

Care Quality Commission

Inspection Evidence Table

Knutsford Medical Partnership (1-578118546)

Inspection date: 22, 23, 24 and 27 June 2022

Date of data download: 09 June 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Improvements had been made to meet the requirement notices from the last inspection of Toft Road Surgery. Processes were in place to monitor and act on safeguarding concerns. Safeguarding policies and procedures had been updated and the records we reviewed showed staff had the appropriate level of training. There was a clear system to process and act on safeguarding information being received by or requested from the practice.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> There were safeguarding lead members of staff at each of the sites operated by the provider. Safeguarding leads told us how they ensured they kept up to date with any changes and how they worked with the local authority to promote the welfare of patients. The practice had arrangements for following up failed attendance of children's appointments in secondary care or for immunisation and would liaise with health visitors when necessary. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Annandale Medical Centre – 01/02/2022 Town Lane Surgery - 01/02/2022 Manchester Road Medical Centre – 03/02/2022 Toft Road Surgery – 28/03/2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: Annandale Medical Centre – 03/03/2022 Town Lane Surgery - 03/03/2022 Manchester Road Medical Centre – 24/05/2022 Toft Road Surgery – 16/02/2022 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Improvements had been made to meet the requirement notices from the last inspection of Toft Road Surgery. A risk assessment was in place regarding patient accessibility to the building. We looked at a sample of safety test records for the premises and equipment. Overall, these were in date and there was a clear system to ensure checks were carried out when they were due. The electrical wiring safety checks were overdue for Annandale Medical Centre and Town Lane Surgery and the emergency lighting contractors check was overdue at Manchester Road Medical Centre. These checks were delayed due to the lack of availability of electrical contractors as a result of the COVID-19 pandemic and had been scheduled for June and August 2022. We looked at the premises at Annandale Medical Centre. Cleaning products were stored in a cupboard in a staff bathroom on the first floor of the building. The cupboard had a slide lock that 	

would be out of reach of small children. As patients used the first floor for appointments, we asked the provider to risk assess this. The boiler was stored in a cupboard on the ground floor which was open on the day of inspection. The provider told us this room was usually locked. This was addressed during the inspection and following the inspection the provider confirmed new locks had been placed on both cupboards.

Infection prevention and control

Overall, appropriate standards of cleanliness and hygiene were met however improvements were needed in the premises and facilities.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Annandale Medical Centre – 11/05/2022 Town Lane Surgery -11/05/2022 Manchester Road Medical Centre – 23/06/2021 Toft Road Surgery – 04/04/2022	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • A new lead for infection prevention and control had been recently appointed. They had a date to undertake training to support them in this role. • The premises at Annandale Medical Centre and Manchester Road Medical Centre were showing signs of wear and tear to the decoration and some carpets were stained (even though they had been cleaned) and worn. The provider told us that they had been planning to move to a new building. These plans were now not going to happen for at least two years and a plan to improve the premises had been drawn up. • The cleaner's cupboard at Toft Road Surgery was not suitable for use. The handbasin and plug hole were dirty. Cleaning equipment was disorganised and stored haphazardly and cluttered. There was no suitable area for wastewater disposal and no evidence of an area to hang mops when cleaned. The provider told us they had moved the cleaning cupboard to free up space for a room with external access during the height of the COVID-19 pandemic. They told us during the inspection that they would move the cleaner's cupboard back to this room to ensure a suitable facility. Following the inspection, they confirmed that this had been addressed. • Some clinical rooms did not have elbow taps or mixer taps in the handwashing basin. This had been identified for improvement during refurbishment. Some sinks in clinical rooms had plugs attached by a chain to the handwashing basins. These were removed following the inspection. • The specimen collection container was situated in the reception. This was an open box, on a low-level table. Following discussion with the operations manager the box was removed and sited behind the reception desk. 	

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Three locations and a branch practice had merged to form the current provider of Knutsford Medical Partnership. The provider had implemented a work-flow hub as part of a quality improvement programme to improve the efficiency of patient correspondence and document management, to better utilise staff skills and improve job satisfaction. The hub had been in place for 18 months. This was based at one site rather than having three separate teams at three different sites. This quality improvement project was part of Knutsford Medical Partnerships vision of One Team One Protocol following the merger of the three practices. Regular meetings had taken place prior to the implementation. Training had been provided to staff. A lead GP monitored that the system was working safely and effectively through audits, meetings and the provision of on-going support to the team.	

