

# Cornerstone Surgery

## Quality Report

Fingerpost Park Health Centre  
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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

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## Overall summary

### Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Cornerstone Surgery which is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 10th March 2015 at the practice location in Fingerpost Park Health Centre. We spoke with patients, staff and the practice management team.

The practice was rated as Good. A safe, caring, effective, responsive and well- led service was provided that met the needs of the population it served.

Our key findings were as follows:-

- There were systems in place to protect patients from avoidable harm, such as from the risks associated with medicines and infection control. There were clear processes in place to investigate and act upon any incident and to share learning with staff to mitigate future risk.

- Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed.
- Feedback from patients showed they were very happy with the care given by all staff. They felt listened to, treated with dignity and respect and involved in decision making around their care and treatment.
- The practice planned its services to meet the differing needs of patients. The practice encouraged patients to give their views about the services offered and made changes as a consequence.
- There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. The practice ensured that staff had access to learning and improvement opportunities.

We saw an area of outstanding practice:-

# Summary of findings

- The practice had set up a GP service for the homeless. Homeless patients were able to register with the practice and the clinicians regularly saw these patients when they were unwell and provided them with health screening and health promotion services. The practice supported homeless patients to attend hospital appointments. For example, hospital appointment letters were sent to the practice and liaison took place with community homeless services to identify a person to accompany the patient to the appointment.

There were areas of practice where the provider needs to make improvements.

The provider should:

- Make a record of the physical and mental fitness of staff during the recruitment process.

**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?

The practice is rated as good for safe. There were systems in place to protect patients from avoidable harm and abuse. Staff were aware of procedures for reporting significant events and safeguarding patients from risk of abuse. There were clear processes in place to investigate and act upon any incident and to share learning with staff to mitigate future risk. There were appropriate systems in place to protect patients from the risks associated with medicines and infection control. The staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met.

Good



### Are services effective?

The practice is rated as good for effective. Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were provided with the training needed to carry out their roles and they were appropriately supported. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed. The practice monitored its performance and had systems in place to improve outcomes for patients. The practice worked with health and social care services to promote patient care.

Good



### Are services caring?

The practice is rated as good for caring. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients felt involved in planning and making decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy. Patients were provided with support to enable them to cope emotionally with care and treatment.

Good



### Are services responsive to people's needs?

The practice is rated as good for responsive. The practice planned its services to meet the differing needs of patients. They monitored the service to identify patient needs and service improvements that needed to be prioritised. Access to the service was monitored to ensure it met the needs of patients. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.

Good



# Summary of findings

## Are services well-led?

The practice is rated as good for well led. There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to. The practice had systems to seek and act upon feedback from patients.

Good



# 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

The practice is rated as good for the care of older people. The practice was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions and information was held to alert staff if a patient was housebound. Home visits were made to housebound patients as requested and to carry out reviews of their health. The practice had a record of carers and used this information to discuss any support needed and to refer carers on to other services if necessary. The practice ensured each person who was over the age of 75 had a named GP, an annual health check and medication review and were seen on the same day as their telephone consultation if appropriate. The practice worked with other agencies and health providers to provide support and access specialist help when needed.

Good



### People with long term conditions

The practice is rated as good for the population group of people with long term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. The practice had a system in place to make sure no patient missed their regular reviews for long term conditions and to follow up unplanned hospital admissions in a timely manner. The practice also maintained a register of housebound patients to ensure that they received a home visit from a nurse at the practice to review any long term conditions. Clinical staff kept up to update in specialist areas which helped them ensure best practice guidance was always being considered. The practice had identified all patients at risk of unplanned hospital admissions and a care plan had been developed to support them. The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients. They had a palliative care register and liaised with other health care professionals to discuss the care and support needs of patients and their families.

Good



### Families, children and young people

The practice is rated as good for the population group of families, children and young people. Child health surveillance and

Good



# Summary of findings

immunisation clinics were provided. Post natal examinations were incorporated into the 8 week health check for babies to ensure women received this service. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. The staff were responsive to parents' concerns about their child's health and had a policy where patients aged 10 and under had telephone triage calls on the same day as they were requested. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular liaison took place with the health visiting service to discuss any children who were at risk of abuse and to review if all necessary GP services had been provided. The practice encouraged breast feeding and a private room was available for this if needed.

