practice held several different meetings with health care professionals to coordinate and deliver shared care arrangements.
- Staff understood the relevant consent and decision making requirements of legislation and guidance.
- Staff use every contact as an opportunity to identify potential risks to patients health and signposted them to support to live healthier lives.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.

Summary of findings

- There was a strong, visible, person-centred culture within the practice. Staff were highly motivated to offer care that was kind and promoted patient's dignity.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. There was information available to signpost patients to support services.
- Patients registered at the practice felt empowered and supported to manage their own health, care and wellbeing.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The services provided by the practice reflected the needs of the population served this ensured flexibility, choice and continuity of care.
- Adjustments had been made to assist less abled patient's easy access to the premises.
- Patients said they found it easy to make an appointment with a named GP. We found there was continuity of care, with urgent appointments available the same day.
- Urgent and non-urgent home visits for frail and house bound patients were triaged by the practice matron, nurse practitioner or duty GP.
- The practice visited two care homes on a weekly basis to undertake ward rounds, as well as requested visits.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and a set of values, with patient's wellbeing as a priority.
- There was a clear leadership structure and staff felt supported by management. All staff were clear about their roles and responsibilities and reported to management regarding their performance in respect of these.
- There was a systematic programme of clinical and internal audit and identified actions were shared and implemented.

Summary of findings

- There was an overarching governance framework which supported the delivery of the practice strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The practice partners encouraged a culture of openness and honesty.
- The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice actively sought the views of a range of stakeholders, including patients, staff, visiting professionals and commissioners. They collated their views and experience of the quality of care and treatment delivered.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs in order to deliver care more effectively. Monthly meetings with wider members of the healthcare team were held to review more complex and vulnerable patients.
- Each GP maintained their own personal list to promote continuity of care and to establish strong relationships with individuals and their families. However patients could see any GP of their choice.
- Longer appointments were available for patients. Double or triple appointment slots could be booked for patients with complex needs.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. These were triaged by the practice matron or duty GP.
- The practice visited two care homes on a weekly basis to undertake ward rounds, as well as requested visits.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions.

- There was proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met these needs and promoted equality. This included patients who were in vulnerable circumstances or who had complex needs. The practice employed a practice matron to provide a bespoke service. This ensured joined up care delivery to patients.
- The matron visited care homes weekly to review patients and to support staff in understanding and managing patient's medical conditions. Home visits were arranged in conjunction with a GP, for the review of patients with long term conditions that were unable to attend the surgery.

Summary of findings

- Reviews of all A&E attendances, hospital admissions and discharges. Where relevant the practice arranged a telephone call or home visit to identify if any support was required.
- The practice matron liaised with the hospitals and follows up the patient on discharge to ensure the patient's health and wellbeing needs had been meet. Reviewed and promoted the carers register ensuring this group of patients received support, advice and checks for their wellbeing.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice achieved above the local and national averages for their performance with a 98% achievement for clinical indicators.
- Longer appointments and home visits were available when needed.
- Patients told us they felt that their long term condition care provided was of a high standard. This was supported by the high QOF performance. For example the percentage of patients with COPD who had a review, undertaken in the preceding 12 months was 94% compared to a CCG average of 88% and a national average of 89%.
- The practice had identified GP leads in specialist clinical areas such as, diabetes, heart disease, asthma and gynaecology; the practice nurses supported this work.
- All patients with a long-term condition received a structured annual review to check their health and medicines needs were being appropriately met.
- For those patients with the most complex needs and associated risk of hospital admission, the practice team worked closely with the local community health providers including the community matron and respiratory team to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were high for all standard childhood immunisations. Childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 100% and five year olds from 91% to 98%.

