Limelight Health and Well-being Hub

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Outstanding**

Overall summary

This practice is rated Good overall.

Limelight Health and Well-being Hub, also known as Brooks Bar at Limelight, moved to its new location in April 2018. It was previously known as Brooks Bar Medical Centre and the current provider was first registered by the Care Quality Commission (CQC) in 2017. Before the new provider, Brooks Bar Medical Centre had been placed in special measures and CQC acted to cancel the registration. This is the first inspection of the newly registered practice and to the new location.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Brooks Bar at Limelight on 20 April 2018 as part of our inspection programme.

At this inspection we found:

- The practice had introduced a comprehensive system to manage risk so that safety incidents were less likely to happen. People were protected by a strong system and a focus on openness, transparency and learning when things went wrong.
- Outcomes for people who used services had consistently improved and were better than expected when compared with other similar services since the change of partnership.
- There was evidence to demonstrate that medicine management and overall prescribing had improved and continued to improve since the change of partnership.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided and ensured that care and treatment was delivered according to evidence- based guidelines.
- People were respected and valued as individuals. Staff were trained to understand patients' needs so that they could provide the correct information for example with recent changes in the appointment system, the move to new premises and other support services available within the premises and within the local area.
- Services were tailored to meet the needs of individual people, specifically those who were vulnerable, and were delivered in a way to ensure flexibility, choice and continuity of care. Examples included multidisciplinary working and "one stop shop" appointments for patients with more than one long-term condition.
- The leadership, governance and culture were used to drive and improve the delivery of high quality, person-centred care.

We saw several areas of outstanding practice:

- When the current provider took over the practice there was significant over prescribing. A high number of patients were being prescribed hypnotic medicines (commonly known as sleeping tablets) and anxiolytic medicines (commonly known as anxiety tablets). Those patients were brought in for review and reduction. The number of hypnotic and anxiolytic items prescribed was reduced month on month and evidence showed a total reduction of 27% between March 2017 and February 2018. There was also a reduction in antibiotic prescribing from 14 units in the first quarter of 2017/18 to 9 units in the last quarter of 2017/18 and, in addition, evidence showed that the number of units prescribed for most medicines had improved. The practice had moved from being the second worst prescribers out of 32 practices in the CCG in 2015/16 to above average in 2017/18.
- The practice monitored all types of health alerts, kept a log and informed staff, and took a very pro-active approach. For example, when a recent measles outbreak was identified in a neighbouring borough, the practice did a search to see how many people were missing a full mumps, measles and rubella (MMR) course. 119 patients were found and invites were sent out for them to come in urgently for the second course of vaccinations. They also alerted staff that any patients attending with rash and high temperature together must be kept isolated. They also discussed immunity with staff and checked staff immunisation status.
- The practice had engaged with the community and patient population by creating and hosting a joint community patient participation group (PPG) at their practice. This had brought about positive and continuous change with the involvement of the wider community. This had fostered a sense of achievement amongst the PPG members who were now actively

Overall summary

engaged in the changes taking place within local healthcare. They were communicating with patients in Trafford about new roles in primary care such as clinical pharmacists and assistant practitioners, that have led to frustration amongst patients when requesting to see a GP or nurse. Reception staff at Brooks Bar have reported less challenge from patients when being booked into non-doctor appointments.

- The lead GP had hosted and been a member of the Building User Group (BUG) for Limelight since its inception. Because of this they could forge good relationships with services and the Limelight Community. They had shared processes with other services such as registration and on-line access so that patients were met with a joined community services approach and they had created a “one door, one building” culture. During patient consultations, all staff were fully aware of the services that patients could benefit from, having learned about them over the previous twelve months through the user group meetings. For example, patients could be signposted immediately to the library for disabled blue badges, where the library staff could progress applications and take photographs for the patients. The progressive work continued and an internal telephone system had been requested so that everyone using Limelight had access to any queries about all the services provided. The lead GP has led on all this to create maximum benefit from every contact that people make.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector **and** included a GP specialist adviser.