## **Working age people (including those recently retired and students)**

The practice is rated as good for the population group of working-age people (including those recently retired and students). The practice was open from 08:00 to 18:30 Monday, Wednesday, Thursday and Friday with extended hours on Tuesday until 20:00 which provided flexibility to working patients and those in full time education. In order to improve patient access to appointments the practice operated a telephone triage system which meant that the GPs booked their own appointments after speaking to the patient. These consultations were flexible to meet the needs of patients. On line bookable appointments and on – line prescription requests were available. The practice monitored patient satisfaction with access to the service through patient feedback. Patient feedback indicated patients were overall satisfied. Health checks were offered to patients who were over 45 years of age to promote patient well-being and prevent any health concerns.

**Good**



## **People whose circumstances may make them vulnerable**

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable. The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. In order to improve GP services provided to the homeless, the practice, in collaboration with St Helens Clinical Commissioning Group (CCG) (formerly the Primary Care Trust) had set up a GP service for the homeless. Homeless patients were able to register with the practice and the clinicians regularly saw these patients when they were unwell and provided them with health screening and health promotion services. The practice supported vulnerable patients such as homeless patients and patients experiencing poor

**Outstanding**



# Summary of findings

mental health to attend hospital appointments when necessary. For example, hospital appointment letters were sent to the practice and liaison took place with community homeless services to identify a person to accompany the patient to the appointment.

A register was maintained of patients with a learning disability and annual health care reviews were provided to these patients. Staff were knowledgeable about interpreter services for patients where English was not their first language. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. For example, if a patient had a learning disability then a double appointment was offered to the patient to ensure there was sufficient time for the consultation. The practice worked closely with various support groups to promote the needs of vulnerable patients. For example, one of the GPs was the lead for drug and alcohol misuse and worked closely with Addaction to ensure these patients receive the support they required. The practice took part in the food bank voucher scheme. One of the staff oversaw the administration of these vouchers to patients in need of this support. Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in this.

## People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). GPs worked with other services to review care, implement new care pathways and share care with specialist teams. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services. The practice had information for patients in the waiting areas to inform them of other services available. For example, for patients who may experience depression or those who would benefit from counselling services for bereavement.

Good





# Summary of findings

## What people who use the service say

We looked at 43 CQC comment cards that patients had completed prior to the inspection and spoke with four patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained, they felt listened to and they felt involved in decisions about their care.

The National GP Patient Survey in March 2014 found that 94% of patients at the practice stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Ninety eight percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. These responses were about average when compared to other practices nationally. Ninety seven percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good. Ninety percent of patients said the GPs were good or very good at involving them in decisions about their care and 90% felt the nurses were good or very good at involving them

in decisions about their care. Eighty three percent were very satisfied or fairly satisfied with opening hours and 81% rated their ability to get through on the telephone as easy or very easy.

We looked at the results of the last patient survey undertaken by the practice in December 2014 and February 2015 to establish patient views about GP consultations. The results were very positive with 100% of patients indicating they were treated with respect, dignity, compassion and empathy and involved in decisions about their care.

We also looked at the results of the last two patient surveys carried out in December 2014 to establish patients' views about access to the service following the introduction of the telephone triage system. The results of the surveys indicated that a large proportion of patients found it easy and convenient to arrange for a GP to call them back and felt their problem had been satisfactorily dealt with. Overall, patients were satisfied with the telephone triage system. Seventy seven percent of respondents to one GP survey and ninety seven percent of respondents to a further GP survey said they were very satisfied, quite satisfied or satisfied with the triage system.

## Areas for improvement

### Action the service SHOULD take to improve

- Make a record of the physical and mental fitness of staff during the recruitment process.

## Outstanding practice

- The practice had set up a GP service for the homeless. Homeless patients were able to register with the practice and the clinicians regularly saw these patients when they were unwell and provided them with health screening and health promotion services. The practice

supported homeless patients to attend hospital appointments. For example, hospital appointment letters were sent to the practice and liaison took place with community homeless services to identify a person to accompany the patient to the appointment.

# Cornerstone Surgery

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC inspector and the team included a GP.

## Background to Cornerstone Surgery

Cornerstone Surgery is based in the Parr area of St Helens, Merseyside. The practice treats patients of all ages and provides a range of medical services. The staff team includes two GP partners, a practice nurse, a healthcare assistant, a practice manager, information and technology manager and six administrative and reception staff.

The practice is open from 08:00 to 18:30 Monday, Wednesday, Thursday and Friday with extended hours on Tuesday until 20:00. The practice operates a telephone triage system where the GPs book their own appointments after speaking to the patient. This was introduced in June 2013, after a great deal of research, to improve the appointment system. After speaking with the patient the GP makes an appointment or home visit if the issue is not able to be dealt with by telephone. The practice has a policy where patients aged 10 and under, or 75 or over would have telephone triage calls on the same day as they are requested. There are also a number of circumstances where the receptionists would book an appointment for the patient. For example, homeless patients or patients booking in for chronic disease management clinics.

