Safer Culture

March 2017

Understanding Safety Culture

Report and recommendations from pilot of safety culture tools in primary care in Salford

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Safer Salford

Introduction

The culture of an organisation influences safety outcomes for patients. Safety culture refers to both the climate among staff and the approach to ensuring patient safety. A first step to enable organisations (or units and departments within an organisation) to improve their safety culture is to understand what the current culture is like for staff working within teams.

A number of tools are commonly used in acute (hospital) settings however limited literature is available in relation to their use in primary care.[1]

Between September and December 2016 Haelo piloted three Safety Culture assessment tools in nine GP practices. The learning from this pilot is intended to inform the roll out of a process to build understanding and improve safety culture in primary care across Salford.

This document outlines learning from the pilot phase and provides recommendations related to the factors which will influence successful roll out to primary care in Salford.

Safety Culture Tools

In this section we provide a brief outline of the safety culture assessment methodologies applied in the Salford pilot. A sample of nine GP practices (of 45 overall in Salford) were identified to participate in this pilot. Practices were identified on the basis of having a pre-existing relationship with Haelo as participants of the PRISMS (Practices Improving Safety of Medicines in Salford) collaborative and the Broughton Flu cytology project. The results from the pilot practices do not seek to be viewed as representative of Salford practices as a whole, but provide a useful indicator for how safety culture tools are received in primary care.

Safequest

Safequest is a safety culture survey methodology developed by NHS Education for Scotland targeted at GP practices[2]. Use and roll-out of this survey methodology is supported by Health Improvement Scotland and all participating practices receive a small payment of £200 on completion of the survey.

This methodology places onus on practices themselves to run and deliver the survey, requiring a representative from the practice (usually a Practice Manager) to log in, enter email addresses to send the survey to and lead de-briefing discussions once the survey report has been produced. Although anonymous, the survey results can be sub-categorised into clinical and non-clinical responses, and management and non-management responses, to enable greater stratification of results. Results are automatically formulated and provided to the Practice Manager once the survey has been completed, the Practice Manager is then expected to lead a de-briefing session with staff to discuss the results and use this

[1] For further reading we recommend the Health Foundation's 2011 Evidence Scan of measuring safety culture, available online: www.health.org.uk/sites/health/files/MeasuringSafetyCulture.pdf

[2] For more information, visit: http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/safety-culture/safequest-safety-climate-survey

information to develop an action plan – a light-touch template is available to support this action plan. The process can be repeated at any time and at any frequency to allow practices to measure any improvement in their culture.

Access to the Safequest survey is available for free online, but requires a practice number to register to use the online tool.

SCORE

SCORE (an integrated survey of Safety, Communication, Organizational reliability, Resilience/Burnout and Engagement) is a safety culture survey methodology developed by Safe + Reliable Care[3] for use in clinical settings, primarily hospitals. In this pilot, the wording of the questions required substantial adaptation to ensure relevancy and comprehension in primary care.

This methodology requires a practice manager (or similar) to provide email addresses for all staff to participate. Participants will then receive an initial email to a unique link to complete the survey, followed by weekly reminders until they have completed the survey. Results are then provided to a SCORE facilitator (training is one-day and can be conducted via WebEx, although face to face is preferential) who will seek to deliver a de-brief to the practice leadership team (this can be done via WebEx), prior to a series of de-briefing sessions with participants (the gold standard approach involves de-briefings with each staff group, prior to a full team de-brief) to discuss the results and use this information to develop an action plan. The SCORE facilitator then reflects back the discussion to the practice via a brief written report. The expectation is that practices will repeat the process at least once in order to measure the effect of any resulting initiatives on the practice culture.

Access to the SCORE survey methodology was provided for free for this pilot in partnership with the South West Patient Safety Collaborative[4]. Future access to the methodology for Salford will require a financial outlay.

MapSaf

MapSaf (the Manchester Patient Safety Assessment Framework) is a tool developed by University of Manchester to support healthcare teams to assess progress to improving safety culture. This framework has been adapted by the developers for a number of different settings, such as acute hospital, surgery, ambulance and care homes, however has not yet been adapted specifically for primary care teams.

The tool is in the form of materials to support a single 2½ - 3 hour workshop to be delivered by a facilitator – this would usually be someone external to the team being evaluated, however this is not essential. All staff within the practice should be present at the workshop. The purpose of the workshop is to collaboratively develop an agreed assessment of the unit's culture, with a view to developing an action plan to improve this (although the latter element is not the emphasis of the workshop).

Access to the MapSaf methodology is freely available online[5].

[3] For more information, visit: https://www.safeandreliablecare.com/surveys/
[4] For more information, visit: http://patientsafetysouthwest.org/score-survey/

Evaluation

Logistics

The pilot was delivered by a project manager based at Haelo, with support from a senior manager based at Salford CCG. The South West Patient Safety Collaborative provided resource to analyse results and facilitate the de-brief sessions for the SCORE methodology.

To complete the surveys a full list of email contacts for each practice was required; this was not readily available in all practices and obtaining lists required some supporting resource from the CCG.

Of the seven practices completing the SCORE methodology, all seven completed the process from survey to debrief, with a range of 53 to 86% of staff completing the survey (the target is 60% completion). Completion of the SCORE survey was linked to participation in the PRISMS[6] programme; informal feedback received from other safety culture assessments has suggested that linking this process to a wider improvement project will increase engagement with the assessment.

Participation in the Safequest survey was pitched to the Broughton GP neighbourhood meeting and three practices came forward to join the pilot (two were already involved in the SCORE pilot). Of the three practices completing the Safequest methodology, only two were able to complete the process, with one failing to collect enough responses to the survey to produce valid data.

It was not possible to arrange a time to complete the MapSaf methodology in any setting. Feedback from teams contacted stated that it would be very challenging for all (or a significant majority) of staff to be booked out at the same time for this activity.

All participating practices were provided with introductory briefing (both verbal and written) including information outlining the purpose of safety culture assessments, details of the assigned methodology, an outline of the Safer Salford programme and communication materials (posters and leaflets) to raise awareness of the survey with staff.

The majority of practices reported relatively low awareness of the surveys and many practice managers were not able to dedicate time to promoting this. Feedback suggests that this was due to two factors; firstly the relatively low profile of the pilot surveys, secondly the time of year that the survey was conducted coincided with a particularly busy period for practices.

With both methodologies, a number of practices reported that online completion was a barrier to participation for a minority of staff due to a combination of low IT literacy and lack of time in the day. Practice managers who gave staff dedicated time at a computer achieved a better completion rate.

[5] For more information, visit: http://www.nrls.npsa.nhs.uk/resources/?entryid45=59796
[6] Practices Improving the Safety of Medicines in Salford – for more information visit: http://www.haelo.org.uk/case-studies/reducing-harm-patients-taking-high-risk-drugs-salford/

Conversations

Consistent throughout the literature relating to the value of safety culture assessment is an emphasis on raising the profile of safety and promoting conversations, therefore it is important to understand how the different tools influence discussions.

There are two primary differences between the tools tested: the display of data and the facilitation of the de-brief session.

Data presentation

The SCORE methodology provides practices with a graphic display (spider diagram) of results for each of the question domains, with specific questions broken down by staff grouping (clinical / non-clinical, GPs / practice management / nurses / reception and admin).

The data provided to each practice does not include any data from other practices, for example, for the purposes of comparison and benchmarking. The benefit of this approach is that it enables practices to retain a focus on continuous improvement in areas of interest to that practice.