Background to Limelight Health and Well-being Hub

Limelight Health and Well-being Hub, also known as Brooks Bar at Limelight, was registered by CQC in April 2018. It was previously known as Brooks Bar Medical Centre and had recently moved to new premises.

Brooks Bar at Limelight was inspected as a new registration and new location situated at Limelight 1-3 St Brides Way Manchester M16 9NW. The practice moved into Limelight on 6 April 2018. It is a community centre that hosts 81 extra care apartments for older and vulnerable people, a day nursery, pharmacy, hair and beauty hub, café, library, and other health care facilities on 6 April 2018.

Brooks Bar at Limelight is one of two general practices located within the centre and it provides services to the surrounding community under a General Medical Services contract provided by Trafford Clinical Commissioning Group. The practice is registered to provide the regulated activities of diagnosis and screening, surgical procedures, maternity and midwifery services and the treatment of disease, disorder and injury.

There are currently 5104 patients registered at the practice which is situated in the second most deprived area of Trafford. People living in deprived areas are more likely to suffer from long term conditions. More than 50% of patients are from black (and other) minority ethnic groups. People from different backgrounds may have an increased risk of developing certain conditions. The majority of patients registered at the practice were between the ages of 15 and 44 and only 6% of the population were over the age of 75.

The medical team of two salaried GPs was led by the sole provider GP. They offered 20 clinical sessions between them and a long-term locum was available for additional sessions when required. There was a full-time practice nurse and a full time assistant practitioner. The clinicians were supported by a full-time practice manager and a team of administration and reception staff. In addition, the practice had input from a practice community pharmacist three days per week.

The practice was open every weekday and at the weekends when the practice was closed, out of hours' services were provided by Mastercall.

Good

Are services safe?

Safety systems and processes

The practice had implemented and embedded clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Clinical staff who acted as chaperones, were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- The practice took a very pro-active approach to keep patients safe. They consistently met, worked and documented discussions with other support agencies, multidisciplinary teams and the wider community to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. We reviewed minutes from meetings that clearly demonstrated where interventions had been positive in a number of cases over a number of different patient populations, for example, patients fleeing domestic violence, child sexual exploitation and patients on the chronic disease register with additional mental health problems.
- The practice carried out appropriate staff checks at the time of recruitment and on an on-going basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Training had been provided to reception and administration staff.
- When there were changes to services or staff the practice assessed and monitored any impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. They had maximised the use of patient alerts within the clinical system and had introduced pop ups to alert clinicians about any prescribing concerns and/or medicine contra-indications.
- The provider of the service had introduced and embedded systems to ensure comprehensive safety and effectiveness. They openly discussed significant incidents within the practice and appropriately outside their organisation and there was a substantial amount of evidence to show where lessons were learned and improvements were made.
- The practice introduced a robust DNA policy, so those patients with mental health who did not attend were called by the clinician to check on their welfare and to arrange another appointment. The GPs felt it was important to keep in contact with patients, especially those with mental health, so they felt cared about and engaged in caring for their health.
- Clinicians made timely patient referrals in line with protocols and referrals were reviewed and discussed in-house to ensure that they were appropriate.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

Good

Are services safe?

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- A senior practice community pharmacist, employed by the Clinical Commissioning Group (CCG) and mentored by the lead GP, worked at the practice three full days a week running regular searches, seeing patients for medicine reviews, improving quality and gaining cost efficiency savings.

Track record on safety

The practice had a good track record on safety evidenced over a period of 12 months and since the new provider had taken over. They identified risk, took action and made changes when things went wrong. They consistently reviewed safety incidents to ensure that errors were not repeated.

- There were consistent and comprehensive risk assessments in relation to safety issues.
- The practice repeatedly monitored and reviewed activity and made changes to processes when required. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned, shared and made improvements when things went wrong.