Appointments with the practice nurse, health care assistant or locum GPs are booked by receptionists. The practice opts in to provide out of hours services via a consortium arrangement known locally as St Helen's Rota. They provide a service locally in Prescot.

The practice is part of St Helens Clinical Commissioning Group. It is responsible for providing primary care services to approximately 2,586 patients. The practice is situated in an economically deprived area. Seventy percent of patients have a long standing health condition which is significantly higher than the national average. Fifty one percent of patients have health related problems in daily life and 20% of patients have caring responsibilities. The practice has a General Medical Services (GMS) contract.

The practice shares a building with two other GP practices and a number of community services such as podiatry, phlebotomy, psychiatry and district nursing.

## 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. This 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.

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.

# Detailed findings

## How we carried out this inspection

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

- 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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people

- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on 10 March 2015.

We reviewed all areas of the practice, including the administration areas. We sought views from patients via comment cards and telephone interviews of patients following the inspection. We spoke with two GPs, the practice nurse, the practice manager, three administrative/reception staff and with the information and technology manager.

# Are services safe?

## Our findings

### Safe Track Record

St Helens Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. Clinical staff told us they completed incident reports and carried out significant event analysis in order to reflect on their practice and identify any training or policy changes required. We looked at a sample of significant event reports and saw that a plan of action had been formulated following analysis of the incidents.

Alerts and safety notifications from national safety bodies were dealt with by the clinical staff and the practice manager. Staff confirmed that they were informed about and involved in any required changes to practice or any actions that needed to be implemented. For example we could see the alert regarding the Ebola outbreak in Africa had been actioned and notices were on display in the waiting room.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. A protocol around learning and improving from safety incidents was available for staff to refer to. We looked at a sample of records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff. One of the GPs told us that they shared learning from significant events with a GP they mentored from another practice and that they had presented their findings from significant events to a CCG meeting so that other practices could use this learning to improve patient care.

Staff we spoke with told us they felt able to report significant events and that these incidents were analysed, learning points identified and changes to practice were made as a result. Staff were able to describe the incident reporting process and told us they were encouraged to report incidents. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events.

There was a central log/summary of significant events that would allow patterns and trends to be identified. We noted that a review of actions taken was not recorded to demonstrate that any actions taken had been appropriately implemented.

### Reliable safety systems and processes including safeguarding

Staff had access to safeguarding policies and procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were available to staff on their computers and in hard copy. Staff had access to guidance flow charts and contact details for both child protection and adult safeguarding teams.

The practice manager had led a safeguarding group which included representatives from the CCG and other practice managers to develop the safeguarding policies and procedures for children and vulnerable adults which were used across St Helens CCG. These procedures were developed to further safeguard patients moving between GP practices to ensure that any information about risks to their welfare were transferred to the new practice.

Records and staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role. Staff we spoke with demonstrated good knowledge and understanding of safeguarding and its application.

One of the GPs took the lead for safeguarding. They attended meetings with and received regular updates from the safeguarding lead from the commissioning organisation. This established link meant that advice and guidance could be easily sought when needed. Regular liaison took place with the health visitor to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided. Codes and alerts were applied to the electronic case management system to ensure identified risks to children, young people and vulnerable adults were clearly flagged and reviewed. Staff were proactive in monitoring if children or vulnerable adults attended Accident and Emergency or missed appointments frequently. These were then brought to the GPs attention.

### Medicines Management

We looked at how the practice stored and monitored emergency drugs and vaccines. Vaccines were securely

## Are services safe?

stored and were in date and organised with stock rotation evident. We saw the fridges were checked daily to ensure the temperature was within the required range for the safe storage of the vaccines. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. We spoke to staff who managed the vaccines and they had a clear understanding of the actions they needed to take to keep vaccines safe. Emergency drugs were in date and held securely.

Spare prescription pads were stored securely. Repeat prescriptions were held securely in the administration office. Prescriptions waiting for collection were monitored to ensure they had all been collected and patients were not missing their medication. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. The practice nurse checked medication held in GP bags. We checked this and found medication was in date and a record had been made of all medication held and expiration dates.

GPs worked with the medicines management team from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits. GPs reviewed their prescribing practices as and when medication alerts were received and in accordance with good practice guidelines.

Patient medicine reviews were undertaken during consultations and chronic condition reviews. The CCG medicines management team carried out audits of patients on four or more medications to ensure medication reviews took place. We noted that an audit to ensure that all medication reviews had been carried out when needed had not been undertaken.