Summary of findings

- The practice provided an online appointment booking facility and online ordering of repeat prescriptions.
- Patients we spoke with on the day, and feedback received from our comment cards, showed young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Baby changing facilities were available and the practice accommodated mothers who wished to breastfeed.
- Personal GP patient lists enabled the doctor to build family relationships, and promote continuity for patients.
- The practice reviewed any children on a child protection plan at their own monthly clinical meeting.
- The practice provided neonatal checks, six week post-natal checks for new mothers and eight week baby checks.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Telephone consultations were available each day for those patients who had difficulty attending the practice due, for example, to work commitments.
- The practice provided an online appointment booking facility and online ordering of repeat prescriptions.
- Feedback from patients was consistently positive. They told us they could get an appointment quickly and at a time that was convenient to them. For example, the January 2016 national GP patient survey indicated that 93% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 92% and a national average of 91%.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice worked with multi-disciplinary teams in the case management of vulnerable people and informed patients how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice provided good care and support for end of life patients. Patients were kept under constant review by the practice in conjunction with the wider multi-disciplinary team.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia whom they carried out advance care planning for.
- Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in and agreed with.
- QOF data from January 2016 showed 90% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was higher than CCG and national averages.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice had processes in place for monitoring prescriptions that were not collected from the dispensary, particularly where patients had been identified as experiencing poor mental health.
- Each GP maintained their own personal list to promote continuity of care and to establish strong relationships with patients and their families. However patients could see any GP of their choice.

Summary of findings

- For patients with dementia, written consent for relatives to share in medical information and treatment planning was encouraged.
- The practice told patients experiencing poor mental health and patients with dementia and their carers about how to access services including talking therapies and various support groups and voluntary organisations. Information was available for patients in the waiting area.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 270 survey forms were distributed and 110 were returned. This represented a 41% response rate.

- 89% of patients found it easy to get through to this practice by phone compared to the CCG average of 64% and the national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 75% and the national average of 76%.
- 85% of patients described the overall experience of this GP practice as good compared to the CCG average of 71% and the national average of 85%.
- 93% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards which were all positive about the standard of care received. Patients described staff as friendly, polite and helpful, and the standard of care they had received as high.

The latest available results from the NHS Friends and Family Test (May 2016) showed that 100% of patients who responded were either likely or highly likely to recommend the practice to friends and family.

We spoke with eight patients three of which were members of the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Patients we spoke with were extremely happy with the care they received. They were complimentary about the staff, describing them as helpful, respectful and caring. Patients told us they felt involved in their care, and that the GP provided guidance and took the time to discuss treatment options with them.

Outstanding practice

We saw an area of outstanding practice that ensured that patients with long term conditions;

- The practice adopted a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met these needs. The practice had employed a practice matron to provide a bespoke service for these patients at the practice. This ensured joined up care delivery to patients.
- The matron visited care homes weekly to review patients and to support staff in understanding and managing patient's medical conditions. Home visits were arranged in conjunction with a GP, for the review of patients with long term conditions that were unable to attend the surgery.
- The matron conducted reviews of all A&E attendances, hospital admissions and discharges. Where relevant the practice arranged a telephone call or home visit to identify if any support was required.
- The practice had identified a delay in receiving discharge information. The practice matron liaises with the hospitals and follows up the patient on discharge to ensure the patient's health and wellbeing needs had been meet
- The practice matron reviewed and promoted the carers register ensuring this group of patients received support, advice and checks for their wellbeing so that they were able to provide the care required.

William Fisher Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor and telephone advice from a specialist advisor from the CQC medicines team.

Background to William Fisher Medical Centre

William Fisher Medical Centre is located in the town of Southminster, situated in the centre of a peninsula in eastern Essex. The practice is a dispensing practice providing medical services to about 6,000 patients living in and around the town of Southminster.

The medical centre is based in a purpose built two story building. The ground floor accommodates the reception and most of the clinical rooms with two nurse rooms on the first floor and the administration team. There is some free parking to the side of the building and there is a public car park nearby.

The practice has three GPs (two male and one female), a female advanced nurse practitioner and a female practice matron. They are supported by two part time practice nurses and two HCAs. The clinical team are supported by a practice manager, a dispensary team, administration and office team.

The practice is open between 8am and 6:30pm Monday to Friday. Appointment times varied between the clinical staff but usually ranged from 8.30am to 12.30pm and 2.30pm to 6pm. Extended hours appointments were offered on Wednesdays from 6.30pm to 8pm. This was for routine appointments with a doctor or a nurse and had to be booked in advance. In addition to pre-bookable appointments that could be booked approximately four weeks in advance, additional appointments were released for face to face consultations and telephone triage each day for those with more urgent needs.