- The practice had introduced a comprehensive system to manage risk so that safety incidents were less likely to happen. People were protected by a strong system and a focus on openness, transparency and learning when things went wrong.
- All staff fully understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. They also communicated with agencies outside of their organisation when things went wrong so that the wider community learned lessons as well.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians (including locum staff) up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and on-going needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had maximised the use of technology within their clinical system to populate existing care plans for existing long-term conditions such as diabetes, asthma and atrial fibrillation. In addition, the practice had designed its own simple and easy to use individualised care plans for patients with complex needs. It was identified that these plans were required because complex patients often turned up in crisis or ad hoc, seeing different clinicians and presenting different problems. The plans were created to ensure that all clinicians worked from the same baseline when delivering treatment and provide continuity of care.
- Staff used appropriate tools to assess the level of pain in patients on the palliative care register.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. The practice worked with the Limelight Building Users Group to keep up to date with the activities that would benefit their older patients such as Zumba for the over 50s and the memory activity games and referred them accordingly.
- The practice also worked closely with the Limelight Extra Care Scheme to provide services to the elderly patients who resided in the building.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had offered and undertaken 168 patient health checks of approximately 306 eligible patients. The practice continued to invite over 75s for health checks on a regular basis.
- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- The practice had introduced a holistic approach to patients with multimorbidity and educated them about their multiple conditions. They had amended the appointment system specifically to accommodate those patients and treated all their conditions at one appointment engaging patients where previously there had been a high number of non-attendances.
- They had a call and recall system that clinical and administration staff shared and all members of staff were productive in making sure these patients were encouraged to attend these longer appointments. They found this had contributed to increased patient attendance, better care and communication and a reduction in missed appointments.
- The practice had introduced protocols for the management of adults with newly diagnosed cardiovascular disease. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate. The practice demonstrated improvement from 2% to 95% for patients receiving the required interventions including the offer of high-intensity statins for secondary prevention.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. They provided evidence that

demonstrated improved outcomes for patients with chronic diseases. They created and sent out invitation letters to all patients identified as being on the chronic disease register to come in for review.

- The practice had a senior clinical pharmacist, provided by the CCG and based at the location for three days a week. They were mentored by the lead GP and could review hospital discharges and have face to face and telephone consultations with patients about their medicines. They reviewed medicine management, completed audits and were present at all clinical meetings.
- Care plans were introduced with patient involvement and patients were empowered with education about disease management. Although the avoiding unplanned admissions (AUA) service was no longer an enhanced service, the practice continued to allow patients on the AUA list access to an urgent line for same day advice or appointments so that unnecessary admissions to hospital could be avoided.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

Families, children and young people:

- The practice monitored health alerts and took action. For example, when a recent measles outbreak was identified in a neighbouring borough, the practice did a search to see how many people were missing a full mumps, measles and rubella (MMR) course. 119 patients were found and invites were sent out for them to come in urgently for the second course of vaccinations. They also alerted staff that any patients attending with rash and high temperature together must be kept isolated. They also discussed immunity with staff and checked staff immunisation status.
- The practice had a safeguarding process, protocol and register which was well used and everyone was clear about their responsibilities to safeguarding young people. Health visitors from both boroughs (Trafford and Manchester) attended the practice monthly safeguarding meetings and communications remained open in-between meetings should any concerns arise. Siblings of any children on the safeguarding register were also recorded on the child protection register. We saw evidence where each safeguarding matter (and any action required) was discussed and reviewed at each meeting until it was no longer pertinent. We saw that all concerns that were raised were discussed, even if they turned out to be irrelevant. This had resulted in increased staff awareness and confidence to raise concerns.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% (89%). The practice nurse communicated with parents, health visitors and community matrons to encourage attendance following missed appointments. For two and three year old patients they were over target and for the population of pregnant women the number of patients receiving flu vaccination had doubled
- There were arrangements in place to investigate failed attendance of children's appointments following an appointment in secondary care or for immunisation. We saw evidence that missed appointments were discussed in safeguarding meetings.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance. An in-house weekly midwife facilitated fast access and obstetric care for the practice and they were able to provide examples where this had proved effective.