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Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.89	0.82	0.79	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	7.2%	8.0%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	4.12	4.87	5.29	Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	122.6‰	147.1‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.50	0.53	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	5.0‰	6.7‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y

Medicines management	Y/N/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed a sample of patient records and found that improvements had been made to meet the requirement notices from the last inspection of Toft Road Surgery. The provider had systems and processes in place to safely manage the repeat prescribing of medication. The provider also carried out regular checks to ensure these systems and processes were working effectively. The safe management of medication was supported by policies and procedures. From our review of patient records we noted that the medication review code did not have a consultation which linked in with the medication the patient was prescribed. 	

- A system was in place to monitor uncollected prescriptions.
- There was a system in place to provide clinical supervision and peer review to non-medical prescribers. Consultations, referrals and prescribing were monitored however these checks were not always documented. Following the inspection, the provider told us how they planned to address this.
- Prescription management at Annandale Medical Centre did not allow an audit to identify which clinicians they had been allocated to. This system was in place at Toft Road Surgery and during the inspection we saw that the provider had implemented it at Annandale Medical Centre also.
- In order to improve efficiency, better utilise staff skills, improve staff support and job satisfaction the provider had developed a prescription hub with all prescriptions being managed by a team of staff based at one site rather than across three separate buildings. This quality improvement project was part of Knutsford Medical Partnerships vision of One Team One Protocol following the merger of the three practices. A clinical pharmacist was available in the hub each day and the hub was monitored by a lead GP. The team had assigned nursing home leads so that the homes and GPs attached to them had a named contact. There was a period of no telephone calls each day to enable staff to manage prescriptions without interruptions, with telephone calls being responded to later in the day. Local pharmacists were made aware of these changes.
- We identified one emergency medication that was out of date. This was removed and put for destruction straight away. The lock to the reception door where emergency medicines were kept and to a treatment room door where emergency medication was also stored were broken. This was addressed following the inspection.
- We identified that two of the medicine's fridges were plugged in to the wall and did not have any signage to prevent them being inadvertently switched off. Following the inspection, the provider confirmed that warning stickers and plug covers had been put in place.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> We reviewed the dispensary and found there were systems in place to ensure patient medication was safely managed. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	22
Number of events that required action:	22
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Improvements had been made to meet the requirement notices from the last inspection of Toft Road Surgery. Records showed that significant events were investigated, and actions were reviewed. Staff told us they knew how to report an incident. We were given examples by staff of significant events that had occurred, and the action taken. The practice had recorded 22 significant events in the last 12 months which was less than thirty-four which were recorded in the previous 12 months. There was a system for sharing information with staff following a significant event. This included events being shared across the four sites. Significant events were reviewed to identify any patterns and trends and make improvements to the service provided. 	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Communication by a patient to reception staff	Analysis of incident indicated that communication between staff and patients needed to be improved. A protocol was developed to assist staff and patients.
Unable to prescribe medication as the patient was not registered with the practice	A new protocol was developed to ensure that new patient registrations were prioritised according to need. This issue was resolved the same day.
Patient issued with wrong prescription.	This was identified by the pharmacy processing the prescription and the medication was not given to the patient. Administrative staff were reminded to ensure that all patients identity was confirmed prior to requesting medication and that all letters received by the prescriptions hub were to be sent to workflow for coding.
Potential safeguarding issue	A regular search of patient records for patients aged 85 and over who had not been seen by a GP or nurse in the previous

	two years was implemented. The care coordinators and Social Prescriber monitored these patients and made welfare calls.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We discussed examples of actions taken on recent alerts for example, cytology bottles. We noted that in accordance with another safety alert the provider should look at providing more patients with steroid cards (helps healthcare staff identify and treat patients with adrenal insufficiency). 	

Effective

Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Clinicians were kept up to date through a system of training and meetings including meetings to discuss the results of in-house audits and changes to practice. There was also a system to keep clinicians up to date via electronic communications.	

Effective care for the practice population

Findings
<ul style="list-style-type: none">The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.Health checks, including frailty assessments, were offered to patients over 75 years of age.Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- We reviewed patient records and found there were systems in place to identify and monitor patients with long-term conditions to ensure their health was monitored.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
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The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	196	208	94.2%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	201	215	93.5%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	201	215	93.5%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	201	215	93.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	228	246	92.7%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

- The practice had met the WHO based minimum national target of 90% (the recommended standard for achieving immunity) for childhood immunisation uptake indicators.
- The practice had a protocol in place to ensure uptake of childhood immunisations. This included following up non-attendance and placing alerts on patient records to indicate that clinicians should remind patients if they attended for another reason.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	79.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	**17.8%	62.1%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	70.6%	67.2%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	67.7%	56.6%	55.4%	No statistical variation

Any additional evidence or comments

- ** The provider told us that this data was incorrect. They had contacted NHS Digital to request that they reviewed the data held as it appeared that the numbers were in the incorrect order. The provider sent us data to indicate that screening was at 71% when the data was checked through the Ardens system (an analytic tool that performs a number of functions including provision of patient data) in June 2022.
- Records demonstrated that the provider monitored cancer screening uptake. There was a quality improvement plan in place to increase uptake. For example, they had developed easy read information about screening for patients with a learning disability, information leaflets in different languages and developed a letter to be sent directly from the provider when patients did not respond to national screening invites.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

- The provider had completed audits which had resulted in improvements to patient care. These included audits of diabetes management, audits to improve the management of vitamin B12 injections and audits to establish if patient conditions were correctly coded.
- The provider carried out a number of quality improvement initiatives. They had just completed one with the nursing team. This looked at how the nursing team operated and improvements that could be made. For example, having specialist long-term condition clinics and wound dressing clinics. The provider had a cancer quality improvement initiative which looked at improving cancer care and screening uptake. They also had a learning disability programme which was a quality initiative to improve uptake of learning disability reviews and standardise training for nurses to ensure best practice reviews were provided.
- A number of quality improvement initiatives had been started this year such as workforce planning, prescription drug dependency and the patient recall system. Further quality improvement initiatives were also planned.
- The provider was part of a diabetic remote study with Manchester University. The diabetic nurse lead met with a diabetic consultant to discuss patients with complex needs. The purpose of this was to improve patient care without the patient needing to attend local hospital and receive care nearer to home. The lead nurse carried out 6-monthly audits of patients with diabetes to ensure they were receiving the right and most effective treatment.
- The provider monitored cardio-vascular disease to ensure targets in patient care were achieved. The practice was part of the Cheshire East Cardiology working group and one of the GP partners was the lead for East Cheshire. A virtual ward round took place with a consultant from cardiology. This had been established for 3 months. The purpose of this was to access advice and guidance and improve patient care so a patient does not always have to wait to see a consultant at hospital.

- The provider was actively involved in the Cheshire East cardiovascular disease (CVD) project. The Integrated Care Partnership had won a bid to invest in primary care to improve the care of heart disease locally. The project was supported by the Clinical Commissioning Group (CCG) and The South Cheshire GP Alliance with information technology, data searches and clinical coding. The main aims of the project were to embed good practice, capture more data for care planning, to help target disadvantaged groups, improve the long-term health of the patient population, help reduce attendance at primary and secondary care and improve life expectancy. East Cheshire GP practices carried out monthly searches and audits. Two GP partners from Knutsford Medical Partnership were the clinical leads for this project which had been running for 12 months. They had been reviewing the outcomes from the audits and searches to determine achievement. Base line figures were set in August 2021 and a comparison in April 2022 showed the project had been affected by the Covid-19 pandemic, but the base line had been achieved.

Any additional evidence or comments

- During the COVID-19 pandemic the provider was part of a medicine trial. Patients were asked if they wanted to enroll on to the study following attendance for Covid-19 testing.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider had a system in place to monitor staff training uptake.• The staff we spoke with told us there were good opportunities for training and development and that they were supported in their roles. For example, one member of staff told us they had completed an independent prescriber's course and were supported to complete this training by an identified GP partner who continued to provide on-going supervision.• Support was provided to staff through a system of clinical and non-clinical meetings. Clinical and non-clinical staff had identified senior and lead staff they could approach for support in their various roles. For example, non-clinical staff who worked at the prescribing and workflow hubs and Additional Roles Reimbursement Scheme (ARRS) staff employed by the PCN had identified lead and senior members of staff to approach for support and guidance.	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Explanation of any answers and additional evidence:

- A virtual ward round meeting took place daily at each of the three sites with district nurses and community matrons. This meeting was held to discuss any patients in the community with acute or high-risk needs who needed help and support. These professionals were able to refer patients to each other via these meetings. The aim of this service was to aid communication between the provider and community teams, and ensure the best practitioner was utilised for community visits. A visiting service was also in place and this linked in with the daily virtual ward round. A representative from this service attended the virtual ward round. The visiting service included staff employed via the PCN in additional roles such as a physician's associate.
- The provider held Knutsford multi-disciplinary meetings every 2 weeks. This included staff from the practice, PCN, social services, mental health, community nursing, pharmacist and a consultant for the care of the elderly. The provider had a large elderly patient population. This meeting was held to identify ways of working together to meet the needs of patients at a high risk of deterioration in health or being admitted to hospital. The provider had identified the top 10% of patients at risk through a risk calculation system. The social prescriber managed three care co-ordinators who provided support to the patients identified to ensure they received the health and social care services they required. For example, they reviewed patient hospital admissions and followed them up on discharge. Data showed Accident and Emergency attendances for patients was below Clinical Commissioning Group (CCG) and national averages.
- The provider had 6-8 weekly meetings with external professionals to communicate about the needs of patients receiving end of life care to ensure consistent and coordinated care.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The provider was an armed forces veteran friendly accredited practice. Alerts were placed on patients records to assist with identification, a priority service was offered and the provider had established relationships with external organisations to signpost veterans to ensure they received prompt care and treatment.	

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<ul style="list-style-type: none">We looked at 8 patient records. Alerts were on patient records to indicate a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision was in place. The forms documenting the decision were not on 3 patients records where the DNACPR had originated from hospital. The provider told us that the hospital did not always send this form to them and that they would address this with the Clinical Commissioning Group (CCG) and Local Medical Committee (LMC).	

- There was a protocol to follow when a patient had been discharged from hospital with a DNACPR. This included ensuring the patient/family had this document, requesting a copy (if appropriate), updating patient records and making the appropriate notifications to out of hours and ambulance services.

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The provider told us that there were systems in place to ensure that patients were provided with timely information to cope emotionally with their care, treatment or condition. Staff told us they had received training and guidance to ensure they understood and respected the differing needs of patients. 	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	97.1%	91.8%	89.4%	Variation (positive)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	98.6%	91.0%	88.4%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	98.4%	96.9%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to	93.9%	86.4%	83.0%	Tending towards

Indicator	Practice	CCG average	England average	England comparison
the overall experience of their GP practice (01/01/2021 to 31/03/2021)				variation (positive)

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence
<ul style="list-style-type: none"> The provider had asked patients for feedback on the dispensary in the last 12 months. Seven responses had been returned and were positive. The provider had also asked for patient feedback on Econsult. There had been a low response rate, but the provider was using the responses to make improvements.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Easy read and pictorial materials were available. For example, to assist patients to make a decision about cancer screening. The Primary Care Network (PCN) employed a social prescriber and three care coordinators who were able to assist patients to identify and access community services and to understand their care and treatment. 	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about	97.3%	94.7%	92.9%	Tending towards variation (positive)

Indicator	Practice	CCG average	England average	England comparison
their care and treatment (01/01/2021 to 31/03/2021)				

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	675 (2.7%)
How the practice supported carers (including young carers).	The provider had two members of staff who were the lead staff for supporting carers. Carers were identified and an alert placed on their records. They were offered an annual health check and additional support from the care coordinators. They were also offered a referral to the East Cheshire Carers Hub
How the practice supported recently bereaved patients.	Following the death of a patient the GP contacted the relatives to offer their condolences. A care – coordinator also made contact if further support was needed. Practical advice was also provided and a referral for support, such as counselling could be made. The provider had a protocol for staff to follow in the event of a patient death.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Outstanding

The provider was rated outstanding for providing responsive services. This was because: -

- People's individual needs and preferences were central to the delivery of tailored services.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- The services were flexible and promoted continuity of care.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider had four sites following the merger of three practices and a branch practice. The sites were old buildings which were formerly residential properties and had insufficient space. There were consulting rooms on the first floor. The provider addressed this by making patients aware and putting alerts in patient records if they would not be able to use the stairs. There were plans to move to more suitable premises.	

Practice Opening Times – Manchester Road Medical Centre	
Day	Time
Opening times:	
Monday	8am – 8pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 8pm

Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 8pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 8pm
Friday	8am – 6.30pm

Practice Opening Times – Annandale Medical Centre	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 8pm
Wednesday	7.30am – 6.30pm
Thursday	7.30am – 8pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 6.30pm
Tuesday	8am – 8pm
Wednesday	7.30am – 6.30pm
Thursday	7.30am – 8pm
Friday	8am – 6.30pm

Practice Opening Times – Town Lane Surgery	
Day	Time
Opening times:	
Monday	9am – 12pm and 1.30pm – 6pm
Tuesday	9am – 12pm and 1.30pm – 6pm
Wednesday	9am – 12pm and 1.30pm – 6pm
Thursday	9am – 12pm and 1.30pm – 6pm
Friday	9am – 12pm
Appointments available:	
Monday	9am – 12pm and 1.30pm – 6pm
Tuesday	9am – 12pm and 1.30pm – 6pm
Wednesday	9am – 12pm and 1.30pm – 6pm
Thursday	9am – 12pm and 1.30pm – 6pm
Friday	9am – 12pm

Practice Opening Times – Toft Road Surgery	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 7.30pm
Wednesday	8am – 7.30pm
Thursday	7.30am – 7.15pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 6.30pm
Tuesday	8am – 7.30pm
Wednesday	8am – 7.30pm
Thursday	7.30am – 7.15pm
Friday	8am – 6.30pm

Further information about how the practice is responding to the needs of their population

- The provider demonstrated that it took part in a range of activities to respond to the needs of its patient population. As already indicated, the provider was involved in a diabetic remote study with Manchester University. It was monitoring cardio-vascular disease to ensure targets in patient care were achieved and was actively involved in the Cheshire East cardiovascular disease (CVD) project.
- The provider had a number of quality monitoring initiatives in place and ones planned for the future to improve the services provided.
- The provider was responsive in how it ensured patients care and treatment was coordinated. Knutsford Medical Partnership had a large elderly population with a large number of patients being housebound (over 250) and it supported five care/nursing homes. The provider had set up a virtual ward round and visiting service with PCN and community staff to support the needs of patients in the community with acute or high-risk needs and ensure the best practitioner was utilised for community visits.
- The provider also held Knutsford multi-disciplinary meetings every 2 weeks to identify ways of working together to meet the needs of patients at a high risk of deterioration in health or being admitted to hospital. The provider had identified the top 10% of patients at risk through a risk calculation system. The social prescriber managed three care co- coordinators who provided support to the patients identified to ensure they received the health and social care services they required. For example, they reviewed patient hospital admissions and followed them up on discharge. Data showed emergency department attendances for patients was below local Clinical Commissioning Group (CCG) and national averages.
- The provider was the lead organisation for the implementation of the Complete Community Care Programme which was a national project which focused on reducing health inequalities. This group (Knutsford Care Community) included the voluntary sector, social care, Patient

Participation Group (PPG) and community services. The group met every two weeks (since 2019) and looked at initiatives to improve the health and wellbeing of the community. The current initiatives included: -

- Revising the Dementia Pathway to enable quicker access to an assessment and to provide ongoing care within familiar surroundings of the GP practice. Due to its success this initiative was being rolled out to the other Care Communities in East Cheshire.
- Providing health checks for patients with atrial fibrillation to identify patients who were at risk of strokes, heart attacks and vascular dementia.
- Trialing a Leg Club to establish if this improved patient's confidence in looking after their leg condition and reduced the adverse effects of this condition on everyday life. (A Leg Club provided community-based treatment, health promotion and on-going care for people who were experiencing leg related problems.)
- District Nurses and Practice Nurses were working together to improve the leg ulcer pathway for patients.
- The provider was working closely with two care homes to provide support and training to care homes and prevent unnecessary GP and hospital visits.
- District nurses and practice nurses were working together to ensure that housebound patients had a full holistic assessment to help patients stay as healthy as possible.
- Knutsford Care Community was also promoting information on health and wellbeing and social prescribing.
- Virtual clinics had been established for general cardiology, geriatrics and heart failure to enable clinicians to obtain advice and guidance in their care of patients and reduce delays in patient treatment where possible.
- Knutsford Care Community established a Monday Club for people who had become isolated, lonely and depressed as a result of COVID-19. Games and crafts were provided as well as hot drinks and biscuits. Some of the first people who attended had taken over the role of helpers. The provider told us that people who had attended the Monday Club have since booked fewer GP appointments.
- The Knutsford Care Community had set up activities to improve physical fitness for the community. The group was currently looking for funding to establish a Tatton Park Cycle path to improve community well-being and was looking to establish Parkletics which would give the opportunity to use exercise equipment outdoors with the help of a coach.
- The Knutsford Care Community was also promoting Making Every Contact Count (MECC), an evidence-based approach to improving people's health and well-being by helping them make changes to their behavior. This approach enabled health and social care workers to engage people in conversations about improving their health by addressing risk factors such as smoking and physical activity. A range of practical resources were available to support staff through Public Health England (PHE).
- The provider had been nominated for a consideration of an award by a local member of parliament (NHS 2022 Parliamentary Award in Excellence in Primary and Community Care Services) for its COVID-19 vaccination programme and its asylum seeker project. The provider offered first, second and third doses of the COVID-19 vaccination along with home visits and spring boosters. The provider told us that at times they were only one of two of the Cheshire PCNs continuing to vaccinate. They offered clinics in the evenings and weekends. The provider was supported by a large number of volunteers. A local paper published two articles about the success of the community vaccination programme.
- In October 2021 50 asylum seekers were provided with accommodation at a hotel in the Knutsford area. In order to support these new patients a protocol was developed, and reception staff had training on how to support non-English speaking patients. The provider worked with the Knutsford Care Community to arrange donations of toiletries, clothes and other essentials.

Following the arrival of these new patients a team of staff from the practice went to the hotel and held a 'drop-in clinic' to register patients who needed medical care and undertake assessments of their needs. All patients identified as needing urgent care were offered a face to face appointment at the practice, with interpreter services. Joint clinics were provided with nurses completing health checks followed by a GP appointment for urgent care. Patients were given 60 minutes for their initial appointment. The clinical team worked with local vaccination programmes to ensure patients were able to receive immunisations and other health prevention care. The provider continues to offer care to new asylum seekers as they are accommodated on a temporary basis at the hotel.

- During the COVID-19 pandemic the provider identified the most vulnerable patients and the social prescriber and care coordinators telephoned these patients (about 200 patients) to see if they needed support. They found a number of patients were struggling with social isolation. Patients were put in contact with organisations for advice and support. An example was given of a care coordinator visiting a patient to have a cup of tea to ease their sense of loneliness.
- Patients had a named GP who supported them in whatever setting they lived.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The provider offered extended access at three of their sites. Pre-bookable appointments were also available to all patients at on a Friday evening and at weekends provided by Vernova, a GP federation.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were able to access care and treatment in a timely way.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">Patients were given a choice as to how they accessed the service. They could use on-line services, telephone or access the service in-person. Patients were also asked how they would like to be consulted and offered face to face, video and telephone consultations. Econsult (electronic consultation service) was also available.For urgent appointments a dedicated GP carried out a triage and invited patients in to be seen as needed. There was a system to identify patients with the most urgent needs. Alerts were also placed on patient records where there was an identified risk to ensure a same day consultation was offered.The provider reviewed access to the service on a regular basis. Records of meetings to review access showed how changes were made to make improvements where needed. For example, a queries list had been developed which allowed receptionists to add patients' names and reason for needing a consultation when they were unsure as to how to best meet the patient's needs. A GP was then able to review the list and identify any patients needing priority attention.Receptionists had been trained in signposting patients to alternative organisations where appropriate. For example, they had completed pharmacy referral training.	

- Care home managers had access to an alternative telephone number when contacting the provider so they could be attended to promptly.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	96.3%	N/A	67.6%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	87.0%	73.9%	70.6%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	72.3%	68.9%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	91.8%	84.1%	81.7%	Tending towards variation (positive)

Any additional evidence or comments

- The practice monitored feedback received through the National Patient Survey. It was above local and national averages for the indicators identified in the table (above).
- We saw that results had been reviewed and an action plan developed. For example, to continue to encourage good patient feedback about receptionists' helpfulness the provider had planned a conflict resolution training course and they held monthly meetings with receptionists to discuss any concerns.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	18
Number of complaints we examined.	3

Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> An annual summary of complaints was presented to the executive board of Knutsford Medical Partnership to identify trends and areas for improvement. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
A trend was identified in patients complaining about how prescriptions were managed.	This led to the development of a prescription hub. All staff managing prescriptions across the services working together at one site to provide consistency and a more efficient service.
A trend was identified in patients complaining about access to the service.	This led to a review of the appointment system to improve access for patients.