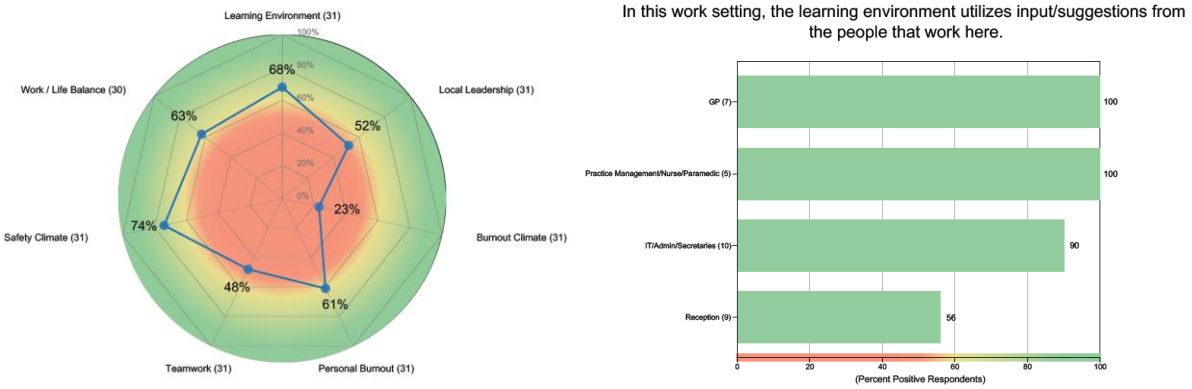


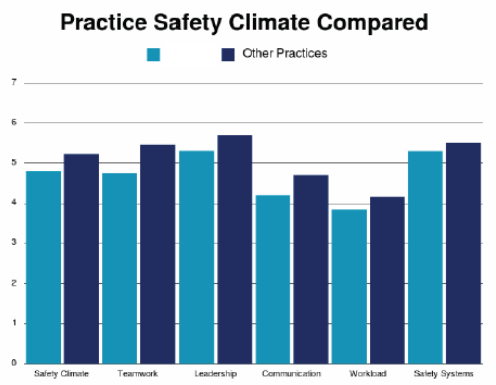
Fig. 1 Sample results from SCORE survey

The SafeQuest methodology provides practices with their raw data and a simple graphical display (histogram) for each of the questions, as well as aggregate scores across each domain. Some questions are broken down by staff grouping (clinical / non-clinical, management / non-management).

The data provided to individual practices also includes a summary of how their results compare with other practices participating in the survey. As this methodology is predominantly used in Scotland, it does not provide a like-for-like comparison, although it may be possible to create a “Salford” sub-unit for each practice to compare against the Salford average. The benefit of this approach is that it enables practices to hone in on areas where they may be performing below the average; however it will not identify “best in class”.

		Your Practice	Your Practice Last Year	All Other Practices
a	Workload	3.9		4.2
b	Communication	4.2		4.7
c	Leadership	5.3		5.7
d	Teamwork	4.8		5.5
e	Safety Systems & Learning	5.3		5.5

Scale: 1: not at all - 7: to a very great extent



The MapSaf methodology does not create quantitative data. Each workshop facilitates the completion of a collaborative assessment of safety on a scale. Scores are not designed to be reported and compared, either with other practices or over time. The benefit of this approach is that ownership remains in the hands of the participants at each practice, but results are harder to report and feedback to those unable to take part in the workshop.

De-brief session

Arranging dates for the de-brief sessions in practices participating in SCORE was a time consuming task with practices very limited in the dates where the whole organisation could be available to participate in a meeting, and this required co-ordination with an external facilitator. This process extended the time taken for the survey from beginning to end, and in some cases extended a gap of more than a month between completion of the survey and de-briefing, losing the momentum of the process.

Feedback from the externally facilitated SCORE de-brief sessions is mixed, with some practices reporting that staff felt able to speak up, whereas others stating that some members of staff were reticent to come forward in a group forum. The structure of the sessions rigorously followed the survey format, with the results from each question shared and discussed in turn. Although the visual display of data was helpful, feedback suggests that this session could be more focused with greater emphasis on questions of greatest interest.

As the Safequest de-brief sessions were locally facilitated, the burden of co-ordination fell onto the practice management rather than an external project team. Generally speaking, the de-briefs took place sooner after the survey was completed as they could be incorporated into an existing sequence of meetings, however feedback suggests that the quality was poorer as time was not dedicated and set-aside specifically on the survey.

Feedback from observers to the de-brief sessions suggest that neither methodology provided an explicit link back to the safety objectives of the survey, although this is implicit in discussions relating to organisational culture.

Experience

All seven practices completing the SCORE survey were able to formulate an action plan of improvements following discussion during the de-brief session. Actions identified range from holding regular practice huddle meetings to formalising lunch breaks for reception staff to provide time away from phones. Of these, many reported that the process had provided an opportunity to surface issues and open discussion about these, putting practice culture on the agenda for the first time. Feedback from participants following the surveys suggested that some debriefing sessions did uncover issues not previously known to the whole organisation / leadership team.

Of the two practices who completed the Safequest survey, both reported that the survey and debrief only highlighted issues that were already known to the practice and that the 'conversations would have happened anyway'. Although practice managers did not attribute the discussion to the survey, a question remains as to whether the survey was in fact a catalyst to prompt a whole staff group meeting (prior to the survey there were no plans to hold such a meeting).

Perhaps unsurprisingly, practices who received 'better' scores tended to report the experience more positively than those where areas for improvement were more significantly highlighted. All, but one, of the participating practices reported the experience as a positive one, with the majority expressing an intention to repeat the process to understand the impact of changes and continue to learn about their culture. Some practices noted that this survey overlapped with other initiatives already underway in individual practices, raising a question as to whether it would be a good use of resources for this survey to be compulsory.

Recommendations

1. **Invest in developing a bespoke Safer Salford culture tool** for use in primary care building on learning from this pilot. Our proposal is to develop an annually repeating online survey for all staff to complete and submit (this should be designed to be completed in paper format or via a login on a mobile device, e.g. iPad). Results will be compiled and reported to practice management in a standard format. Practices will be expected to feedback these results in a de-brief session to encourage discussion and development of improvement actions. Further review is required to determine whether an external facilitator is required or whether recommendation 2 will be sufficient.

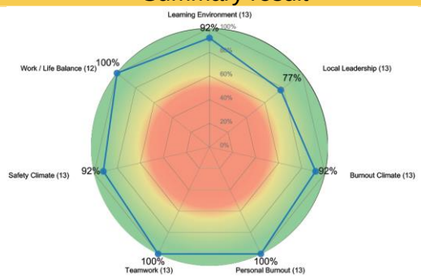
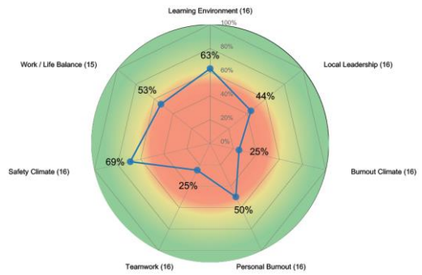
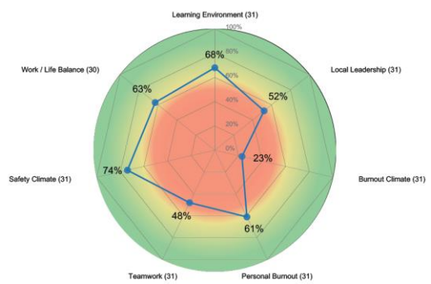
2. **Provide training and resources** to support practice leaders to facilitate and deliver the safety culture assessment tool. We anticipate that the requirement for support will be higher in the first year of the survey, with need decreasing as practices become more familiar with the process. Resources will include materials to support delivery of a debriefing session and be made available online on the Safer Salford website. Additionally, we propose to explore options for a training package for practice managers to raise awareness and provide skills in facilitation and managing challenging conversations. Training could be delivered at neighbourhood meetings or in a single event for all practice representatives.

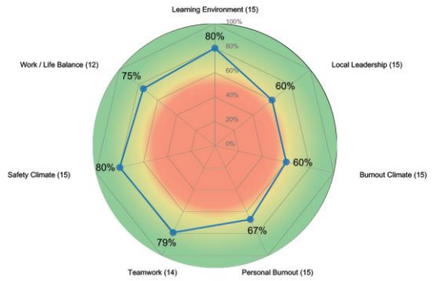
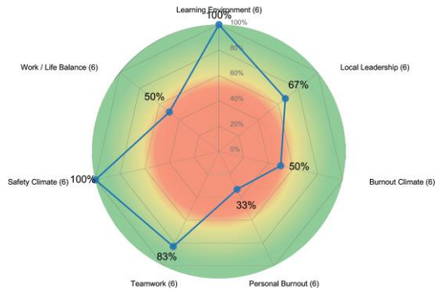
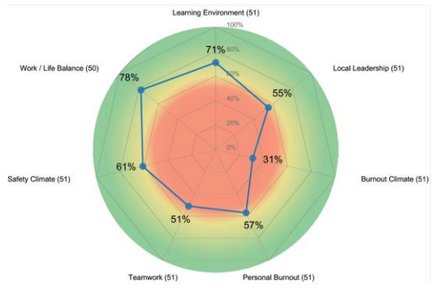
3. **Consider creating incentives** to encourage participation and completion of safety culture tools. Feedback from the pilot suggests that when practices have completed the process once, the value in the process becomes more intrinsic, therefore incentives may be provided on a sliding scale (e.g. a higher incentive in the first year than in subsequent years). Options include:
    a. Involvement of senior CCG representatives and neighbourhood leads
    b. Creation of a small financial incentive via inclusion in the Salford Standard
    c. Establishing safety culture tools as a necessary component of involvement in other 'more desirable' improvement initiatives, for example, PRISMS.

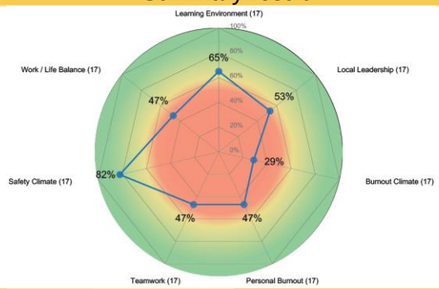
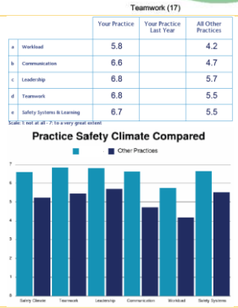
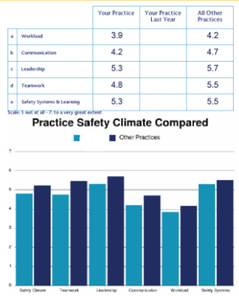
4. **Refrain from linking safety culture results to a formal performance metric** – this will centralise ownership of the process away from individual practices and threaten the open nature of discussion.

5. Timing of the survey launch and roll-out should be co-ordinated to **avoid busy periods of the year** for primary care. Based on feedback from participants we propose April / May (preferred) or September / October to avoid the busy winter period and summer holidays when staff are not so readily available.

Appendix 1 – summary of learning

Method	Location	Summary result	Logistics – survey completion	Logistics – debrief	Conversations	Experience
SCORE	Practice 1		People read emails and ignored them Once staff reminded and prompted in person by Practice Manager, got results Simple to do Did get automatic reminders Staff awareness low until explained by PM Had poster and leaflets out- these helped people looked at them	No barriers to organising WebEx, normal time constraints. Clinical lead wouldn't have made much difference. GPs usually happy to deflect this type of thing to PMs Lots of people on AL at time of debrief and other staff off. Most part time and on shifts. Depends on way practice is run. If able to arrange with more months' notice would have helped. Prefer not to close practice as they aim to provide constant service to their patients.	Quite enjoyed WebEx. Wasn't expecting such a positive outcome therefore was a really positive experience. Found report and layout of information really useful- liked visual presentation and made report more engaging Staff all pleasantly surprised and quite happy to get together to receive results Clinicians perhaps more engaged than admin staff Staff were open and honest, staff not afraid to speak up	Staff not always aware of when PM and assistant available Have since tried to make staff more aware of who is in when and where, more vocal around this. Results were positive therefore one outcome was to continue good work e.g. getting involved in improvement projects If doing again- would stick to same process- well organised process Could try to block off clinical sessions for debrief "put a pause" on the day Would recommend to other practices Would like to repeat in a year's time
SCORE	Practice 2		Many people without email account – this situation has now improved and most staff have nhs.net It would be helpful to have a breakdown of who has and hasn't completed to enable PM to chase. An alternative method of completion would help, e.g. paper or a link for staff to use in protected time. Those who do have email often discarded the SCORE emails due to a high volume of email, especially the GPs who had to be constantly chased Promotion- difficult to promote due to time constraints, other than mentions within team meetings. Posters were of limited value as staff did not know what they related to as practice failed to explain internally. Now that staff are familiar with the process they should be more likely to respond next time. Some people thought that certain questions did not apply to them and therefore answered neutrally. This was reflected negatively in the results and therefore possibly inaccurate. There may have been some difficulties interpreting some of the questions, depending on literacy.	Good to have independent facilitation Getting people to attend was "easy" as they now have monthly protected time for training. Only recently introduced. Had to 'bite the bullet' and make dedicated time. "can't move forward without taking this time to reflect" WebEx was easy enough to arrange but the challenge was protecting time on the day due to unpredictability of the practice environment. Staff who had completed the surveys were interested in results but other staff were less engaged as had little idea what the debriefing was for.	PM disappointed that senior partner didn't come to meetings but he was interested and found the feedback useful. Senior partner not surprised by results and keen for repeat. Lots of discussion generated among staff and gave 'food for thought' Themes incorporated into appraisal discussions During debriefs, PM's impression was that not all staff were open and honest especially the staff group (reception) who had responded more negatively It was noted that the reception staff who had not completed the surveys contributed to discussions but staff who had completed the surveys were reluctant to then air their views. Splitting into teams probably would help to create open discussion Keeping leadership outside discussions may also help with candour. Although this might be uncomfortable for practice leads it would be accepted as necessary and CQC feedback is gleaned in a similar way. PM would feel confident to address issues surfaced in this way.	Problems surfaced: • Poor morale in reception • Time constraints • Same day service (a previous innovation) has created a call-centre environment and this has had negative effects Improvements: • Trying to ring-fence time for receptionists to come away from desk to undertake other admin • This is constrained by resources. Having to use locums to achieve this. • When bringing new staff in (initially on temp basis), using staff feedback to assess how well a new person fits in and achieve a good balance of personalities. • Meeting more often • Using SCORE feedback in appraisal conversations to support objectives • Staff seem to be responding well to changes. • Practice keen to run a repeat in ~March 17. Suggestions for future: • Consider other ways of collecting responses and engaging staff with surveys. • Next time round, practice will be more "switched on and able to get people to engage. • Provide internet link up front so that PM can make PC available in dedicated time
SCORE	Practice 3		Staff who didn't complete weren't aware of the purpose of the survey, communication could have been better. Email was a good way to do it. Handwritten surveys would have been an alternative and might have helped with awareness Timeframe was a reasonable ask. Posters tend to get lost in mountains of other patient info on display. Heads or dept/line managers should know objective of the surveys to enable them to communicate it to staff. E.g. PM, Business mgr, IT mgr, recep supervisor, GP partner	No barriers to getting staff together ½ day closing is used to facilitate such activities, combined with other training Practice keen on staff having this educational time set aside anyway Would have been v difficult to achieve without this Some staff were not sure how to interpret some of the questions, e.g. 'leadership', make questions more explicit Staff attitude was OK- not disgruntled. Again, awareness low beforehand so communication could have been better internally	Results matched expectations Groupings could have been better on reflection- e.g. having leaders present. Some staff may have felt unable to be honest, smaller groups might help Not awkward or uncomfortable Staff engagement seemed good Now have a plan in place to have an appraisal annually for ALL members of staff as a result of the discussions. Importance underlined by staff discussions. Already knew this was an issue No real surprises Level of positivity about colleagues and working as a team stood out	Huddle meetings/"buzz" meetings suggestions really valuable Have implemented a lot (majority) from that day If repeating: Try different staff groupings Be able to brief staff more clearly about the purpose of debrief meeting Would like to do it again to see results (6/12) Support was really good. Would like a facilitator to explain whole process and sell benefits Make people aware opportunity to make small changes, increase efficiencies A really worthwhile exercise. Would love to review results in 6/12. List of actions/ideas from meeting. Most of these have now been put in place:

Method	Location	Summary result	Logistics – survey completion	Logistics – debrief	Conversations	Experience
SCORE	Practice 4		PMs weren't aware that emails had been sent out. "Even I didn't realise what it was when it was sent it out and deleted it. Some staff though the email was junk and deleted it. If PMs were more aware they could have driven it. Had to have surveys re-sent. Questions were slightly ambiguous, open to interpretation. Other staff reported this as well... Not time consuming. Don't recall getting posters and leaflets. Staff need to know what they are filling in and why, so PMs needed to be better informed.	No barriers to management debrief. Didn't have GP involved. However, been without 3 of 5 GPs so would have been difficult to involve them. Most staff part time (work ~5 hours) therefore having use cross-over time and asking staff to stay longer. Staff happy to do this and take time back. Problems getting clinical staff in were due to staff being off sick etc. but normally getting different groups together is doable. Anything more than 1.5 hours is difficult to arrange. Staff moaned at first but were happy to attend.	Staff didn't really air their feelings in the meeting. However, some staff carried on the conversation afterwards, about the meeting and the conversation. One member of staff came to PM on the back of this to air grievances which was useful, cleared the air, as did other staff. Some people not comfortable to speak up in front of a big group. No surprises in the results.	Highlighted that receptionists didn't feel their role valued by organisation. A little surprised by this. Had a meeting afterwards for leadership to provide reassurance to receptionists that their role is really valued. The meeting was a catalyst for further discussion. Had a lot of problems this year with loss of clinical staff, resulting in numerous changes. No one in the practice who has taken ownership of the results- mainly due to time. Mgt need to be aware of process and then give staff a good heads up on the surveys. Do want to repeat process when all staff back and back to normal.
SCORE	Practice 5		Some people without nhs.net email- was told needed to be nhs.net Hard copy alternative might help Did tell people about it but people without emails assumed it didn't apply to them On reflection could just set up emails	Some staff came in on day off- happy to do so Used Weds pm closing- closed 1 hour earlier and payed for out of hours Good attitude towards attending Felt it was appropriate to do this	Results largely matched expectations On answer skewed- questioned interpretation of question Felt conversations honest Staff who hadn't completed joined in Staff not afraid to pitch in	Issue with people not taking lunches – trying to lunch a bit more and get out of building Email communication needed Need to meet more often Improvements in pipeline Weds sessions Barriers- can't find meeting times to suit everyone. Can't always get rooms Would be interesting to repeat One GP has taken results to appraisal Could explain more to practices what the survey is about Equipping PMs to do that with staff Like with everything- it can be perceived as just another thing to complete After result- found it really useful.
SCORE	Practice 6		Participation was good Some staff deleted link then found couldn't borrow a link from colleague (unique) Technology not a particular issue Awareness among staff was good. By the time of debrief (>4 months later) some staff had forgotten Disseminated to teams via normal channels, newsletter, etc. Also communications from CCG Email reminders	WebEx was quite achievable but frustrating Only got report immediately before Was essentially talking through each chart High level discussion would have been more useful, focussing on highlights or issues, inevitably ran out of time Needed a chance to read it first and then speak to 'author' to gain insights. Also meant didn't have question prepared. Unique in that 85 staff across 4(!) sites Amount of time unrealistic Training time is allocated each month but v precious and expensive as have to close service. Have more requests than can accommodate Even harder to protect time for reception staff as reception has to stay open at all times Staff had forgotten about the survey Nurses felt they were forced to come/reluctant Could have been doing other tings Didn't find it useful Reception staff on other hand found it very useful and were interested to see the views of their colleagues Reception staff who couldn't attend were disappointed- tend to get pushed to the back of the queue for training etc. If doing it again, would be good to roll out internally, given the tools to repeat themselves. Would have better engagement, multidisciplinary Feel that even without external facilitation, staff could be open and honest Staff at this practice are quite happy to speak up- this might not be the same at all practices Small groups help. Large groups would be a barrier to staff speaking up.	Nothing contentious and some of the issues were already known and being dealt with Nursing staff felt the instructions weren't clear around what constituted a negative answer- weren't convinced about the validity of the findings- response numbers didn't match staff numbers, e.g. number of nurse didn't tally. Would have liked to see a breakdown of who completed Staff were honest and open Admins staff were very comfortable with each other, might have been quieter other wise	Staff feel valued but pressured and overworked (Admin) Reception the last to know Since completing survey, now have new front of house manager so would hope things have improved – aiming to do work on communication Also making reception staff feel prioritised along with clinicians Consistent one to ones and meetings, bridging with management meetings, ensuring training provided and helping staff understand why they are doing Previous staff survey and training session had already highlighted some issues around burnout and teamwork. GP began 'Making it better' programme for staff, including workload. Felt there was duplication with this and SCORE If doing the process again: It felt like a big piece of work to do at the same time as PrISMS, Salford Standard, Flu, QoF- spread the workload, use practices not involved in other things Have tools to repeat yourselves

Method	Location	Summary result	Logistics – survey completion	Logistics – debrief	Conversations	Experience
SCORE	Practice 7		Barriers- engagement with staff. Lots of changes going on at the time- changes to working hours, staff disgruntled. Also 2 nurses on mat leave. Getting staff to use/check emails difficult because staff had never had to before PM perhaps didn't disseminate the information straight away, maybe didn't understand importance of it, therefore staff awareness low. Not sure what would have helped. If doing it now, would be a different story, could expect higher response.	Big practice, don't take time out of the day and don't switch phones off. Sometimes run training late evening or early but have to pay overtime. Practice meetings take place but GPs only. Are now using 5 min huddles 3x a week- introduced as a result of Productive General Practice and PrISMS. Only other avenue would be evenings/Saturdays		If doing again, would include in staff newsletter (set up recently) and promote in huddles and meetings. These things weren't previously in place. Wouldn't look for anything different in the way support.
SafeQUEST	Practice 8		A good response was received although some questions were ambiguous. Technology was no issue and level of staff awareness was good. Staff time was given to complete the survey.	The discussion was definitely achievable although the feedback/de-brief was done in an informal manner due to time constraints in a quick 10 minute huddle. It was hard to get all the staff together due to capacity issues. Despite this, staff had a positive attitude to meeting up. In future, we should set dedicated/protected time aside for this rather than do a rushed de-brief. There is a current re-structure taking place internally anyway so this was discussed too informally.	Very positive in all areas and the practice manager was not surprised with the results. The atmosphere in the workplace is good and staff members engaged well. The discussion was honest and open however, was a little rushed due to lack of staffing.	Any improvements identified: Most of the issues that were highlighted in the survey are issues that we are already aware of and will hopefully be addressed once the re-structuring takes place (due to 2 of the practices merging). We would probably set more time aside if we were to do it again especially when feeding back to staff. We would look at work load of staff and redesign as areas of improvement.
SafeQUEST	Practice 9		Staff meeting time precious as used for other training GPs see such surveys as very low priority compared to other NHS issues Multiple agencies pressing the surgery for info Particular pressure around Christmas - QOF, Salford Standard Organising survey and carrying it out was time consuming and 'annoying'		Questions misleading, not sure if staff understood The team questioned the validity of the results- their assumption is that people didn't understand the questions and just ticked "middle of the road" responses. Didn't know what the "other practices average" was based on so again, questioning validity. Had whole staff group meeting last week last week (Surgery closed) - really valued by all. Staff brought list of staff issues- circulated and discussed. Most issues addressed there and then and others to be picked up at next meeting. The practice felt they would have had meeting anyway- survey made no difference.	"These conversations have happened away" Would it be of benefit to repeat in 1 year? No because we can tell that improvements are happening anyway. Doesn't give enough information to justify time spent- don't see value in this exercise. Time would be better spent on other exercises. "Paperwork exercise" Feedback from staff was that the wording was vague and a paperwork exercise. Staff didn't want it, PM didn't want it and GPs didn't want it.
SafeQUEST	Practice 10	No Results Available	Surveys printed out but not distributed to staff Difficult time of year and general workload, QOF reporting deadline at this time year- vital to GP income and health improvement. 9 month indicators set in April, therefore busy on this between September and Dec. Flu season This would be the same for other practices Staff leave Mid-late April tends to be quieter Attending practice meetings to sell the process might help GP newsletter- all staff are supposed to read this Alternative delivery route would be to attach to a workshop/learning session/meeting i.e. existing protected time with captive audience Private 1:1 interviews might work if practice given enough notice	Once questionnaires completed, would have impetus to discuss findings with staff. Recognises potential to drive improvement Discussion in practice meeting would be feasible. Could also be discussed at cluster level. E.g. CCG workforce planning workshops.		If repeating- Set aside time for staff Would want to get staff together in groups Would like support for facilitation Push from CCG would help Newsletter Definitely something they still want to do and fits with/vital part of workforce planning
MapSaf	Practice 11	No Results Available	It was not possible to obtain a date to complete this survey due to the commitment required from staff (all required to attend for 2.5hrs minimum)			