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

- The previous practice's uptake for cervical screening had been lower than average. The practice identified the cause could possibly be due to the nature of the population and contacted Voice of the BME in Trafford (VBMET). In-house training was arranged and the practice nurse was offered support on how to address the shortfall. Data provided by the practice on 20/4/2018 demonstrated that screening figures had increased from 58% in 2017 to 75% in 2018. This was still slightly lower than the 80% coverage target for the national screening programme and the practice continued to work on ways to make improvement.
- The practices' uptake for breast and bowel cancer screening was in line with the national average.

Good

Are services effective?

- Students were offered Meningitis C vaccinations where appropriate and given appropriate sexual health advice or signposted to relevant services when required.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- The practice undertook an audit of patient deaths over the previous 12 months to determine if the Brooks Bar MC Palliative Care register (PCR) and processes in place were effective. The audit identified that standards were being met; all patients on the PCR were discussed at each palliative care meeting. It also identified that two patients who died in the previous year were on the "watch list" but should have been on the PCR. The practice was now considering a regular death analysis meeting with an aim to do as well as, or better than, the local and national average when looking after patients on their palliative care register.
- When the practice was made aware of an alert from the fire service, aimed at carers for patients who used paraffin based creams, they acted to identify patients that may be at risk. They made arrangements to alert carers through notes on prescriptions, educated other patients during medicine reviews, contacted care homes and alerted families (specifically smokers) when prescribing cream for children with eczema.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. They pro-actively identified and pro-actively called in patients who needed flu vaccinations. For example, they recently contacted the manager of a nearby residential home and identified and called in 11 patients who required vaccination. They invited the flu co-ordinator to their practice meeting who explained the targets and reported that the practice had achieved the national target of 40%.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The practice held a register of palliative care patients and discussed their progress monthly at meetings attended by all clinicians. When necessary and/or appropriate, district nurses and/or carers were invited to those meetings.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

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

- Over the past 12 months a 2% increase in patients with poor mental health with a care plan was demonstrated. As the result of a safeguarding meeting, the practice recognised that people with mental health problems did not access health care in the same way as other patients. They recognised that this group of patients also had poorer outcomes in terms of life expectancy, developing more long-term conditions, problems with access to housing, social and financial problems. They identified that patients often presented on a crisis-led basis and quickly learned that they had to be proactive instead of only having contact with them on a crisis-led basis.
- On the day of their appointment, any patient who lived in a mental health care home was telephoned by a receptionist to remind them of their appointment and explain the reason for it. They recognised that those patients had bad days when they did not want to leave the house so they ascertained if and when they were coming and used the appointments for another patient if they decided to cancel. There was a robust Did Not Attend (DNA) policy, so those patients were called by the clinician to check on their welfare and to arrange another appointment. The GPs felt it was important to keep in contact with this group of patients so they felt cared about and engaged in caring for their health.
- Prior to the provider taking over this practice there had been no learning disability register. 31 patients had now been identified as having a learning disability and were offered annual health checks. Following a discussion about accessible standards the practice re-wrote the invitation letter for patients with learning disabilities to make it easier to understand and to increase communication and attendance at reviews.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Good

Are services effective?

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement and activity and routinely reviewed the effectiveness and appropriateness of the care provided. There was a rolling audit register. 10 clinical audits had been completed since October 2017, and other administration audits were undertaken by non-clinical staff.

The practice mentored a community pharmacist. They had trained this person and customised them to the requirements of the practice, running regular searches, monitoring uncollected prescriptions, linking all medicines to active conditions and carrying out quality and cost saving exercises. In addition, the practice accommodated regular visits from the CCG prescribing team who were present at practice meetings and assisted in the monitoring of appropriate prescribing. The practice could demonstrate evidence of change and improvement based on this input. For example, the practice moved from the 93rd to the 28th centile (from second worst prescribers to above average) over the previous twelve months.

Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines, including a review of polypharmacy (the concurrent use of multiple medicines by a patient). All medicines were coded according to condition and unnecessary medicines were reduced or stopped so that people received maximum benefit with least waste.

There was a high reduction in antibiotic prescribing demonstrating that appropriate treatment was provided to patients with viruses that could not be treated with antibiotics.

Where appropriate, clinicians took part in local and national improvement initiatives. The lead GP was a member on several committees discussing the future of general practice, GP Federations and improvement in patient care. In addition, the practice had been a key contributor to a business plan which aims to gain funding for Care Navigators across Trafford to work within GP practices.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- There was an effective induction system for temporary staff tailored to their role. In particular a revised locum pack had been prepared by a member of locum staff after a significant incident had occurred. A feedback and handover form had been created to ensure that patient care continued appropriately following consultation by a locum GP. The information to be handed over to a substantive GP included any tests to be ordered, any complex patient issues, referrals, safeguarding issues (even if dealt with) and any significant incidents (including broken equipment and/or safety hazards).
- Clinical and non-clinical staff were supported to progress in their careers for the benefit of patients. The health care assistant had been supported in their progression to assistant practitioner and was able to provide an increased support role to the practice nurse. The practice nurse was being developed into a prescribing role. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making. The practice nurse mentored the assistant practitioner and the GPs worked alongside the practice nurse to promote best practice decision making for the care and treatment of patients. Administration staff were being supported into champion and lead roles such as complaints lead and carer's champion. One of the salaried GPs was being supported into the position of partner and medical student trainer.
- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews. The practice nurse had recently been on a diabetic course.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with on-going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.

Good

Are services effective?

- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked wholeheartedly with other health and social care professionals to deliver effective care and treatment, including the police, social workers and other non-clinical professionals to support patients holistically and socially.

- We saw consistent documentation that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies. They found that standardised templates were not appropriate for some patients and created their own templates to suit those patients, for example, patients with very complex needs.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable (such as other family members) because of their circumstances.

Helping patients to live healthier lives

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

- 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.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The national patient survey results were still slightly lower than average but were improving as the practice continued to make changes based on the requirements of its patient population.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (AIS) and had made improvements to the way people were communicated with, such as changing the learning disability invitation letter. (The AIS is a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. Outcomes improved for one person in particular from another country who did not engage in any services. A whole community was opened to them after staff made enquiries for them.
- The practice proactively identified carers and supported them. The number of carers identified had increased to 52 following an in-house competition to raise awareness. This was just over 1% of the practice population.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice as good for providing responsive services overall and across all the population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patients' needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs particularly in relation to the transient population, women fleeing domestic violence and social housing. They were aware that the population was changing, new housing was being built and more home owners were arriving in the area.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours. In addition, practice nurses accommodated cervical smear appointments in the evening if patients were unable to attend during the day.
- The facilities and premises were new and appropriate for the services delivered. The practice made reasonable adjustments when patients found it hard to access services. The practice was making alternative arrangements to enable consultations with a patient who was unable to enter the building.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and appropriately outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families and young people

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- There were a high number of children at risk on the practice register and those patients were discussed regularly to ensure that communication remained open at all times. In many cases the practice communicated regularly with police, schools, social workers and children's' mental health services to ensure that the patients received the best possible care and treatment available to them.

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

- The needs of this population 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, extended opening hours and Saturday appointments.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- New patient health checks and well person health checks were offered.

People whose circumstances make them vulnerable:

- Vulnerable patients were clearly identified via an alert on their medical record. Newly identified vulnerable patients were discussed at monthly multidisciplinary meetings attended by health visitors, safeguarding teams, care home managers and carers (where appropriate). We saw evidence where patients (and in some cases their family members) were identified as

vulnerable because of their circumstances. Each case was evaluated on its own merits and discussed each month (or more often if required) until it was no longer relevant.