### Cleanliness & Infection Control

There was a current infection control policy with supporting processes and guidance. There was a lead member of staff for infection control who had completed training relevant to this role and who attended regular infection control meetings with the Clinical Commissioning Group. Non-clinical staff had received in-house training in infection control. The non-clinical staff we spoke with demonstrated general knowledge around infection control to support them in their role.

The patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found them to be clean. The treatment rooms, waiting areas and toilets were in good condition and supported infection control practices. Surfaces were intact, easy to clean and the premises were uncluttered. Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms.

The practice carried out infection control audits on a six monthly basis. The last one was undertaken in November 2014 and indicated that overall the practice was meeting effective infection control standards. An action plan had been put in place to address the shortfalls identified. A cleaning schedule was in place and regular checks were undertaken by the practice manager to ensure cleaning was carried out to a satisfactory standard.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Checks were carried out to ensure items such as instruments, gloves and hand gels were available and in date. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

The premises were leased from NHS Property Services who carried out legionella testing to ensure the safety of the water supply.

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We were shown a certificate to demonstrate that equipment such as the weighing scales, vaccine fridge, thermometers and blood pressure machines had been tested and calibrated. All portable electrical equipment was routinely tested.

### Staffing & Recruitment

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences staff covered from within the service. Duty rotas took into account planned absence such as holidays. GPs

## Are services safe?

and the practice manager told us that patient demand was monitored through the appointment system and staff and patient feedback to ensure that sufficient staffing levels were in place. It had been identified that further clinical and reception hours were needed to meet patient demand and action had been taken to address this.

The practice had a procedure for the safe recruitment of staff. This included guidelines about seeking references, checking qualifications/clinical registration and obtaining Disclosure and Barring service (DBS), formerly Criminal Records Bureau (CRB) checks (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

We looked at the recruitment records of two reception/administrative staff who were the last two staff to be employed and we looked at the records of a member of staff who was being recruited. We found that the recruitment procedure had in general been followed and the required checks had been undertaken to show the applicants were suitable for their posts. We noted that a record of the physical and mental fitness of staff had not been made.

All staff had received a CRB or DBS check and we looked at a sample of records to confirm this. The practice manager was in the process of renewing these checks for both GPs.

The professional registration of clinical staff was checked prior to appointment and there was a system in place to record checks of on going professional registration with the General Medical Council (GMC) and Nursing Midwifery Council (NMC).

### Monitoring Safety & Responding to Risk

The practice had other systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, dealing with emergencies and monitoring

the safety of equipment. Health and safety information was displayed for staff to see around the premises. A health and safety policy and procedure was available. The practice manager was the lead for health and safety and these issues were discussed at staff meetings. The building was leased from NHS Property Services. The buildings manager ensured that checks were undertaken of the fire safety systems. A sample of records confirming this were seen.

### Arrangements to deal with emergencies and major incidents

Emergency medicines were available and staff knew of their location. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice had access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Records showed that checks were made of the defibrillator to ensure it was working and ready to use.

Staff told us they had up to date training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR) and use of the defibrillator. Samples of training certificates confirmed that this training was up to date. We noted that drills to test out the accessibility of emergency equipment and staff response times were not undertaken.

A disaster recovery and business continuity plan was in place. The plan included the actions to be taken following loss of building, loss of telephone system, loss of computer and electrical equipment, loss of utilities and staff incapacity. Key contact numbers were included for staff to refer to.

Panic buttons were available for staff on their computers in treatment rooms and in the reception area for staff to call for assistance. The majority of reception staff had received training in managing abusive or aggressive patients.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Clinical staff we spoke with told us how they accessed best practice guidelines to inform their practice. GPs and the practice nurse attended regular training and educational events provided by the Clinical Commissioning Group and they had access to National Institute for Health and Care Excellence (NICE) guidelines on their computers. The GPs and practice nurse told us that they met to discuss new clinical protocols, review complex patient needs and keep up to date with best practice guidelines and relevant legislation. The practice nurse said that they received good clinical support from the GPs. The practice nurse met regularly with the health care assistant to provide guidance and support. The practice nurse met with nurses from other practices which assisted them in keeping up to date with best practice guidelines and current legislation.

The GPs specialised and lead in clinical areas such as diabetes, coronary heart disease and asthma. They also specialised and took the lead with different patient groups such as women's health, mental health and the homeless and vulnerable. The practice nurse managed specialist clinical areas such as diabetes, heart disease and asthma. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

The GPs used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital and the referrals were monitored to ensure an appointment was provided within two weeks.

The practice provided a service for all age groups. They provided services for patients in the local community with diverse cultural and ethnic needs, patients with learning disabilities, patients living in deprived areas and care homes, patients experiencing poor mental health and homeless patients. We found the management team were familiar with the needs of patients and the impact of the socio-economic environment and they had tailored the services provided to meet these needs. For example, the homeless were able to register with the practice and the GPs regularly saw these patients and provided them with health screening and health promotion services. The practice had access to language translator services for patients whose first language was not English.

### Management, monitoring and improving outcomes for people

There were systems in place to evaluate the operation of the service and the care and treatment given. We saw that audits of clinical practice were regularly undertaken and that these were based on best practice national guidelines. Examples of clinical audits seen included an audit on the diagnosis and treatment of hypertension. A full audit cycle had been completed and showed clear improvements had been made to patient care. We also looked at an audit of the new telephone triage system which looked at how many telephone consultations had resulted in face to face appointments. A full audit cycle had been completed which demonstrated modifications and improvements made to the system. Both GPs had attended training on telephone triage to improve their approach to telephone consultations. The GPs told us clinical audits were often linked to medicines management information, safety alerts, clinical interest or as a result of Quality and Outcomes Framework (QOF) performance. We found evidence that outcomes from audits were shared with other staff as necessary.

The practice worked with the Clinical Commissioning Group (CCG) to monitor and improve outcomes for patients. The practice was one of 13 practices involved in the CCG cancer audit, that provided practices with the opportunity to review cancer cases, reflect on patients experiences and through this provide evidence to inform CCG priorities and actions for the future.

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication, for example for mental health conditions.

The GPs and practice nurse had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, safeguarding and palliative care. The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients. They kept a record of patients needing palliative care. Gold Standards Framework meetings were held with frequent

# Are services effective?

## (for example, treatment is effective)

liaison occurring outside these meetings with district and palliative care nurses to review the needs of patients on the palliative care register. The out of hours service were updated to ensure good communication of changes in care and treatment.

### Effective staffing

An induction protocol and check list were in place which identified the essential knowledge and skills needed for new employees. Records of induction were in place on a sample of staff records looked at.

An appraisal policy was in place. Staff were offered annual appraisals to review performance and identify development needs for the coming year. We looked at a sample of records for administrative/reception staff which indicated they had received an annual appraisal. We spoke to two reception/administrative staff who told us the practice was supportive of their learning and development needs. They said they had received an appraisal in the last 12 months and that a personal development plan had been drawn up as a result which identified any training needed.

We spoke to both GPs and the practice nurse who told us they had annual appraisals and we saw records to demonstrate that they undertook training/learning to inform their practice. GPs told us they had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. Revalidations of both GPs had taken place. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) that their knowledge is up to date, they are fit to practise and are complying with the relevant professional standards.

The staff we spoke with told us they felt well supported in their roles. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. For example, the practice closed one afternoon per month for in-house developmental meetings or to enable staff to attend external training events. The GPs and nurse met informally to discuss new protocols, to review complex patient needs and keep up to date with best practice

guidelines. Practice meetings involving the whole staff team took place every three months and provided an opportunity to share information vital for the operation of the service.

The practice manager kept a record of training carried out by reception and administration staff. This showed that they had completed mandatory training such as safeguarding adults and children and training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). They had also undertaken role specific training such as chaperone training, fire warden training, the repeat prescribing process and information governance. Some records showed that training updates were due and the practice manager had a plan in place to address this. We saw training records for the practice nurse which demonstrated that they had undertaken mandatory and role specific training. The GPs kept a record of their own clinical training. On discussion with both GPs it was evident that they kept their skills and knowledge up to date. Clinical and non clinical staff told us they had the training they needed to support them in their roles.

### Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example A&E or hospital outpatient departments were read and actioned by the GPs in a timely manner. GPs described how blood result information would be sent through to them and the system in place to respond to any concerns identified. There was a system in place to identify patients at risk of unplanned hospital admissions and to follow up the healthcare needs of these patients within 72 hours.

Multi-professional working took place to support patients and promote their welfare. Clinical staff met with and liaised with health visitors, district nurses, Macmillan nurses and social workers to discuss any concerns about patient welfare and identify where further support may be required. GPs were invited to attend reviews of patients with mental health needs and child and vulnerable adult safeguarding conferences, when they were unable to attend these meetings they provided a report detailing their involvement with the patient. Gold Standards Framework meetings were held with frequent liaison occurring outside of these meetings with district and



# Are services effective?

## (for example, treatment is effective)

palliative care nurses and the out of hours service to review the needs of patients on the palliative care register. Feedback from visiting health professionals and two charitable organisations indicated the practice worked well with them to support the needs of their patient population.

We received feedback from a local service that provided training to people who needed support with substance misuse and mental ill-health. This indicated that the practice referred patients on to the training programmes and provided the on-going support patients needed. The GPs had invited the service to Cornerstones Surgery to run a small drop-in clinic to help make the transition to a new service easier for patients.

### Information Sharing

There was a confidentiality policy and data sharing policy which gave clear guidance to staff. Information about access to records and data protection was available for patients to refer to.

The practice was implementing the electronic Summary Care Record and information was available for patients to refer to (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared.

The practice had systems in place to communicate with other providers. For example, there was a system for communicating with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

### Consent to care and treatment

The practice had a consent to treatment policy which set out how patients were involved in their treatment choices so that they could give informed consent. The policy identified where best interest decisions may need to be made in line with the Mental Capacity Act 2005 when someone may lack capacity to make their own decisions. We found that both GPs were aware of the Mental Capacity

Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they would implement it in their practice. We noted that a record was not made of assessments of capacity. A recording tool to enable this was available and the practice manager and GP partners advised us that this information would be recorded in the future.

The GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). We noted that there was no procedure around assessing Gillick competence in place to provide guidance to staff.

### Health Promotion & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

Quality and Outcomes Framework (QOF) information showed the practice was generally meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing cervical screening, diabetes checks and flu vaccinations to high risk patients. The QOF indicated worse than average scores for the percentage of patients with diabetes with a record of a foot examination within the preceding 12 months and the percentage of patients with physical and/or mental health conditions whose notes recorded smoking status in the preceding 12 months. We were informed that where these shortfalls were within the remit of the practice to address an action plan was in place.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions

## Are services effective?

(for example, treatment is effective)

such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

# Are services caring?

## Our findings

### **Respect, Dignity, Compassion & Empathy**

We looked at 43 CQC comment cards that patients had completed prior to the inspection and spoke with four patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey in March 2014 found that 94% of patients at the practice stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Ninety eight percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. These responses were about average when compared to other practices nationally. Ninety seven percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good.

We looked at the results of the last patient survey undertaken by the practice in December 2014 and February 2015 to establish patient views about GP consultations. The results were very positive with 100% of patients indicating they were treated with respect, dignity, compassion and empathy. Thirty two patients responded to the survey in December 2014. The results showed that 97% rated the GP as outstanding or excellent at listening to their concerns. Ninety four percent rated the GP as outstanding or excellent in showing care and compassion. Thirty patients responded to the survey in February 2015. Ninety two percent of patients said the GP was outstanding or excellent at making them feel at ease. Ninety two percent rated the GP as outstanding or excellent in fully understanding their concerns and not overlooking or dismissing anything.

We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit. Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was a room available if patients wished to discuss something with them away from the reception area. The telephones were answered away from the reception area which promoted patient privacy and confidentiality.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

### **Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the National GP Patient Survey in March 2014 showed 90% of practice respondents said the GPs were good or very good at involving them in decisions about their care and 90% felt the nurses were good or very good at involving them in decisions about their care.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and supported.

We looked at the results of the last patient survey undertaken by the practice in December 2014 and February 2015 to establish patient views about GP consultations. The results were very positive with 100% of patients indicating they were involved in decisions about their care.

### **Patient/carer support to cope emotionally with care and treatment**

Information was on display in the waiting area about the support available to patients to help them to cope emotionally with care and treatment. Information available included, information about the Citizen's Advice Bureau, advocacy services, mental health support services and

## Are services caring?

bereavement services. GPs and nursing staff were able to refer patients on to counselling services. There was a carers noticeboard providing information for carers about the various avenues of support available to them.

Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. GPs and the practice nurse were able to refer patients on to counselling services. A condolence card was sent to bereaved relatives.

The practice took part in the food bank voucher scheme. One of the staff oversaw the administration of these vouchers to patients in need of this support.

The practice had been given a grant from St Helens Clinical Commissioning Group to establish a support service for patients. A plan was underway to set up an advocacy service to support patients.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice engaged with St Helens Clinical Commissioning Group (CCG) to address local needs and service improvements that needed to be prioritised. The practice had assessed the needs of its patient population and tailored the services provided to meet these needs. In order to improve GP services provided to the homeless, the practice, in collaboration with St Helens Clinical Commissioning Group (CCG) (formerly the Primary Care Trust) had set up a GP service for the homeless. Homeless patients were able to register with the practice and the clinicians regularly saw these patients when they were unwell and provided them with health screening and health promotion services. The practice supported homeless patients to attend hospital appointments when necessary. For example, hospital appointment letters were sent to the practice and liaison took place with community homeless services to identify a person to accompany the patient to the appointment.

The practice nurse visited housebound patients to carry out long term condition reviews. The practice had identified all patients at risk of unplanned hospital admissions and a care plan had been developed to support them.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

Referrals for investigations or treatment were mostly done through the "Choose and Book" system which gave patients the opportunity to decide where they would like to go for further treatment. Administrative staff monitored referrals to ensure all referral letters were completed in a timely manner.

The practice worked to the National Gold Standard Framework in end of life care (The National Gold Standards Framework (GSF) Centre in End of Life Care provides training to enable generalist frontline staff to provide a gold standard of care for people nearing the end of life). The practice had a palliative care register and had

multidisciplinary meetings to discuss patient's and their families' care and support needs. Due to a re-organisation of health care staff these meetings were not always taking place on a six weekly basis. The lead GP for palliative care and the practice manager told us the practice was supporting a few patients with palliative care needs and regular liaison took place outside of these meetings with district nurses, the community matron and out of hours service to ensure changes in care and treatment were communicated.

The practice offered patients a chaperone prior to any examination or procedure. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff we spoke with said they had received sufficient guidance around carrying out this role. Records demonstrated that staff who acted as chaperones had received training in this.

Up until 12 months ago the practice had an active Patient Participation Group (PPG). The purpose of the PPG was to meet with practice staff to review the services provided, develop a practice action plan, and help determine the commissioning of future services in the neighbourhood. Records showed the meetings held with the PPG to discuss changes to the service such as the introduction of the triage system. Records also showed changes made to the practice as a result of feedback from surveys and meeting with the PPG, for example, improving access to the service and the arrangements for collecting prescriptions. The practice manager was working with the CCG to re-establish the PPG and to look at ways of encouraging patients to participate.

### Tackling inequity and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as in the consulting and treatment rooms. There were comfortable waiting areas for patients attending an appointment and car parking with designated disabled spaces was available nearby. There were disabled toilet facilities.

Staff were knowledgeable about interpreter services for patients where English was not their first language. Information about interpreting services was available in the waiting area. The GPs told us how they worked with the travelling community to ensure that they had access to GP and other health care services when needed. The practice provided GP services to the homeless community.

# Are services responsive to people's needs?

## (for example, to feedback?)

Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. For example, if a patient required interpreting services or had a learning disability then a double appointment was offered to the patient to ensure there was sufficient time for the consultation.

Staff spoken with indicated they had received training around equality, diversity and human rights. When the homeless service was introduced a training session was provided to the reception staff around treating patients equally and being non-judgemental to ensure that these patients were provided with a service that was supportive and promoted their well-being.

### Access to the service

The practice was open from 08:00 to 18:30 Monday, Wednesday, Thursday and Friday with extended hours on Tuesday until 20:00. The practice operated a telephone triage system which meant that the GPs booked their own appointments after speaking to the patient. This was introduced in June 2013, after a great deal of research, to improve the appointment system. Appointments with the practice nurse, health care assistant or locum GPs were booked directly by receptionists.

On requesting an appointment to see the GP the receptionists gathered basic information, including if the patient agreed, some brief details about the reason for the appointment. The GP then telephoned the patient on an agreed day and time convenient to the patient. The majority of triage requests were normally dealt with on the same day, however this was dependent on demand. The GP made an appointment or home visit if the issue was not able to be dealt with by telephone. The practice had a policy where patients aged 10 and under, or 75 or over would have telephone triage calls on the same day as they were requested. There were also a number of circumstances where the receptionist booked an appointment for the patient. For example, homeless patients or patients booking in for chronic disease management clinics. Information about the triage system was available in the patient information leaflet, on the practice website and existing patients had been made aware of these changes through leaflets in reception and the practice website.

The triage system was monitored to ensure that any issues around access to GP consultations were identified. A survey

was conducted over a two week period in August 2013 which indicated overall satisfaction. Further surveys were carried out in December 2014 as part of the GPs appraisal process. The results of the surveys in December 2014 indicated that a large proportion of patients found it easy and convenient to arrange for a GP to call them back and felt their problem had been satisfactorily dealt with. Overall, patients were satisfied with the telephone triage system. Seventy seven percent of respondents to one GP survey and ninety seven percent of respondents to a further GP survey said they were very satisfied, quite satisfied or satisfied with the triage system. As a result of patient surveys changes had been made to the way the triage system operated. Information about updates to the system, changes made and the benefits of the system was provided to patients to keep them informed.

The National GP Patient Survey in March 2014 found that patients were overall happy with access to the service. Eighty three percent were very satisfied or fairly satisfied with opening hours and 81% rated their ability to get through on the telephone easy or very easy.

We looked at 43 CQC comment cards that patients had completed prior to the inspection. A number of the comments indicated that patients were happy with the telephone triage system. Two comments indicated that these patients would prefer face to face consultations with their GP. We spoke with four patients. Three said they were happy with access to GP consultations. One said that they preferred seeing a GP rather than talking to them on the telephone. Patients said they were satisfied with arrangements for repeat prescriptions and that if a referral to another service was needed this had been done in a timely manner.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaint policy and procedure were available in the reception area. Reference was made to how to make a complaint and the complaint policy on the practice's website and in the patient information leaflet. The policy included contact details for the Patient Advisory Liaison Service (PALS) and the Health Service Ombudsman, should patients wish to take their concerns outside of the practice. We noted that contact details for NHS England were not included.

We looked at the record of complaints and found documentation to record the details of the concerns raised

## Are services responsive to people's needs? (for example, to feedback?)

and the action taken. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint. We found that changes to the service had been made as a result of patient complaints.



# 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

Cornerstone Surgery was a Christian practice and its mission statement and vision reflected this:-

“Our mission is to work together as a practice team, all using God-given gifts and talents, to provide holistic care for our patient population in an environment of compassion and acceptance.”

“Our vision is to increasingly bring God’s government of love to our staff and patients; as such we are empowered to be safe, effective, responsive and caring in a well led environment.”

The mission statement was displayed at the practice and on the practice website for patients to refer to. We noted that this was not included in the practice information leaflet for new patients. The practice population included patients from a variety of faiths. The staff spoken with were clear about the vision and mission statement of the service and endeavoured to ensure this was reflected in their work with patients.

### Governance Arrangements

Meetings took place to share information, look at what was working well and where any improvements needed to be made. The GPs and nurse met informally to discuss new protocols, to review complex patient needs and keep up to date with best practice guidelines. Practice meetings involving the whole staff team took place every three months and provided an opportunity to share information vital for the operation of the service. The practice manager and a GP partner met weekly to discuss the operation of the practice and any actions needed to improve the operation of the service.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in a paper format. Policies and procedures were regularly reviewed and the sample we looked at were up to date. We spoke to staff who were aware of how to access policies and procedures.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The GPs spoken with told us that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. Examples of clinical audits seen included diagnosis and treatment of hypertension and an audit of the telephone triage system. Records and a discussion with the GPs showed improvements had been made to the operation of the service and to patient care as a result of the audits undertaken.

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Staff told us and minutes from practice meetings indicated that the outcome of significant incidents and complaints and how they were to be learned from were discussed.

### Leadership, openness and transparency

There was a leadership structure in place and clear lines of accountability. We spoke with 8 members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or as they occurred with the practice manager or one of the GPs. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made.

We reviewed a number of human resource policies and procedures that were available for staff to refer to, for example, the induction, sickness and absence and disciplinary procedures. These procedures were in a staff handbook which was updated on an annual basis. A whistle blowing policy and procedure was available and staff spoken with were aware of the process to follow.

### Practice seeks and acts on feedback from users, public and staff

Patient feedback was obtained through carrying out surveys, reviewing the results of national surveys, comments and suggestions forms located in the patient waiting area and available on-line and through the complaint procedure. We looked at the results of the last patient surveys undertaken by the practice in December 2014 and February 2015. The results showed that patients



# Are services well-led?

Good 

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

were very satisfied with their experience of GP consultations. Survey results for December 2014 showed that patients were overall satisfied with access to the service.

Up until 12 months ago the practice had an active Patient Participation Group (PPG). The purpose of the PPG was to meet with practice staff to review the services provided, develop a practice action plan, and help determine the commissioning of future services in the neighbourhood. Records showed the meetings held with the PPG to discuss changes to the service such as the introduction and reviews of the triage system. Records also showed changes made to the practice as a result of feedback from surveys and meeting with the PPG, for example, improving access to the service. The practice manager was working with the CCG to re-establish the PPG and to look at ways of encouraging patients to participate.

A leaflet was on reception and handed out to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results for January 2015 showed that 131 out of 141 patients were “extremely likely” or “likely” to recommend the practice. Results for February 2015 showed that 59 out of 60 patients were “extremely likely” or “likely” to recommend the practice.

Staff told us they felt able to give their views at practice meetings. Staff told us they could raise concerns and felt they were listened to.

## **Management lead through learning & improvement**

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff were offered annual appraisals to review performance and identify development needs for the coming year. Staff told us the practice was supportive of their learning and development needs and that they felt well supported in their roles. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were disseminated via email, verbally and discussed at practice meetings and if necessary changes were made to the practice’s procedures and staff training.