The practice opted out of providing GP out of hour's services. Unscheduled out-of-hours care is provided by Primecare services and patients who contact the surgery outside of opening hours are provided with information on how to contact the service. This information is also available on their website and the NHS choices website.

The practice provides the following directed enhanced services:

- Dispensing medicines.
- Childhood immunisations and vaccinations.
- Dementia screening.
- Flu vaccinations.
- Unplanned hospital admissions avoidance.
- Improving on-line access.

Minor surgery

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 August 2016. During our visit we:

- Viewed information provided by the practice, which included feedback from people using the service about their experiences.
- Spoke with a range of staff (receptionists, practice nurses, practice manager, administrators and doctors) and spoke with patients who used the service.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. If staff were unsure of the level of concern the practice manager would assist with the assessment and recording of their concerns. We found the incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events, and findings were regularly discussed at partners and staff meetings. Records showed a total of four significant events had been recorded over the last 12 months. We saw that learning had been applied when unintended errors or unplanned events had occurred. For example, when a medicines dosage error was identified an investigation identified a change in practice which had been implemented.
- Any dispensing errors were recorded and investigated to identify learning from them. There was a standard operating procedure in place and this was being reviewed annually to ensure it was fit for purpose.

The practice had a robust approach to information received from the Medicines and Healthcare Regulatory Agency (MHRA). The MHRA is an agency of the Department of Health and provides safety information relating to healthcare products. A clear audit trail was maintained to demonstrate the effectiveness of the system in place. The practice provided evidence of how they had responded to alerts in checking patients' records and taking action to ensure they were safe. We reviewed safety records, incident reports and minutes of meetings where these were discussed. Safety alerts were reviewed by the duty GP on the day the practice received them. It was their responsibility to identify if the alert was relevant or not relevant to the practice; if relevant the document was circulated to the necessary individuals. We saw evidence of two alerts that had been received in June 2016. Staff identified as needing to be made aware of the alert had all signed the document to indicate they had read, understood and implemented any action required. All alerts were then filed in the practice manager's office for future reference if required.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding who was trained to safeguarding level 3. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The chaperone recorded their attendance on the patient record system.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept

patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local medicines management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- The practice matron and nurse practitioner were independent prescribers and prescribed medicines for specific conditions. They received mentorship and support from the GPs for this extended role.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. We saw that medicines incidents or 'near misses' were recorded for learning. Dispensary staff were involved in reviewing them regularly and we saw that they had made changes to improve the quality of the dispensing process. The dispensary manager showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We noted that these procedures had been signed by dispensary staff to show that they had read them
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- The fridge used for the storage of medicines and vaccinations was monitored regularly for temperature control and records were kept. A cold chain policy and procedure was in place and being followed. The stock of medicines and vaccines was rotated and monitored and the system in use was efficient and effective.
- The practice had processes in place for monitoring prescriptions and medicines that were not collected from the dispensary, particularly where patients have been identified as experiencing poor mental health. A clinician was tasked to identify the reasons for the non-collection of the prescription by looking at the patient record. This identified where patients might be at risk of deteriorating health because they had not collected vital medicines. These were then followed up to ensure the patient was safe and well.
- The practice had a robust approach to cascade information from alerts from the National Patient Safety Agency. A clear audit trail was maintained to demonstrate the effectiveness of the system in place. The practice provided evidence of how they had responded to alerts and taken action to ensure that patients were safe.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, provision of dispensing services, Legionella and infection control.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Non-clinical support staff were trained in the various roles required by the practice. This enabled them to cover their colleague's role during annual leave and absence. The practice GPs would cover periods of leave for their clinical colleagues.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers and a panic button in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

People's care and treatment was planned and delivered in line with current evidence based guidance (including National Institute for Health and Care Excellence (NICE) best practice guidelines), standards, best practice and legislation. For example;

- We were shown by a nurse the person-centred, joint care planning template the practice used for annual health checks for people with a learning disability. There was evidence of individualised goals, patient engagement and referrals onto other services where required. If required the practice matron would undertake a home visit if it had been identified that the patient was anxious when away from their own environment.
- The role of the practice matron had been used to provide effective care and treatment to patients with long term conditions. This was achieved by providing a bespoke service for this population group and included home visits, reviews of all attendances at hospital so that support needs could be identified at an early stage, liaison with hospitals so that care and treatment needs could be planned in advance and supporting carers so that they were able to maintain their health and caring responsibilities.
- Effective needs assessments included assessment, diagnosis, when people were referred to other services and when managing people's chronic or long-term conditions, including for people in the last 12 months of their life. This was monitored to ensure consistency of practice.
- Care and treatment was based on risk assessments that balanced the needs and safety of patients registered at the practice with their rights and preferences
- All consultations were carried out in accordance with the Mental Capacity act 2005. This would include best interest decision making.
- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Staff demonstrated that they had a thorough understanding of the physical and psychological needs assessment in patients with long-term conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD). They had well established programmes of care, incorporated motivational educational sessions to educate and empower patients to manage their condition optimally.
- The practice had identified GP leads in specialist clinical areas such as, diabetes, heart disease, asthma and gynaecology; the practice nurses supported this work. One of the practice nurses had a special interest in diabetes and heart conditions and another practice nurse supported respiratory conditions.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results reflected that the practice had achieved 100% of the total number of points available.

The practice had an overall exception reporting of 16%, compared to a CCG average of 9% and national average of 9%. Exception reporting is the exclusion of patients from the list who meet specific criteria. This includes, for example, patients who choose not to engage in screening processes or accept prescribed medicines.

Feedback from patients confirmed they felt that their long term condition care provided was of a high standard and this was supported by the high QOF performance. Performance for diabetes related indicators was 95%. This was above the CCG average of 79% and the national average of 89%. The practice diabetic indicators were similar or above CCG and national rates.

- The percentage of patients with diabetes whose blood sugar levels were managed within acceptable limits was 91% compared to the CCG average of 72% and national average of 77%.
- The percentage of patients with diabetes whose blood pressure readings were within acceptable limits was 87% compared to the CCG average of 74% and national average of 78%.

Good

Are services effective?

(for example, treatment is effective)

- The percentage of patients with diabetes whose blood cholesterol level was within acceptable limits was 82% compared to the CCG average of 75% and national average of 81%.

These checks help to ensure that patients' diabetes is well managed and that conditions associated with diabetes such as nerve damage, heart disease and stroke are identified and minimised where possible.

The practice performance for the treatment of patients with conditions such as hypertension (high blood pressure), heart conditions and respiratory illness was above or within the range of the national average for example:

- The percentage of patients with hypertension whose blood pressure was managed within acceptable limits was 85% compared to the CCG average of 84% and national average of 83%.
- Those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB medicines was 100% compared to the CCG average of 97% and national average of 98%. The practice exception reporting rate was 14% compared to the CCG and national average of 6%.
- The percentage of patients with asthma who had a review within the previous 12 months was 71% compared to the CCG average of 71% and national average of 75%.
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had an assessment of breathlessness using the Medical Research Council scale was 94% compared with the CCG average of 88% and national average of 90%.

The practice was signed up to the national avoiding unplanned admissions enhanced service and also a locally agreed enhanced service which focused specifically on vulnerable patients and those over 65 years of age. The practice used computerised tools to identify patients who were at high risk of admission to hospital and automatically ensured housebound patients were on this register so that this specific group of vulnerable patients could have their needs met. Patients on this register had annual reviews of their collaborative care plans, which we were shown, and the matron acted as co-ordinator for their care. We saw that after these patients were discharged from hospital they were followed up by the matron to ensure that all their needs were continuing to be met.

Clinical audits demonstrated quality improvement. Clinical audits were a standing item on the clinical meeting agenda. This raised awareness of salient issues and avoided duplication. We saw several two cycle completed audits and others in progress. For example an audit on antibiotic prescribing identified a high prescribing rate in some areas. The result of the first was discussed at the clinical meeting actions were identified and implemented. The second audit showed a significant reduction and the use of certain antibiotic was now within line with NICE guidance. Further audits completed included high risk medicines prescribing and an audit of emergency appointment usage.

The practice participated in local audits, national benchmarking, accreditation, peer review and research. For example, a recent audit had identified high usage of a particular class of antibiotics. The practice used antibiotic toolkit audits from the Royal College of General Practitioners. The findings were presented at the clinical meetings and this led to a reduction in the use of those antibiotics.

Effective staffing

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice. Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme, they had undergone extended training and updates to ensure nationally recognised evidence based guidance was being incorporated in their care delivery.
- We were shown by a nurse the person-centred, joint care planning template the practice used for annual

health checks for people with a learning disability. There was evidence of individualised goals, patient engagement and referrals onto other services where required.

- The practice had identified GP leads in specialist clinical areas such as, diabetes, heart disease, asthma and gynaecology; the practice nurses supported this work. One of the practice nurses had undertaking specialist training in COPD and asthma and another practice nurse had specialist training indiabetic care
- All staff spoken with in the day told us that they received an annual appraisal from their line manager and said that it acknowledged their contribution to the practice and identified areas of improvement and learning. They were encouraged to complete a form prior to the appraisal interview to highlight their performance throughout the year and to identify any learning and/or development needs they might have. They told us their performance was graded and objectives set for them for the forthcoming year. They felt these objectives were linked to the overall aims and objectives of the practice. Staff told us that the practice were very positive in making available additional training for them.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The systems to manage and share the information that was needed to deliver effective care were coordinated across services and supported integrated care for patients.

- The patients care and treatment was designed to make sure it met their needs. This included risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Weekly antenatal clinics were held at the practice. Any concerns identified were discussed with the GP. The health visitor would liaise with the practice matron any identified concerns. Any patient identified was discussed at the GPs weekly clinical meeting unless urgent action needed to be taken immediately.
- The practice held several multidisciplinary team meetings on a weekly rotational basis ensuring all aspects of patients care was reviewed. Professionals in attendance would include a GP, the practice manager, community matron, a district nurse and a social worker. A plan of action was identified with professionals, actions and requirements were documented for each patient discussed and the outcomes reviewed at the next meeting.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- < >taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it.
  When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in and agreed with.
- Written consent was obtained for minor surgery procedures where the relevant risks, benefits and possible complications of the procedure were explained.

Supporting patients to live healthier lives

Good

Are services effective?

(for example, treatment is effective)

Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with a patient was used to do so.

- We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering weight loss advice for overweight patients and smoking cessation advice to smokers.
- The practice focused on helping patients understand their conditions, and signposted patients to relevant services such as Empower for patients newly diagnosed with diabetes, exercise on prescription, smoking cessation and healthy lifestyle clinics.

The practice had a similar to local and national average of new cancer cases. They told us they encouraged their patients to attend national screening programmes by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. Data from the National Cancer Intelligence Network showed the practice had comparable performance in comparison with local and national rates of screening for their patients in some areas. For example;

- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 82% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for breast and bowel cancer screening. The breast cancer screening rate for the past 36 months was 72% of the target population, which was below the CCG average of 76% but was in line with the national average. Furthermore, the bowel cancer screening rate for the past 30 months was 60% of the target population, which was in line with the CCG average and above the national average of 55%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 100% and five year olds from 91% to 98%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

There was a strong, visible, person-centred culture within the practice. Staff were highly motivated to offer care that was kind and promoted patient's dignity. We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with respect.

- Staff made sure patients privacy was respected when they received treatment. We saw curtains were provided in consulting rooms.
- All reasonable efforts had been made to ensure that discussions about care, treatment and support only took place in an area that could not be overheard. We observed that consultation room doors were closed and there was a quiet room available for patients who wanted to discuss sensitive issues or appeared distressed.
- All 30 Care Quality Commission comment cards we received contained positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.
- Staff wore name badges so that it was clear to patients who they were speaking with.
- Staff were aware of their responsibilities for patient confidentiality and knew what they needed to do to ensure patient information was kept secure.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey, published in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 95% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 97% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 97% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the CCG average of 86% and the national average of 87%.

The practice, with the assistance of the PPG, had undertaken its own in-house patient survey during October 2015 and January 2016. The practice surveyed 300 patients and their results were also positive with 93% of patients who responded rating the service overall as good or better than good.

We also spoke with six patients who were attending the practice on the day of our inspection. All of the patients we spoke with gave us positive feedback about the service they received from the GPs, practice nurses and reception staff. Staff were commended for their commitment, professionalism and compassion.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

We saw that personalised care plans were in place for the practice's most vulnerable patients with long term conditions and complex care needs and those results from health reviews were shared with patients.

Results from the national GP patient survey, published January 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 96% said the GP was good at listening to them compared to a CCG average of 88% and a national average of 88%.
- 93% said the last GP they saw was good at explaining tests and treatments (CCG average of 84%, national average of 86%).
- 95% said the last GP they saw was good at involving them in decisions about their care (CCG average 84%, national average of 85%).

Nursing staff received similar positive results. For example:

- 92% said the last nurse they saw or spoke to was good at listening to them (CCG average of 92%, national average of 91%.
- 89% said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG average of 90%, national average of 90%.
- 91% said the last nurse they saw or spoke to was good at involving them in decisions about their care (CCG average of 87%, national average of 85%).

Staff told us that translation services were available for patients who did not have English as their first language. They also told us the information available to patients could be provided in alternative language or formats if this was required by the patients.

Patient and carer support to cope emotionally with care and treatment

Patient's emotional and social needs were seen as important as their physical wellbeing. There was a large amount of information leaflets available in the waiting area. These provided information on how patients could access a number of support groups and organisations and included signposting patients to counselling services and advocacy services. Information about health conditions and signposting information was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 93 patients as carers (1.6% of the practice list). The practice had recognised this as an opportunity for improving the services provided and the practice matron was reviewing and monitoring these patients. The practice matron also looked after the frailty patient list and was in a good position to identify carers. The practice website contained information about local care services, community services and a range of information about different conditions, lifestyle advice and support services. Written information was available to direct carers to the various avenues of support available to them.

Staff told us the practice had a protocol for supporting families who had undergone bereavement. GPs told us that they individualised their response accordingly to the family's needs. Usually following bereavement, families were contacted where this was appropriate and an appointment or other support was provided as needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There was proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met these needs and promoted equality. This included patients who with long term conditions, those living in vulnerable circumstances or who had complex needs. The practice employed a practice matron to provide a bespoke service. This ensured joined up care delivery. For example

- The matron visited care homes weekly to review patients and to support staff in understanding and managing patient's medical conditions.
- Home visits to learning disabilities homes when patients did not like attending the surgery because it made them anxious.
- Home visits undertaken in conjunction with the duty GP for the review of patients with long term conditions that were unable to attend the surgery.
- Reviews of all A&E attendances, hospital admissions and discharges. Where relevant the practice arranged a telephone call or home visit to identify if any support was required.
- Monitoring of patients that were in hospital; identifying discharge date to ensure contact can be made to identify any changes in their care requirements.
- Reviewed and promoted the carers register ensuring this group of patients received support, advice and checks for their wellbeing.
- The practice had identified an emergency carers list to support patients that needed a carer when their primary carer had to be admitted to hospital.

Patient's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.

- There were longer appointments available for patients with a learning disability or poor mental health. Practice staff had a flexible approach to appointments to ensure those who were difficult to reach could still get the care they needed.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice, these patients were on the admission avoidance list and the practice matron would visit post discharge from hospital.
- Same day appointments were available for children and those patients with medical problems that required a same day consultation.
- Although the practice was a partnership, each GP maintained their own personal list of frail patients to promote continuity of care and to establish strong relationships with individuals and their families. However, any patient could request to see the doctor of either sex for a particular issue or a sensitive health concern.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately were referred to other clinics for vaccines available privately.
- There were facilities for the disabled and translation services available.
- Adjustments had been made so that less able patients could access and use the practice. For example most clinical rooms were on the ground floor except for the nurse practitioner and practice matron whose rooms were on the first floor with only stair access. If a patient was unable to ascend the stairs there were arrangements in place for the nurse to use a room on the ground floor.
- For patients with dementia, written consent for relatives to share in medical information and treatment planning was encouraged and well documented.
- The practice told patients experiencing poor mental health and patients with dementia and their carers about how to access services including talking therapies and various support groups and voluntary organisations. Information was available for patients in the waiting area.
- All staff at the practice had undertaken training to become 'dementia friends'. Dementia Friends is about giving staff an understanding of dementia and the small things that would make a difference to patients registered with the practice.
- The triage service allowed home visits to be prioritised for urgency.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The Advanced Nurse Practitioner ran a daily urgent care clinic (overseen by the duty doctor); they were able to see patients with a variety of conditions. The receptionist staff had a referral criterion to ensure patients were appropriately referred to them.
- The practice visited two care homes on a weekly basis to undertake ward rounds. We spoke to one of the managers of the care homes who told us that a close working relationship had developed between the home and the practice. We were told that the practice provided support for patients requiring end of life care and for those suffering with dementia.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointment times varied between the clinical staff but usually ranged from 8.30am to 12.30pm and 2.30pm to 6pm. Extended hours appointments were offered on Wednesdays from 6.30pm to 8pm. This was for routine appointments with a doctor or a nurse and had to be booked in advance. In addition to pre-bookable appointments that could be booked approximately four weeks in advance, additional appointments were released for face to face consultations and telephone triage each day for those with more urgent needs. We saw that the next available routine appointment with a GP was available on the day of our inspection and the next available appointment for a blood test was within one working day of our inspection.

Results from the national GP patient survey, published in January 2016 showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 86% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 78%.
- 89% of patients said they could get through easily to the practice by phone compared to the CCG average of 64% and the national average of 73%.
- 89% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 75% and the national average of 76%.

The practice had a system in place to assess, whether a home visit was clinically necessary or there was an urgent need for medical attention. Urgent and non-urgent home visits for frail and house bound patients were triaged by the practice matron, nurse practitioner or duty GP. They had a list of patients who had been identified to require home visits and they assessed each request on an individual basis. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for dealing with these.

We saw that information was available to help patients understand the complaints system. There were leaflets and posters displayed in the waiting area and information was available on the web site. Patients we spoke with were not aware of the process to follow if they wished to make a complaint. They told us they would speak with either the GP or the practice manager and felt confident their concerns would be listened to and where required action would be taken. We saw that verbal complaints were recorded and reviewed to identify any trends.

We reviewed complaints that had been received in the last twelve months and found these had been dealt with appropriately and where relevant had been dealt with as significant event.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

William Fisher Medical Centre had a clear direction and vision. This was to provide a high standard of medical care and be patient centred. This was understood by staff and used in patient literature.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Staff told us they worked as a team and supported each other in achieving good patient care.
- Clear methods of communication that involved the whole staff team and other healthcare professionals disseminated best practice guidelines and other information.
- Policies and procedures were tailored to the practice and were available to all staff. They were reviewed annually and staff were informed of any changes.
- Staff attended a range of meetings to discuss issues, patient care and further develop the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- A comprehensive understanding of the performance of the practice was maintained and changes were made when concerns were identified. For example, with satisfaction rates highlighted in the National GP Patient Survey or from the PPG.
- There were robust arrangements for identifying, recording and managing risks. All concerns were raised and fully discussed in staff meetings.

Leadership and culture

The partners of William Fisher Medical Centre and its management team had the necessary experience and skills to run the practice and provide appropriate high quality care to patients. They were visible in the practice and staff told us they were approachable at all times.

All staff we spoke with during the inspection demonstrated that they made positive contributions towards a well- run practice. They understood and prioritised safety, on-going service improvements and compassionate care.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- Patients affected were supported, given an explanation and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- There was a clearly defined management structure in place and staff were supported. Staff told us there was a culture of no blame within the practice.
- Staff told us the practice held regular team meetings and we saw minutes of meetings to confirm this. Staff told us they could raise any issues at team meetings.
- Staff we spoke with told us felt valued and supported. All staff were involved in discussions at meetings and in appraisals and were invited to identify opportunities to improve the service offered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice actively sought the views from a wide range of stakeholder, including patients, staff, visiting professionals and commissioners about their experience of and quality of care and treatment delivered.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

- The practice had an active Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who worked with the practice to improve services and the quality of care. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, finding ways to resolve problems with the telephone system.
- The practice gathered and used feedback from staff through staff meetings, appraisals and discussion.
- The latest available results from the NHS Friends and Family Test (May 2016) showed that 100% of patients who responded were either likely or highly likely to recommend the practice to friends and family.
- The practice actively recorded all compliments received and shared these with staff.