- Protocols for patients who missed or arrived late for appointments ensured that vulnerable patients could access care easily and provided a safety net that flagged those patients up to clinicians when they were not seen in clinic as expected. All members of staff were aware of the protocols and fully complied with them.
- For patients with the most complex needs, the GPs all worked with many other health and care professionals to deliver a coordinated package of care. In addition, the practice had designed and introduced a simple and easy to use individualised care plan for patients with complex needs. These had come about after it was identified that complex patients often turned up in crisis or ad hoc, seeing different clinicians and asking for different prescriptions or treatment. The plans ensured that all clinicians worked from the same baseline when delivering treatment and provided continuity of care.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was affiliated to three residential homes in the area for people with mental health conditions. They identified that this group of patients continually failed to turn up for appointments to assess and monitor their physical health. To address this issue, a member of staff got in touch with the managers of the homes and educated them on the importance of these health checks. Then they created a register of each patient, their key worker contact information and other information such as their smoking, drug or alcohol dependant status. The staff member from the practice then prepared invitation letters and hand delivered them, asking that the key workers to hand the letters to each patient individually, re-enforcing the importance of attending the appointment. They also invited the key workers to attend the appointments with the patients if that was the patient's choice. The practice could demonstrate that this improved the attendance of patients for their health check appointments and they have continued to maintain open communication with the managers and key workers at the homes.
- The practice held GP led dedicated mental health and dementia appointments. Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to care and treatment

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Some patients reported that the new appointment system was not as easy to use and to combat this staff were promoting on-line access and other ways to make appointments.
- Various ways of requesting repeat prescriptions, including by email, were available to patients.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately and encouraged them to discuss their concerns with the practice manager or a GP. All comments about the practice were responded to in detail, for example, those made on the practice website or on other sites such as NHS Choices.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.
- The practice held a running verbal complaints/ comments log with details of the person's concern, what investigations were undertaken, what action or recommendation was made and whether or not the complainant was satisfied. They had logged 56 comments over a twelve month period and each one had an investigation and action logged.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding for providing a well-led service.

The practice was rated as outstanding for providing well led services because there was evidence that the leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. There was a systematic and analytical five year plan and already evidence of improvement in line with that plan. In addition, a systematic approach was taken to working with strategic organisations to improve care outcomes, tackle inequalities over specific population groups and obtain best value for money.

The current provider had been a salaried GP at the previous practice, Brooks Bar Medical Centre and was unable to facilitate change, when that practice was placed in special measures in 2016. Since taking over the practice they had improved outcomes for patients by reducing over prescribing, participating in extended services and engaging with the Clinical Commissioning Group and other groups in the community to the benefit of the patients in their practice.

They were one of the original members of the Limelight Building User Group (BUG) and they were an active member on several committees in Trafford driving forward general practice and integrated services for the Trafford community.

Leadership capacity and capability

Leaders had the capacity and skills to drive and improve outcomes for patients.

The lead GP and the wider leadership group, including the practice manager were knowledgeable about issues and priorities relating to the quality and future of services. They grew up and went to school in the area, understood the challenges and were addressing them. They actively sought out patients that needed extra support, particularly those who were vulnerable patients, including children and those with mental health conditions.

- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had created effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- They were actively involved in the education of practice staff through protected learning time and in-house awareness sessions

Vision and strategy

There was a strong, clear vision and a credible strategy to deliver high quality, sustainable care shared and recognised by all members of staff.

- There was a clear mission statement and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- All staff were aware of and understood the vision, to create a medical practice that served the community's health needs. Staff understood the values and strategy and their roles and responsibilities to help to achieve them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients. They had changed the way the practice worked, with many new processes, a new appointment system, more access to advice and a more structured service. They recognised that the changes had been difficult for patients who were used to seeing the same GP for 30 to 40 years and could just "drop in". All members of staff could explain to patients the reasons for the changes and how they would benefit from them.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Outstanding ☆

Are services well-led?

- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management that had not been in place before.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The new provider had introduced a structure whereby each member of staff had a line manager and received support and supervision when necessary.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. Significant issues, complaints, concerns and patients at risk were discussed regularly and openly. Staff were furnished with knowledge that increased awareness and provided confidence to raise concerns even if they turned out to be futile.
- As well as discussing significant events with staff, incidents were discussed when appropriate with people outside the practice so that ideas for improvement could be shared. Examples included discussions with a consultant at Trafford General Hospital and another with the radiology department to highlight significant incidents that had occurred and prevent any repeat in the future.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence that actions taken had improved patient outcomes in several areas, particularly patients with long term conditions and those who were vulnerable or mentally ill.
- Regular protected learning time had been introduced so that staff could work through mandatory training together as well as ad-hoc training. When an alert about oxygen cylinders not opening was brought to the attention of the practice, the leaders arranged for education to all practice staff (including administration staff) on how to maintain the oxygen cylinders and what to do in the event of failure. The practice nurse created a flow chart. During a protected learning time seminar attended by all staff, they discussed symptoms and eventualities that might amount to urgent assessment or medical emergency.
- The practice had plans in place and had trained staff for major incidents. This included training in Prevent, safeguarding people and communities from the threat of terrorism.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians and reception or administration staff, to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Outstanding ☆

Are services well-led?

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice demonstrated that it has worked hard to engage its Patient Participation Group (PPG) and as a result, provided an innovative range of services.

- There was an active PPG for the practice with representatives from different cultures of the population. The leaders attended the meetings to listen to patient concerns, engage in patient surveys and provide feedback of improvements made. They had hosted a joint community PPG at their practice, and had brought about positive and continuous change. A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation particularly where the practice was involved in changing lifestyles and improving health within the local community.

- There was a focus on continuous learning and improvement. Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice participated, via a nominated representative, in the Greater Manchester strategy, Stronger Together. It brings together leads from each place to understand what it takes to transform whole areas on behalf of their organisations, systems and places of work. Its aim is to create a stronger community of capable, resilient leaders across Greater Manchester, and within localities, who are able to lead within, and on behalf of, organisations, systems and places. The outcome is to help leaders across all areas to learn from each other, share ideas, insights and change their leadership practice to provide a more joined up public service and to improve the lives of people in Trafford. One of the GPs leads on the Place Based Challenge for Trafford which is an initiative preventing homelessness, creating suitable emergency accommodation and reducing evictions.
- One of the GPs leads on the Place Based Challenge for Trafford which is an initiative preventing homelessness, creating suitable emergency accommodation and reducing evictions. It remains on the agenda at relevant meetings at Brooks Bar and in wider conversations within Limelight to contribute as much as possible to the project from a health perspective. Staff are already much more understanding of the challenges that face patients with housing and homelessness issues being flexible and seeking advice around registrations and signposting to the relevant support available within Limelight and beyond.
- Brooks Bar at Limelight is the pilot practice for the One Trafford Response in the North. This is another initiative in its early stages with three members representing the practice. They have completed training and within the last three months have started to make connections. They are already working much more closely with partners outside of Health to help their patients by seeing them more holistically and understanding their problems as part of a wider network of challenges rather than just a health issue. Partner organisations can

Outstanding ☆

Are services well-led?

include education, unemployment services, domestic abuse services, anti-social behavior counsellors, substance misuse and/or housing associations. They are also tackling isolation in the community.

- The lead GP had been a member of the Building User Groups for Limelight since its inception and has hosted the group for the most part of 2017 until Limelight was up and running. They were fully engaged with the Limelight building and recognise that Limelight requires all building users and services to collaborate and cross-refer so that the maximum benefit can be made from every contact that people make.
- The practice planned to introduce care navigators and increase social prescribing within the community with a view to making every contact count.
- The practice is also involved in a diabetes pilot in Trafford, to increase the care and education for patients in the community.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation