# Kenneth MacRae Medical Centre

## Quality Report

32 Church Road
Rainford
St Helens
Merseyside
WA11 8HJ
Tel: 01744 882606
Website:

Date of inspection visit: 5 March 2015
Date of publication: This is auto-populated when the report is published

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

This is the report from our inspection of Kenneth MacRae Medical Centre. The Kenneth MacRae Medical Centre is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 5 March 2015 at Kenneth MacRae Medical Centre. We reviewed information we held about the services and spoke with patients, GPs, and staff.

Overall the practice is rated as good.

Our key findings were as follows:

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice had a holistic approach to patient care. The practice promoted health education to empower patients to live healthier lives.
- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The practice was responsive and acted on patient complaints and feedback.
- The staff worked well together as a team.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about patient safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their role.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others in the local area for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture.

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

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and learning points from complaints were discussed in practice meetings.

**Are services well-led?**

Good

The practice is rated as good for being well-led. Staff were clear about the values of the practice being patient centred. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, the avoidance of unplanned admissions scheme. The practice had a designated named GP for patients who are 75 and over and the practice was in the process of carrying out full assessments for these patients. GPs also followed up emergency and some elective hospital admissions to ensure that patients' needs were met to reduce the risks of patients being re-admitted to hospital.

The practice carried out home visits and also visited two local nursing homes on a regular basis. The practice had Silverline information leaflets available to help direct patients if they were lonely or isolated.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. All these patients had as a minimum a structured annual review to check that their health and medication needs were being met. The practice had adopted a holistic approach to patient care rather than making separate appointments for each medical condition.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. One GP was the safeguarding lead for the practice. There were systems in place to identify and follow up children living in disadvantaged circumstances. The GPs met with the health visitor on a regular basis to discuss any cases.

The midwife visited the practice once a week and there were immunisation clinics available.

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

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example the practice offered Monday morning open surgery for issues that could be dealt with quickly

# Summary of findings

| | |
|---|---|
| therefore reducing the need to seek out of hours or emergency care over the weekend. The practice offered online prescription ordering and online appointment services. Telephone consultations were available instead of patients having to attend the practice. | |
| **People whose circumstances may make them vulnerable**<br>The practice is rated as good for the care of people whose circumstances may make them vulnerable. A benefit of being a small practice was that staff knew patients and their families well and arranged appointments to suit patients' needs. | **Good**  |
| **People experiencing poor mental health (including people with dementia)**<br>The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and sign posted patients to the appropriate services. | **Good**  |

# Summary of findings

## What people who use the service say

As part of our inspection process, we asked for CQC comment cards for patients to be completed prior to our inspection.

We received 33 comment cards and spoke with five members of the Patient Participation Group (PPG). There was not one negative comment received at our inspection. Many comments received told us the care was exceptional. Reception staff, nurses and GPs all received praise for their professional care and patients said they felt listened to and involved in decisions about their treatment. Patients told us that they were treated with compassion and that GPs went the extra mile to provide care when patients required extra support. Many comments highlighted that the community held the practice in very high regard.

For the surgery, our findings were in line with results received from the National GP Patient Survey. The results showed that the practice was rated in the top ten surgeries in Merseyside. For example, the latest national GP patient survey results showed that in January 2015, 96% of patients described their overall experience of this surgery as good (from 125 responses) and 98% found the receptionists helpful (which is higher than the national average).

Results from the National GP Patient Survey also showed that 98% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 100% had confidence and trust in the last GP they saw or spoke to which is higher than the national average.

# Kenneth MacRae Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor.

## Background to Kenneth MacRae Medical Centre

The Kenneth MacRae Medical Centre is located in a rural area in Rainford St Helens and is a family run practice that has been established since 1908. There were approximately 3750 patients on the practice list and the practice had an above average number of elderly patients.

The practice is owned by two sisters who are the main GPs. In addition there is nurse and reception and administration staff. The practice is open 8.30am to 6.00pm Monday to Friday. Patients requiring a GP outside of normal working hours are advised to contact the surgery and they are then automatically transferred to an external out of hours service provider (St Helens Rota). However, the practice does carry out its own out of hours for terminally ill patients and others who have more complex needs. The practice has a GMS contract and also offers enhanced services for example; various immunisation and learning disabilities health check schemes.

## Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

## How we carried out this inspection

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

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

We also looked at how well services 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
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances

# Detailed findings

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

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 5 March 2015.

We spoke with a range of staff including two GPs, the practice nurse, reception staff and administration staff, on the day. We sought views from representatives of the patient participation group and looked at comment cards and reviewed survey information.

Good

# Are services safe?

## Our findings

There was a system in place for reporting and recording significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process. NHS England and the Clinical Commissioning Group had no concerns about the track record of this provider.

**Learning and improvement from safety incidents**

The practice held weekly meetings at which significant events were a standing item on the agenda and were discussed in order to cascade any learning points. We viewed documentation which included details of the events, details of the investigations, learning outcomes including what went well and what could be improved.

The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and undertook on-going audits to ensure best practice.

**Reliable safety systems and processes including safeguarding**

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.

All staff had received safeguarding children training at a level suitable to their role, for example the GPs had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were identified as at risk.

The practice nurse and reception staff acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. Staff had received training to carry out this role and all relevant staff had received a disclosure and barring check.

**Medicines management**

The practice worked with pharmacy support from the local CCG and regular medication audits were carried out with the support of the pharmacy team to ensure the practice was prescribing in line with best practice guidelines.

The practice had one fridge for the storage of vaccines. The practice nurse took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely and available in the reception area. The practice medications manager had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

**Cleanliness and infection control**

All areas within the practice were found to be clean and tidy. Comments we received from patients indicated that they found the practice to be clean.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Hand gels for patients were available throughout the building. Clinical waste disposal contracts were in place and spillage kits were available.

The practice nurse was the designated clinical lead for infection control. There was an infection control policy in place and staff had received up to date training. The practice took part in annual external audits from the local community infection control team and acted on any issues where practical. The practice would book appointments for patients who were undergoing chemotherapy and therefore had a lowered immunity at a time that other patients were not waiting to avoid them contracting anything which would make them seriously ill such as a common cold.

**Equipment**

All electrical equipment was checked to ensure the equipment was safe to use.

Good

# Are services safe?

Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

The practice nurse carried out monthly checks on emergency equipment such as the defibrillator.

**Staffing and recruitment**

Staff told us there were enough staff to cope with the needs of patients but they could do with additional staff. Staff covered for each other in the event of unplanned absences. The practice occasionally used GP locums but used when possible the same group of regular locums for consistency. Appropriate recruitment checks, induction and supervision were carried out for all GP locums.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All relevant staff working at the practice had received a disclosure and barring service check to ensure they were suitable to carry out their role. Many staff had been employed by the practice for a number of years.

**Monitoring safety and responding to risk**

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff. The practice had up to date fire risk assessments in place and had recently carried out a fire drill. Fire equipment was checked weekly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as infection control, legionella testing and control of substances hazardous to health.

**Arrangements to deal with emergencies and major incidents**

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the reception. The practice had a defibrillator available on the premises and oxygen.

The practice had a comprehensive disaster handling and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found staff were aware of the practicalities of what they should do in the event of a major incident.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

Once patients were registered with the practice, the practice nurse carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. The practice nurses referred the patient to the GP when necessary.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register.

The practice took part in the avoiding unplanned admissions scheme. The clinicians discussed patient's needs at meetings and ensured care plans were in place and regularly reviewed. Patient attendances at the local A&E were below the average for the local area.

**Management, monitoring and improving outcomes for people**

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice.

All GPs and nursing staff were involved in clinical audits. Examples of audits included various medication audits.

Patients who had long term conditions were sent up to three invitations a year to attend health reviews and they also added reminders to attend on prescriptions. The practice provided an in house monitoring for patients on anti- coagulants but would also monitor patients at home if they were too poorly to attend.

The practice held quarterly meetings with MacMillan nurses, district and community nursing staff to discuss care needs for those patients who needed palliative care. One GP was working on improving palliative care for patients discharged from hospital.

**Effective staffing**

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

Staff received in house training that included: - safeguarding, fire procedures, chaperone training and basic life support and information governance awareness. Staff also had access to e-learning training modules.

The practice nurse attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training. The nurse was given protected learning time and supported to attend meetings and events.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). There were annual appraisal systems in place for all other members of staff.

**Working with colleagues and other services**

Incoming referral letters were scanned onto patient notes and passed onto both GPs for action.

The GPs would individually discuss referral options with patients so that they were aware of the types of services and waiting times so that the patient could make an informed decision about their care.

The practice had monitoring systems in place to check on the progress of any referral. We saw several examples whereby the GPs had been vigilant and double checked any discharge medication or treatment with hospital consultants to ensure their patients were receiving optimal care.

The practice liaised with other healthcare professionals such as the Community Diabetic Specialist and the Community Matron.

**Information sharing**

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. Individual clinical cases were analysed at a team meeting

Good

# Are services effective?

## (for example, treatment is effective)

as necessary. For example, the practice in conjunction with community nurses and matrons held regular Gold Standard Framework (GSF) meetings for patients who were receiving palliative care.

The practice used summary care records compiled by the GPs for all their patients to ensure that important information about patients could be shared between GPs at the practice or healthcare settings. The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding end of life care arrangements for patients who may require assistance during the weekend.

The practice had several systems in place to ensure good communications between staff. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues for example alerts were in place if a patient was a carer. There was a handover book available at reception which all staff read prior to working their shift so that they were aware of any new issues. The reception had a folder with all necessary information available for staff to easily refer to such as telephone numbers for other services.

**Consent to care and treatment**

The GPs made use of national and local guidance for help with determining mental capacity of patients. GPs were aware of mental capacity issues and made use of support available to them such as the British Medical Associations Mental Capacity Act toolkit. We were made aware of cases whereby the practice had worked with local initiatives such as the Care Home Project with geriatricians to help in decision making processes. The practice worked closely with two nursing homes and understood deprivation of liberty standards and treatments in the best interests of patients.

Written or verbal consent was recorded for all child vaccinations and if a legal guardian did not attend with a child the vaccination was postponed until consent could be given. We spoke with the GPs about their understanding of the Mental Capacity Act 2005 and Gillick guidelines. They were aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

**Health promotion and prevention**

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on dementia.

The practice staff sign posted patients to additional services such as lifestyle management clinics.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone.

CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity. Results from the national GP patient survey (from125 responses) also showed that 98% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 97% said the last GP they saw or spoke to was good at listening to them, which is higher than the national averages.

The practice had participated in the Friends and Family test since the 1 December 2014. So far there had been 105 responses with 99 patients saying they were extremely likely to recommend the practice and five saying likely to recommend.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy in place and all staff were required to sign to say they would abide by the protocols as part of their employment contract.

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

Results from the national GP patient survey showed that 97% said the last GP they saw or spoke to was good at explaining tests and treatments and 95% said the last GP they saw or spoke to was good at involving them in decisions about their care which was higher than the national average. Ninety five percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was higher than the local average.

Patients told us that they were always involved in decisions about their care and gave us examples of when patients were referred to other services, they were offered a choice but also what the waiting times were and whether this was the best service for them on an individual basis.

Patients told us that not only were treatments discussed at the surgery, GPs would visit patients and their carers at home to talk through support required.

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme to ensure all care plans were regularly reviewed.

The GPs wrote their own monthly newsletter for patients so they could be made aware of for example, any changes to appointments systems or promoting vaccination programmes.

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

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. Patients who had been bereaved were often contacted to see if they required any additional support and GPs would attend funerals if invited.

GPs supported palliative care patients by attending to patients out of hours and ensured patients who needed extra support had access to their personal mobile telephone.

Patients who had been admitted to hospital as an emergency were always contacted by GPs to ascertain if they required further support. One GP had started to work on an initiative to improve care for palliative care patients following discharge from hospital.

There was supporting information to help patients who were carers on a designated notice board in the waiting room. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support. For example carers could only make appointments at certain times because of their responsibilities and the receptionists knew to offer appointments accordingly.

Good

# Are services caring?

Comment cards we received from carers and the disabled or patients with more complex needs all stated that the practice treated them with dignity and respect and supported them at all times.

The practice had Silverline information leaflets available to help direct patients if they were lonely or isolated. The practice had good links with the local churches and would refer patients to church ministers if they felt patients would benefit in times of distress.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available on the practice's website. The PPG met quarterly and patient surveys were sent out annually.

We spoke with five members of the group who told us the practice had been responsive to any of their concerns. For example, the practice in response to patient's comments had kept the system of GPs going into the waiting room to personally call in patients rather than using a tannoy system.

**Tackling inequity and promoting equality**

The surgery had access to translation services. The building had appropriate access for disabled people and a hearing loop system for deaf or hard of hearing patients.

The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

**Access to the service**

The practice was open between 8.30am to 6.00pm Monday to Friday. The practice operated a mixture of routine, same day and emergency appointments. Appointments could be booked up to four weeks ahead and the appointment system allowed GPs flexibility so they could make up follow up appointments when necessary within the same week. The practice had an open surgery on Monday mornings. This had been an open access clinic but in response to patient feedback, the practice gave out allocated times.

Results from the GP national Patient survey showed 94% of respondents find it easy to get through to this surgery by phone. Patients and reception staff told us patients were always given a choice of who they wanted to see and when they wanted to attend. The practice offered a very personal service and GPs and staff knew patients and their relatives well and provided services to meet their needs.

**Listening and learning from concerns and complaints**

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

Information about how to make a complaint was available on the practice's website and the practice leaflet available in the waiting room. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint and written apologies were given.

The practice kept a complaints log book and recorded verbal as well as written complaints. The practice reviewed the complaints received on an annual basis to identify any trends in issues which would require any improvements. We saw there had been very few complaints received over the past 12 months. Learning points from complaints were also discussed at staff meetings.

# 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**

Staff we spoke with were aware of the culture and values of the practice of keeping a traditional ethos of a traditional family surgery whilst making use of modern technology. Comments we received were very complimentary of the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care.

**Governance arrangements**

The practice had a small number of practice specific policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy and 'Infection Control' policy. All the policies were regularly reviewed and in date and staff we spoke with were aware of the contents.

**Leadership, openness and transparency**

Staff had specific roles within the practice for example safeguarding and infection control. The practice manager managed all administration and support services.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

**Practice seeks and acts on feedback from its patients, the public and staff**

Results of surveys and complaints were discussed at staff meetings. There was a patient participation group (PPG) in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with five members of the PPG who told us the PPG felt that the practice was responsive to any issues raised by the group. They told us that the practice was very patient centred and had involved patients so that they could have their say.

The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patients feedback. There was also a suggestions box available at reception. All suggestions received were monitored and discussed as a standing item on agendas for PPG meetings.

**Management lead through learning and improvement**

The practice worked well together as a team and held meetings for team learning and to share information. Despite being such a small practice team there was not an over reliance on informal meetings and the clinicians held formal weekly meetings with set agendas covering all aspects of patient safety. The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and ensured the whole team was involved in driving forward improvements. They recognised future challenges and areas for improvement.