Well-led

Rating: Good

Leadership capacity and capability

Leaders had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider had identified that the main challenges were the current premises. The practices were based in old buildings which were formally residential properties and had insufficient space. The provider was continuing to have discussions with the Clinical Commissioning Group (CCG), local council and hospital trust with a view to relocating to a local hospital site. This would also improve working with stakeholders to further benefit patients.• The provider was also aware of the challenges that could be presented by an unstable staff team. They therefore had systems in place to support staff and to assist them to develop.• There were clear plans to develop and improve patient care. This has been demonstrated through the quality improvement projects that the provider had in place.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider had a 5-year plan which was regularly reviewed by the executive board and partners and had been shared with all staff. This included plans for staffing, premises, technology, patient services and financial sustainability.	

- The provider had a number of plans for the improvement of the service which were discussed at dedicated meetings and the progress reviewed. For example, the workflow and prescription hubs and meetings to improve cancer uptake and learning disability reviews.

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The provider had introduced a staff health and wellbeing group in January 2022 to improve staff health and well-being. Quarterly meetings were planned to review this initiative. Changes made included training staff as mental health first aiders (to signpost staff, reduce stigma around mental health and encourage positivity in the workplace) introducing walking meetings, book club and encouraging staff to take part in community events such as the Race for Life (race to support Cancer Research). Each site had a well-being representative. A newsletter was also planned with one being completed so far. The provider had also created a Teamnet page for health and well-being. • The provider had set up a Facebook group (by invitation only) to keep staff informed about external events to support their health and well-being. • The provider had access to an Employee Assistance Programme which included short-term counselling and referral services for employees and their immediate family. • The provider had introduced a mentorship scheme where a member of staff could meet with a peer to look at any work-related issues that were problematic to encourage a resolution. All staff had been trained on staff coaching to assist with this. • The provider had commenced a quality improvement initiative to make the service more environmentally friendly. The provider had planned quarterly meetings and a newsletter. We 	

reviewed the first newsletter from May 2022 which contained tips on how to lower carbon footprints and be more sustainable online. The provider had sought feedback from staff on changes that could be implemented.

- The provider was awarded the RCGP Active Practice Award in 2022 for reducing sedentary behavior in staff and patients, increasing physical activity in staff and patients and being part of an active community.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
staff interviews	<ul style="list-style-type: none"> • Staff told us they felt valued. They said there was good support and good opportunities for learning and development • They said that the service was well run by a good management team. • The nursing staff said they could be busy and would like more staff but acknowledged the providers plans to expand the team when there was more building space available.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The provider had a system of regular meetings to ensure the effective operation of the service. These included executive board and partnership meetings, clinical meetings, meetings to review patients' needs and communicate with external professionals and to review quality improvement initiatives. • Away days were organised for staff groups to discuss their day to day work, new developments and identify improvements to be made. • Weekly updates were sent out to all staff regarding operational matters such as IT and staffing via internal email. • Monthly newsletters were sent to staff from the Executive Board (since April 2020). We saw the last two which covered issues such as COVID-19 updates, training dates, new staff, appointment system changes, new developments, such as the health and well-being improvement plans. Staff could also ask questions of the Executive Board and have the answer posted in the newsletter. • There were very clear roles and responsibilities and lines of accountability. The provider had lead members of staff for all aspects of service provision. For example, there were lead staff for quality improvement initiatives, for improving patient care, lead clinician for the dispensary, prescribing lead and lead members of staff for finance and IT. 	

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Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The provider had sent a staff survey to 90 staff members in March 2022. There was a 62% uptake. The results had been analysed by the executive manager and an action plan developed. Overall, the results were positive. One of the actions was to improve staff health and well-being being. The provider had introduced the staff health and wellbeing group, together with changes such as mental health first aiders, walking meetings and other actions to support staff. We saw evidence of engagement with staff around introduction of changes to working such as the prescription and work-flow hub and regarding ways to improve the operation of the service for example suggestions for changes to make the service more environmentally friendly. The practice sought feedback from patients. The practice met with a Patient Participation Group (PPG) every 6 months and also engaged with a virtual Patient Participation Group. They discussed patient issues and sought feedback on the services provided. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> We met with three members of the PPG who told us that they were kept informed about changes at the practice, asked their opinion and felt listened to. They said that changes had been made at the practice as a result of their feedback. For example, the provider made changes to the reception to encourage privacy and made changes to how flu clinics were organised. The PPG had in the past run health promotions for patients. For example, health events such as diabetes and dementia awareness. They were looking at possible future events. They were working on increasing their membership and making it more representative of the patient population. They had worked with a local sixth form college and asked they undertake a survey of student views about access. They completed a report which the PPG told us had been well received by the partnership with changes being made to access as a result. They also requested

the provider make a presentation to students on mental health awareness which the provider is planning to deliver.

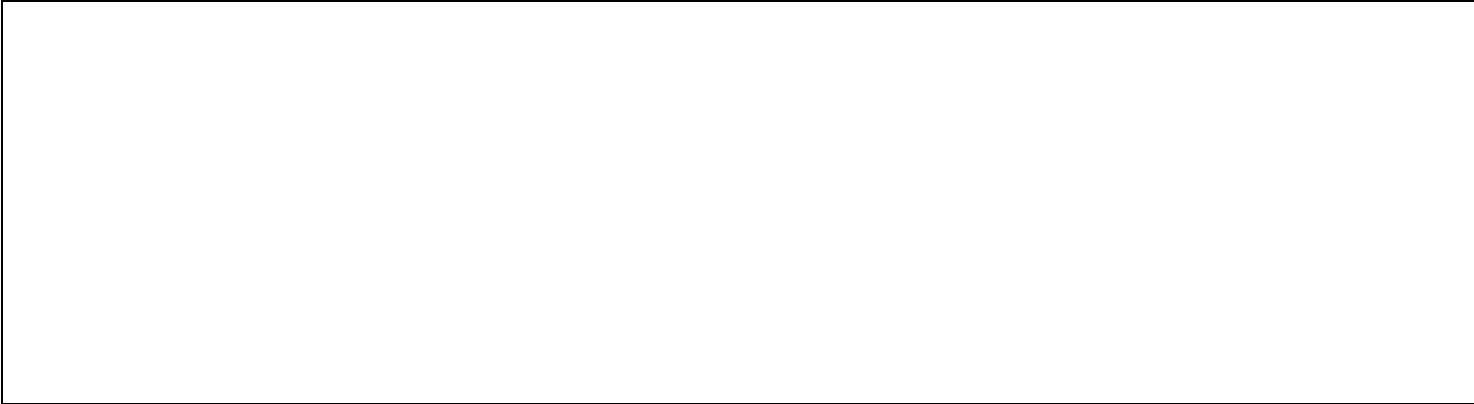
Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

- The provider had recently employed mental health support staff through the PCN. They planned on the child and adolescent mental health worker working closely with schools and visiting schools to offer support and information to students and teaching staff.
- The provider had plans in place to further develop the co-ordination of patient care and treatment. Knutsford Medical Partnership had a large elderly population. The provider was therefore planning to develop a Community Support Practice Team based at a local hospital by August 2022. This team would be dedicated to patients recently discharged from hospital, at risk of admission or who required care in their own home. There would be a multi-disciplinary team, led by a GP who would provide active and acute care Monday to Friday to support this group of patients. The plan was that the current ward round and visiting service would also be managed from the community hospital. Having a multi-disciplinary team in one place would mean that patients could see multiple healthcare professionals during one appointment, and it would act as a single point of contact for care/nursing home professionals to allow a more efficient service.
- The provider had introduced more specialist clinics over the past couple of years such as sexual health services including coils, implants and family planning, minor surgery clinics, which include excisions, dermoscopy and cryotherapy services. The nursing team worked with NHS Improvement on a Quickstart Project to set up a respiratory hub for a one stop respiratory diagnostic service.
- All of the sites were training practices and the provider offered a range of training posts from clinical (GP, nursing, physicians associate) to administrative posts (apprenticeships). The provider received a Gold Award as a result of student feedback from medical students at Manchester University.



Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease.
- UKHSA:** UK Health and Security Agency.
- QOF:** Quality and Outcomes Framework.
- STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰** = per thousand.