The Castle Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Castle Medical Centre on 5 March 2015. Overall the practice is rated as outstanding.

Specifically we found the practice to be good for providing safe and caring services. It was outstanding for providing effective, responsive and well led services. The practice was outstanding for providing services to families, children and young people, working age people and those whose circumstances may make them vulnerable. It was also outstanding for providing services to people with long term conditions, older people, and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice assessed patients' needs and planned their care following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice valued the importance of quality, improvement and learning and were actively involved in GP education and training and in primary care research.
- Patients said they were treated as individuals and that they were involved in their care and decisions about their treatment. Patients described the practice as caring, helpful and friendly.
- Information about services and how to complain was available and easy to understand.
- Patients could speak on the telephone and make an appointment with a named GP. Routine as well as urgent appointments were available on the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Plans were in hand for extending and improving the building to enable the practice to respond to future patient needs.
- There was a clear leadership structure and staff felt supported by management. The practice worked

Summary of findings

closely with its patient participation group and proactively sought feedback from staff and patients. They listened to what patients told them and made improvements accordingly.

We saw several areas of outstanding practice including:

- The practice had effective assessment, care planning and recall arrangements for patients with long term conditions. Their emergency admission rates for a number of long term conditions including chronic heart disease and chronic obstructive pulmonary disease (COPD) were significantly below the national average. The practice also had low accident and emergency admission rates.
- The practice team included a part time pharmacist employed by the practice to support the clinicians in providing safe and effective medicines management. Their role included supporting the GPs and nurses with pharmacy advice, reviewing prescribing and monitoring medication safety alerts to make sure these were acted on in a timely way. The practice told us that having a pharmacist had resulted in them being one of the most cost effective prescribers within the CCG. National data showed prescribing levels for specific types of medicines where caution should be exercised were lower than the national average.
- The practice was working to develop the service it provided to patients with dementia and their carers. In addition to care planning and reviews of their care they had arranged a talk for patients and carers by staff from the Office of the Public Guardian (OPG) about how to make a lasting power of attorney (LPA) and another by the Alzheimer's Society. These were the first of a series of patient education evenings the practice planned to arrange for patients each year.
- The practice attended a weekly multi-disciplinary meeting at a local care home that was involved in an early discharge from hospital initiative. One of the GPs visited patients staying at the home under this scheme every day. Appointments for older patients' health reviews were 30 minutes long and hour long appointments were booked for those most at risk.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents to help them improve. Information about safety was highly valued and was used to promote learning and improvement. Risks to patients and within the practice were assessed and well managed. There were enough staff to keep people safe. Arrangements for the management of medicines were clear and overseen by a part time pharmacist employed by the practice.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with National Institute for Heath and Care Excellence (NICE) guidelines and other locally agreed guidelines. We saw evidence to confirm that the GPs used these to influence and improve practice and outcomes for patients. The practice used locally agreed protocols for ensuring that patents received the care and support they needed at the end of life.

The practice used clinical audit to monitor the effectiveness of the care and treatment they provided and had been a host practice since February 2011 as part of an NHS primary care research initiative.

The practice's emergency admission rates for a number of long term conditions including chronic heart disease (3.7% compared to 7.5%) and chronic obstructive pulmonary disease (COPD) (4.6% compared to 12.88%) were significantly below the national average. The practice's review rates for COPD were also higher than the local and England averages (90% of patients with these conditions compared to 88% within the CCG and 81.4% for England). Data showed that the practice was effective in supporting patients with diabetes to manage their health and had low accident and emergency admission rates.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients told us their GP gave them the time and attention they needed and several mentioned feeling well supported over the years or during extended periods of treatment.

Summary of findings

Patients used words such as brilliant, superb, caring and considerate to describe the team. Managers of local care homes confirmed that the practice cared about patients and treated them as individuals.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The practice had made changes to the appointment system based on feedback from patients and a period of research. The new system had been well received. Patients could arrange appointments with the GP of their choice and could expect to see a GP on the day they telephoned the practice whether this was for routine or urgent appointments. Appointments were available on Saturdays mornings.

There was a clear complaints system with evidence demonstrating that the practice responded to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service. Managers of local care homes confirmed that the patients living in those homes received responsive care. The GPs provided a specific service to patients in one care home as part of an initiative to enable patients to be discharged from hospital for ongoing care and assessment of their future needs. This involved daily visits to the care home and weekly meetings with other health and care professionals.

The practice had begun to arrange education evenings at the practice for patients and carers and these had commenced with talks about lasting power of attorney arrangements by the Office of the Public Guardian and one about dementia by the Alzheimer's society.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for providing well-led services. The practice had an open and supportive leadership and a clear vision with quality, improvement and learning as its top priorities. The practice promoted high standards and the team took pride in delivering a high quality service to its patients. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly to review the delivery of care and the management of the practice. The practice had systems in place to monitor and improve quality and identify risk.

Summary of findings

The practice proactively sought feedback from staff and patients and responded to suggestions made. The practice had an active patient participation group (PPG). A PPG is made up of a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

There was evidence that the practice had a culture of learning, development and improvement including their involvement in GP education and primary care research. An example of this was that both practice managers had master's degrees in primary care management and the practice was supporting the reception manager to undertake a level five diploma in primary care management.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

This practice is rated as outstanding for the care of older people. Patients over the age of 75 had a named GP and GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice exceeded the national average for providing flu vaccinations to patients over the age of 65. The practice provided a responsive service to patients living in two local care homes. The practice provided other professionals and its own staff with clear information about patients receiving end of life care who might need an urgent response if they requested medical assistance. They had a register of patients who needed care and support at the end of their lives and took part in meetings with other professionals involved in their care. Patients over 75 were offered a 30 minute appointment to discuss their health and plan their care with the aim of avoiding unplanned hospital admissions. The practice was about to begin a review of all of their patients aged over 75 in partnership with Age UK. The aim of this work was to empower patients and to identify those most at risk due to their levels of frailty. The practice explained that they planned to carry out more preventative care and as part of this offered one hour appointments for those older patients at highest risk. They provided a specific service to patients in one care home as part of an initiative to enable patients to be discharged from hospital for ongoing care and assessment of their future needs. This involved daily visits to the care home and weekly meetings with other health and care professionals.

People with long term conditions

Outstanding ☆

This practice is rated as outstanding for the care of people with long term conditions. The practice had effective assessment, care planning and recall arrangements for patients with long term conditions. Practice nurses and GPs had lead roles for the management of patients with long term conditions and the practice had identified patients at risk of unplanned hospital admissions. They had identified the 2% of patients registered with the practice who were at the highest risk and had developed written care plans for those patients following a minimum of 30 minutes appointment to review their health and discuss their care and treatment needs with them. Those patients and others with long term conditions had annual reviews of their health and medicines. Longer appointments or home visits were arranged for these according to individual need.

Summary of findings

The practice's emergency admission rates for a number of long term conditions including chronic heart disease (3.7% compared to 7.5%) and chronic obstructive pulmonary disease (COPD) (4.6% compared 12.88%) were significantly below the national average. The practice's review rates for COPD were also higher than the local and England averages (90% of patients with these conditions compared to 88% within the CCG and 81.4% for England). Data showed that the practice was effective in supporting patients with diabetes to manage their health and had low accident and emergency admission rates.

Families, children and young people

Outstanding ☆

This practice is rated as outstanding for the care of families, children and young people. The practice provided childhood immunisations and appointments for these could be booked throughout the week and on Saturday mornings to provide flexibility for working families. The practice provided a family planning service and a range of options for contraception. The GPs and nurses worked with other professionals where this was necessary, particularly in respect of children living in vulnerable circumstances.

Working age people (including those recently retired and students)

Outstanding ☆

This practice is rated as outstanding for the care of working age people, recently retired people and students. Appointments were available from 8am for patients unable to visit the practice later in the day and on Saturday mornings. The practice appointment system aimed to enable patients to speak direct with a GP on the telephone and arrange an appointment at a time to suit them or to have telephone consultations with a GP where this was suitable. Patients could book telephone calls with a GP and order prescriptions online. We had some information to suggest that some working patients did not find the new system convenient because they could not arrange time out of work in advance.

People whose circumstances may make them vulnerable

Outstanding ☆

This practice is rated as outstanding for the care of people living in vulnerable circumstances. The practice had a learning disability (LD) register and all patients with learning disabilities were invited to attend for an annual health check. Longer appointments were available for this and the practice used information in suitable formats to help them explain information to patients. Staff told us that the practice did not have any homeless people or traveller families currently registered at the practice. Staff at the practice worked with other professionals to help ensure people living in

difficult circumstances had opportunities to receive the care, support and treatment they needed. The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

This practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice held a register of people experiencing poor mental health and invited them to attend for an annual health check. Longer appointments were arranged for this and patients were seen by the GP they preferred. The annual reviews took into account patients' employment, home circumstances and support networks in addition to their physical health. One of the GPs monitored progress in seeing all of these patients during the year and data showed that in the year ending April 2014 92.11% of patients with mental health needs had a care plan in place compared to the national average of 86.09%.

The practice had taken steps to ensure they had identified patients at the practice living with dementia and provided annual reviews for them. These were booked as 30 minute appointments and patients' main carers were invited to attend with them. The GPs went to patients' homes for these reviews if this was easier for the patient and their carer.

The practice had arranged a talk for patients and carers by staff from the Office of the Public Guardian (OPG) about how to make a lasting power of attorney (LPA) and another by the Alzheimer's Society. GPs and other staff were completing 'Dementia Friends' training provided by the Alzheimer's Society with a view to becoming a dementia friendly organisation.

Summary of findings

What people who use the service say

We gathered patients' views by looking at 15 Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with four patients one of whom was a member of the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. Data available from the NHS England GP patient survey results during 2013/2014 showed that the patients had reported positive views about the practice. The practice had a slightly higher than average score in respect of overall satisfaction with the care they received (86.4% compared to 85.75%). However, their scores for opening hours and getting through on the telephone were slightly lower than the national average. The practice had recognised this as an area to improve and had recently introduced a new telephone and appointment system which was receiving a positive response from patients. Several patients specifically mentioned this improvement in their comment cards and gave examples of how well the new system had worked for them. However, one patient commented that it was inconvenient for them. They said it was difficult to arrange time away from work because they needed to leave home before the practice was open.

Information from patients gave a positive picture of their experiences. Patients told us they were very happy with the service they received and included all staff groups within the practice's team in their praise. Some patients described specific examples of the care the practice had provided to them or members of their family. They described receiving swift and effective treatment which in one case had been in response to a medical emergency. The patient described how a GP had responded to this during their lunch break and then made sure the patient received the care they needed subsequently. Some patients commented that they were pleased that they could see or speak with the GP who knew them best. Patients told us their GP gave them the time and attention they needed and several mentioned feeling well supported over the years or during extended periods of treatment. Patients used words such as brilliant, superb, caring and considerate to describe the team.

Outstanding practice

- The practice had effective assessment, care planning and recall arrangements for patients with long term conditions. Their emergency admission rates for a number of long term conditions including chronic heart disease and chronic obstructive pulmonary disease (COPD) were significantly below the national average. The practice also had low accident and emergency admission rates.
- The practice team included a part time pharmacist employed by the practice to support the clinicians in providing safe and effective medicines management. Their role included supporting the GPs and nurses with pharmacy advice, reviewing prescribing and monitoring medication safety alerts to make sure these were acted on in a timely way. The practice told us that having a pharmacist had resulted in them being one of the most cost effective prescribers within the CCG. National data showed prescribing levels for specific types of medicines where caution should be exercised were lower than the national average.
- The practice was working to develop the service it provided to patients with dementia and their carers. In addition to care planning and reviews of their care they had arranged a talk for patients and carers by staff from the Office of the Public Guardian (OPG) about how to make a lasting power of attorney (LPA) and another by the Alzheimer's Society. These were the first of a series of patient education evenings the practice planned to arrange for patients each year.
- The practice attended a weekly multi-disciplinary meeting at a local care home that was involved in an early discharge from hospital initiative. One of the GPs

visited patients staying at the home under this scheme every day. Appointments for older patients' health reviews were 30 minutes long and hour long appointments were booked for those most at risk.

The Castle Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a Care Quality Commission (CQC) inspector and included a GP specialist advisor, a practice manager specialist advisor and CQC's national nursing advisor who was shadowing the inspector.

Background to The Castle Medical Centre

Castle Medical Centre is in the town of Kenilworth and has a catchment area with low levels of social and economic deprivation. It has around 12,250 patients. The practice is in a purpose built building on two floors with lift access for anyone unable to use the stairs. The practice has designated disabled parking spaces at the front of the building and is a short walk from a town car park.

The practice population includes higher than the national average of people over 40 and also has a higher than average number of older patients of 75 and above. The number of younger adults and children is lower than the national average. People living at two local nursing homes for older people and one for younger adults with physical disabilities are registered with the practice.

The practice has five partners and five salaried GPs. Five of the GPs are male and five are female providing patients with a choice. The practice has three practice nurses, two health care assistants, a phlebotomist (a person trained to take blood) and a practice pharmacist. A primary care research nurse works with the practice for two days a week.

The clinical team are supported by two practice managers, a reception team manager and a team of reception staff, medical secretaries and administrative staff.

The practice provides a range of minor surgical procedures to patients.

Castle Medical Centre is a training practice providing up to two GP training places for up to two GP trainees. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The practice is also a teaching practice and provides placements for medical students who have not yet qualified as doctors.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a General Medical Services (GMS) contract with NHS England.

Data we reviewed showed that the practice was achieving results that were higher than or in line with national or Clinical Commissioning Group (CCG) averages in respect of most conditions and interventions.

The practice does not provide out of hours services to their own patients but provided information about the telephone numbers to use for out of hours GP arrangements. There were two numbers (a doctors' answering service and NHS 111) depending on the time of day patients called and this information was explained on the practice website. The website explained that patients could expect either a telephone consultation, a home visit or to be asked to attend the GP walk in centre based at Warwick Hospital which is operated by an organisation called Care UK.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included South Warwickshire Clinical Commissioning Group (CCG), NHS England Area Team and Healthwatch. We carried out an announced visit on 5 March 2015. We sent CQC comment cards to the practice before the visit and received 15 completed cards giving us information about those patients' views of the practice.

During the inspection we spoke with four patients and a total of 17 staff including the practice management and support team, GPs, GP trainees, practice nurses, a healthcare assistant pharmacist and a phlebotomist (a person trained to take blood). One of the patients we spoke with was a member of the practice's patient participation group (PPG) who came in to the practice to meet with us. We also spoke with the managers of three local nursing homes who provided information about the service provided by the practice to patients living in those homes.

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

The practice used information from a variety of sources to help them identify and manage risk, learn from adverse events and improve patient safety. These included national and local safety alerts, comments and complaints from patients and the results of patient surveys.

The staff we met understood the importance of recognising, reporting and recording significant events and gave us examples of situations the practice team had discussed. We saw minutes of meetings where the team had discussed significant events dating back to 2011 showing that the practice had an established system for monitoring safety.

Learning and improvement from safety incidents

The practice had a significant event policy and clear systems for reporting, recording and monitoring these. All significant events and accidents were colour coded using a traffic light system to highlight the level of importance and risk of each of these.

The practice received alerts about patient safety in respect of medical products, equipment and medicines and circulated these to all staff. Medicines alerts were managed by the practice's pharmacist who ensured that the GPs and nurses were aware of these and took any necessary action. All alerts were filed on the computer system in an organised way.

We saw evidence that the team discussed significant events at quarterly meetings specifically for this purpose. Staff told us that everyone working at the practice attended these so they could all take part in discussions about how to prevent adverse events happening again. Staff told us that the meetings were constructive and open so if a member of the team had made an error they felt supported. Action plans and minutes relating to significant events were circulated to all members of the staff team.

Records of significant events contained details of the events discussed and the changes in practice procedures they had made as a result. These included alert information being added to the records of patients sharing the same name, taking more notice of patients reporting medicines side effects and changes to the practice's business continuity plan following multiple power failures over a four month period. We saw information that showed the practice had reflected on serious adverse events, including the learning needs of individual members of staff to help reduce the risk of the same things happening again.

Reliable safety systems and processes including safeguarding

The practice had a children and young people safeguarding policy and an adult safeguarding policy. These were based on national and local guidance and were tailored to the needs of the practice. They provided guidance for staff about identifying and reporting abuse and neglect. A safeguarding flow chart and information about important contact numbers for the multi-disciplinary child and vulnerable adult safeguarding teams was available for all staff to refer to.

The practice had a lead GP and could access two clinical commissioning group (CCG) named nurses for safeguarding. Staff we spoke with knew who they were. Staff understood their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect and knew where to find information about safeguarding on the practice's computer system. We saw evidence that staff regularly completed safeguarding training for children and vulnerable adults at a suitable level according to their role at the practice. This training was provided by the safeguarding lead from the clinical commissioning group (CCG).

The GPs and nurses took part in regular multi-disciplinary meetings with health visitors to discuss children and young people known to be living in vulnerable circumstances including those with child protection plans or in the care of the local authority. Staff told us that the meetings with health visitors were held every two weeks. GPs and other staff gave us examples of situations they had recognised as safeguarding concerns and reported through the appropriate multi agency safeguarding arrangements. These included concerns about financial abuse, self-neglect and a child whose well-being they were concerned about.

The practice computer system provided clear information for staff so that they were aware of any patients who may be vulnerable or at risk. This included patients receiving care at the end of their lives as well as children who had a child protection plan in place. Staff showed us that the practice telephone system logged abandoned calls from

patients. The practice was developing a system to use this information to check that patients who were unsuccessful in getting through to make sure that they were alright and did not need assistance.

The practice had a chaperone policy which staff knew about. A chaperone is a person who acts as a witness to safeguard patients and health care professionals during medical examinations and procedures. The policy was available on the practice computer system if they needed to refer to it. Signs were displayed within the practice to inform patients that chaperones were available. The practice used an external trainer to provide training for staff who fulfilled this role and obtained criminal record checks for them through the disclosure and barring service (DBS). We saw that 22 staff had been trained for this role so a chaperone was always available. Staff confirmed they had been trained and understood what they were expected to do. The GPs recorded the name of the member of staff who had acted as a chaperone in the patient's notes but the member of staff did not always add their own confirmation of this which would be best practice.

The practice had a whistleblowing policy which included information about the rights and responsibilities of staff. Staff knew that this was available on the practice computer system and told us that the team had discussed whistleblowing at staff meetings. Staff who told us they would not hesitate to report any concern because they knew they would be well supported by the practice.

We saw that there were posters about domestic violence in the public toilets so that patients who needed support could make a note of helpful contact information in privacy.

Medicines Management

The practice had policies and procedures relevant to the safe management of medicines and prescribing practice. They employed their own pharmacist who worked at the practice one day a week. They were responsible for supporting the practice team to ensure safe, evidence based management of medicines and prescribing at the practice. Part of their role was to receive and review national safety alerts about medicines. They emailed these to the GPs, saved them on the computer system and made sure any necessary action was taken. The pharmacist had arranged an education session for staff with an external speaker following which the practice produced an evidence based and cost effective list of inhaled medicines for patients prescribed these. The pharmacist had also worked with local care homes to improve stock control of medicines.

Patients could order their repeat prescriptions in person, by telephone, online or by post. Patients could choose to have their prescription sent to a pharmacy of their choice so they did not need to go to the practice to collect it. Patients could also use a system which gave them the option to obtain repeat prescriptions for a year and were asked to discuss this with their GP if this would be suitable for them. Whichever system patients chose to use for their repeat prescriptions the practice carried out medicines reviews at suitable intervals depending on the needs of individual patients. There was a separately owned pharmacy on the same site as the practice. This made it convenient for patients to collect medicines after an appointment.

Several patients commented that their medicines were reviewed annually or more often and that the GPs and nurses explained what their medicines were for and how to take them.

The practice had secure arrangements for storing prescription pads and printer sheets. They did not have a system for recording when GPs were allocated blank prescriptions but set one up on the day of the inspection once we identified this. The practice had appropriate medicines available in the event of medical emergencies and these were stored securely. We saw evidence that staff checked these each week to make sure they were available and within expiry dates.

The practice nurses were responsible for the management and administration of vaccines. They told us that they had regular contact with the local CCG immunisation lead who provided annual training updates. They also kept themselves updated by reading immunisation publications available on the internet. We saw that the practice had arrangements for the receipt, storage and recording of all vaccines coming into the practice. The practice had purpose designed medicines refrigerators and the staff monitored the temperatures of these to make sure vaccines were stored within the required temperature range. Staff were able to explain the process they would follow if the temperature recorded was outside the expected range. This including putting the contents out of use until they obtained guidance from the manufacturers. The nurses and health care assistants administered

vaccines using patient group directions (PGDs) produced in line with legal requirements and national guidance. We checked a sample of these and found that they were up to date.

Cleanliness & Infection Control

The practice was visibly clean and most patients specifically remarked on the cleanliness of the practice. One patient described seeing their GP wash their hands three times during the course of an examination.

One of the practice nurses was the lead for infection prevention and control (IPC) and the practice manager was the lead for legionella precautions. Legionella is a bacterium that can contaminate water systems in buildings. The practice manager had completed a legionella risk assessment and staff monitored the hot and cold water temperatures to help minimise the risk of legionella developing. Some but not all rooms had thermostatic controls on the taps to make this easier to manage. The practice manager told us that when the building is refurbished during 2015 they intend to upgrade the taps in all the rooms.

Staff received IPC training and told us that practices in the area were working together to introduce standardised IPC training that they could all access. The practice carried out IPC related audits and the most recent of these was in September 2014. We saw that the practice had addressed the actions identified in this.

The cleaning staff had a cleaning schedule to follow to ensure all areas of the practice were cleaned as necessary. Cleaning equipment and products were kept securely and information about safe use of cleaning materials was readily available. There were arrangements in place to ensure that clinical equipment was cleaned when used and at regular intervals.

Specific equipment and products were available to deal with any bodily fluids that might need to be cleaned and staff knew where these were kept. The practice had a plentiful supply of personal protective equipment, such as disposable gloves and aprons, for staff to use. We saw that suitable foot operated bins were provided for general and clinical waste. There were disposable privacy curtains in treatment rooms and staff had recorded the date these had been changed on the labels provided for this.

There was a sharps injury policy and procedure so staff had information about the action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice had written confirmation that all staff were protected against Hepatitis B. All instruments used for minor surgery or examinations were single use and staff monitored these to ensure they were within their expiry dates.

The practice had a contract with a specialist company for the collection of clinical waste and had suitable locked storage for this and 'sharps' awaiting collection. We saw that the practice had risk assessments for the control of substances hazardous to health (COSHH) and that these were available for all staff to refer to.

Equipment

Staff we spoke with confirmed that they had the equipment they needed for the care and treatment they provided. We saw evidence that equipment was maintained and that portable electrical equipment was tested to ensure it was safe for use. We saw evidence of calibration of equipment used by staff including blood pressure monitors, weighing scales, fridges and nebulisers.

Staffing & Recruitment

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. The overall staffing levels and skill mix at the practice ensured that they had sufficient staff to maintain a safe level of service to patients. The practice nurses told us that they provided cover for each other for unplanned absences and staggered their holidays to ensure continuity of the service.

The practice had a recruitment policy and we saw evidence in staff files that the practice followed this so that they obtained the required information for any member of staff they appointed. We saw that the practice carried out checks through the Disclosure and Barring Service (DBS) for the majority of staff working at the practice. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. Written risk assessments were available for staff where no DBS check was considered necessary (such as staff who never had unsupervised contact with patients) to record the reasons why this decision was reached. We saw that the practice also had thorough processes for checking the suitability and appropriate professional registration

status of any locum GPs employed to work at the practice. There were structured induction arrangements for new members of staff, GP registrars and medical students and locum staff.

Monitoring Safety & Responding to Risk

We saw that the practice had a health and safety policy. Staff told us that they carried out visual health and safety checks throughout the building each day but that these were not recorded. There was a board for staff to write any repairs that needed to be done. Staff told us that this was being replaced by a structured fault and repair reporting form. The practice was about to embark on a major refurbishment of the building to improve the layout and capacity of the building. The practice was using the opportunity to upgrade specific aspects of the building. This included replacing some taps with thermostatically controlled ones and updating the fire alarm system.

The practice had systems for identifying patients who may be at risk. There were practice registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice computer system was used to inform staff of individual patients who might be particularly vulnerable. Staff working in reception and answering the telephones had information to help them prioritise potentially urgent cases.

Doors within the building were secured by keypads to ensure security and safety.

Arrangements to deal with emergencies and major incidents

The practice computer system had the facility of a panic alert button for staff to use if they needed to summon urgent help from other members of the team. All staff at the practice had completed Cardiopulmonary Resuscitation (CPR) training and the practice had a system for monitoring when refresher training was due.

The practice had oxygen and an automated electronic defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). There were appropriate medicines available for use in a medical emergency at the practice. We saw evidence that staff checked these regularly to make sure they were available and ready for use when needed.

The practice had a bag for the GPs which contained appropriate medicines for use when visiting patients in emergency situations. The contents of this bag were routinely checked every two weeks. The GPs had another bag which they used for routine home visits and this did not contain any medicines.

We saw that there was a fire risk assessment and that staff took part in fire drills and fire training. Fire safety training was booked for 24 March 2015 and staff had taken part in a drill on 3 March 2015.

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. The plan was available to all staff on the practices computer system and staff had access externally should this be necessary.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and nurses showed that that they were aware of and worked to guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment. NICE guidance and local clinical guidelines were all available on the practice's computer system and the GPs and practice nurses knew where to find them. Data available to us showed that the practice had average or higher than average achievement levels for the Quality and Outcomes Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements.

We saw that the GPs and practice nurses used bespoke diagnostic and assessment templates that the practice had developed based on national guidance. We saw examples of the templates used for patients with mental health needs and high blood pressure. These were clear and well-designed tools to assist the clinicians provide patients with effective care. We also saw that the clinical audits that GPs had done over a period of five years reflected information from NICE guidelines.

One of the GPs was trained to use a dermascope, equipment used to assist improved accuracy of diagnosis of melanoma, the most serious type of skin cancer. The GP had established through their minor surgery audits that their use of this equipment since August 2014 had improved the practice's diagnostic accuracy and resulted in more effective use of the secondary care dermatology service for skin cancer by reducing referrals by an approximately 50%. The practice's referrals were also about 50% lower that the CCG referral rates. This was because they were able to carry out procedures within the practice as a first step which also meant that patients did not have to wait to for hospital appointments. We looked at the minor surgery audits for 2013 and 2014 and noted that waiting times for procedures at the practice had reduced from an average of 23.55 days to 19.56 days.

Management, monitoring and improving outcomes for people

The practice had identified 200 patients with the most significant care needs who needed support to reduce the risk of unplanned admissions to hospital. The practice had a process to provide care plans for those patients and we saw evidence that these were comprehensive.

Patients experiencing poor mental health were offered an annual health review which the practice booked as a 30 minute appointment at a time convenient for the patient and with the GP they preferred to see. The practice explained that in certain circumstances they worked closely with other professionals involved in patients' care to make sure they had the support they might need to attend their appointment and gain the most benefit from this. One of the GPs co-ordinated these reviews, monitored the register of patients and checked the welfare of those who did not come for their appointments. We learned that the annual reviews took into account patients' employment, home circumstances and support networks in addition to their physical health. We saw that the GPs used a template for these reviews which they had developed themselves based on national guidelines. The template ensured the reviews covered all the necessary information so that they were as effective as possible. At the time we did the inspection the practice knew that they had reviewed 66 of the 83 patients (80%) on their mental health register between April 2014 and the beginning of March 2015. Reviews of patients' health included three monthly blood tests for those on specific medicines. These were done by the phlebotomist (a person trained to take blood) and the results were all monitored by one GP. Data showed that in the year ending April 2014 92.11% of patients with mental health needs had a care plan in place compared to the national average of 86.09%.

The practice explained to us that they had always had low numbers of patients living with dementia and had been surprised by this. They had audited their patient records to identify patients they may have missed and had recently used a national audit tool which had led them to identifying more patients who might have dementia. The practice provided annual reviews for patients who had a diagnosis of dementia. These were booked as 30 minute appointments and patients' main carers were invited to attend with them. The GPs went to patients' homes for these reviews if this was easier for the patient and their carer. The practice encouraged carers to register on the practice's carers register so the practice were more aware of their needs and they could be put in touch with local carer

support organisations. Patients and their carers were actively encouraged to plan for the future including providing the practice with the carers' contact details and consent to discuss care and treatment needs with them. One of the GPs had the lead responsibility for making sure patients' reviews were arranged and in 2013/14 data for the practice showed they were in line with the national average for this work.

Two of the GPs had a specific interest in the needs of patients with learning disabilities and they carried out all of the annual reviews for those patients. The review appointments were booked for 30 to 40 minutes to make sure there was enough time to speak with patients and explain things to them. The practice told us that this meant they had built up relationships with those patients who trusted them and were comfortable discussing their care needs with them. The practice used formats which were suitable for patients' communication needs and included pictorial prompts and short, easy to understand words and phrases.

Every patient over the age of 75 had a named GP who had been agreed with each of them based on their preference. During 2014 the practice had identified the 2% of their practice population who were most at risk of hospital admission. They told us that many of these patients were over 75. Each of these patients was offered a 30 minute appointment to discuss their health and plan their care with the aim of avoiding unplanned hospital admissions. The practice was about to begin a review of all of their patients aged over 75 in partnership with Age UK. The aim of this work was to empower patients and to identify those most at risk due to their levels of frailty. The practice explained that they planned to carry out more preventative care and as part of this offered one hour appointments for those older patients at highest risk. GPs made daily visits to a local nursing home which was contracted to provide 12 places for patients discharged from hospital under a scheme to facilitate early discharge and provide intensive assessment.

The practice had a register of their patients who were receiving care and treatment at the end of life so that the team were aware of these patients and could respond promptly when needed. They provided information about those patients to the local out of hours and ambulance services to help ensure a seamless approach to patients' needs. We saw that the practice had a white board with key information for staff to refer to so that these patients and their carers received a prompt response when they telephoned the practice. Patients at the end of life had written care plans and where appropriately agreed had 'do not attempt resuscitation' information available so that patients would not be resuscitated against their wishes. The practice team used a locally agreed variation of the gold standards framework for end of life care. The manager of a local care home confirmed that the GPs involved appropriate people in discussions about patients care at the end of life.

The practice had a proactive approach to the care of patients living with long term conditions. They had identified the 2% of patients at the highest risk and had developed written care plans for those patients following a minimum of 30 minutes appointment to review their health and discuss their care and treatment needs with them. The review appointments also looked at patients' medicines and lifestyles. The practice contacted patients on their birthdays to arrange reviews because this was convenient, memorable for patients and avoided duplication. Patients with more than one condition which needed monitoring had one appointment where their overall health was checked so they did not need to visit the practice more than once. Staff showed us the admissions avoidance register on the computer system and how they monitored this to follow up patients who had not responded to requests to come in for their routine health reviews. The practice believed the effectiveness of their recall system was reflected in the fact that their emergency admission rates for chronic heart disease and chronic obstructive pulmonary disease (COPD) was significantly below the national average. For example for the period October 2013 to September 2014 the data value for admissions for patients with COPD was 4.66% compared to the national figure of 12.88%. For the same period chronic heart disease admissions figures were 3.7% compared to 7.95%. A practice nurse told us they and the GPs met regularly to discuss the management of diabetes to ensure they provided evidence based care and appropriate monitoring.

The Practice Nurses provided wound care and were trained to treat complex leg ulcers. They were also appropriately trained to carry out measurements (known as ankle brachial pressure index or ABPI) of the fall in blood pressure in the arteries supplying the blood supply to the leg for those patients.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Clinical audits are a process by which practices can demonstrate ongoing quality improvement and effective care. We saw evidence that the GPs had been carrying out full clinical audit cycles over a number of years. For example a GP was in their fifth year of auditing their clinical audits of minor surgery. Another GP had completed two full audit cycles relating to the effectiveness of joint injections. One of the GPs was continuing work to audit women on the combined contraceptive pill in respect of their body mass index (BMI). They were working in conjunction with the practice nurses to monitor the health and weight of women using this method of contraception. Between September 2013 and April 2014 the number of women with a BMI of over 30 had reduced from 34 to 21 and the number with a BMI over 35 had reduced from three to two. One woman had been changed to an alternative contraception method. The GP had also added alerts to the patient records and updated the practice protocol. They intended to complete a further audit to assess the impact on recording of BMI, contraceptive prescribing and the multiple risk factors for women with a high BMI scores.

The practice team included a pharmacist to support the practice in providing safe and effective medicines management. Their role included supporting the GPs and nurses with pharmacy advice, reviewing prescribing and monitoring medication safety alerts to make sure these were acted on in a timely way. The practice told us that having a pharmacist had resulted in them being one of the most cost effective prescribers within the CCG and had helped with the smooth introduction of electronic prescribing. The pharmacist told us they worked with local care homes to improve medicines stock control. They also told us that they had carried out an audit of high dose inhaled medicines which had resulted in stepping down treatment for patients in line with evidence based guidance.

We identified that the practice did not have a system for making sure that women receiving long acting contraceptive injections were reviewed every two years by the prescriber as set out in clinical guidance from the Faculty of Sexual and Reproductive Healthcare. The practice nurses and GPs discussed this on the day and told us they would set up a system for this straight away.

Effective staffing

We found that the partners were very aware of the value of education and effective skill mix not only for the GPs but also for members of all staff groups within the practice. Castle Medical Centre was a training practice providing GP training places for up to two GP trainees. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The practice also provided placements for medical students who had not yet qualified as doctors. As well as a team of five experienced GP partners who were well established at the practice the salaried GPs were also enthusiastic and committed to the practice. We learned that two of them had joined the practice having previously worked there as registrars during their GP training.

During the inspection we met with the two GP trainees who were currently working at the practice. They described having a two week induction when they started which had included spending time with staff in all roles at the practice. They confirmed that they had gradually been introduced to seeing patients both independently and with the partners and salaried GPs and said they always had access to an experienced GP if they needed advice. They told us that the partners took an interest in them and that they were benefitting from the breadth of skills available within the practice. A salaried GP who had not been at the practice long gave a similarly positive view of their experiences of joining the practice.

The practice had two managers who job shared this role and during the inspection demonstrated that they worked effectively as a team. They had both worked at the practice since 1989 and both had master's degrees in primary health care management. The practice also had a reception manager who was responsible for leading the team of reception staff. They had been promoted to this post in September 2014 and told us they had started a level five diploma in primary care and health management. They told us they were being supported and funded by the practice to do this and had half a day each week protected learning time to help them do the work involved.

The GPs, nurses and healthcare team at the practice had knowledge and skills which enabled the practice to offer a wide range of services to patients. The nurses and healthcare team gave us examples of training they had done. We met a healthcare assistant (HCA) who provided phlebotomy (taking blood samples). They had completed their NVQ level three and were also a national phlebotomy

trainer. The HCA was also trained to do electrocardiograms (ECGs) and spirometry (a spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function). The practice nurses had completed training at diploma level in respect of asthma, diabetes and chronic obstructive airways disease. The practice provided wound care including for leg ulcers which were slow to heal. The practice nurses were appropriately trained to carry out measurements (known as ankle brachial pressure index or ABPI) of the fall in blood pressure in the arteries supplying the blood supply to the leg for those patients.

The GPs' annual external appraisals and requirements for revalidation were up to date. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

All the staff we spoke with felt supported by the practice and were encouraged to develop their knowledge and skills. There was a structured system for providing staff in all roles with annual appraisals of their work and training needs.

The GPs were attending dementia friends training provided by the Alzheimer's Society to increase their knowledge and awareness of dementia and become a dementia friendly organisation. Some staff at the practice had also recently attended training about care of patients at the end of life.

Working with colleagues and other services

The practice worked with health and social care professionals in a range of arrangements for patients with differing circumstances. The GPs met every six weeks with community and Macmillan nurses to discuss the care needs of patients with cancer and those receiving palliative care. A GP also told us that the practice worked closely with the specialist team from a local hospice. They met every two weeks with health visitors to review the care of children and young people known to be living in vulnerable circumstances such as those with child protection plans in place.

The practice provided GP care to older people living in a local care home which was contracted to provide 12 beds for patients discharged from Warwick hospital with a planned length of stay of six weeks. Their role in this project involved taking part in weekly multi-disciplinary meetings with the hospital discharge team, nursing home staff, occupational therapists and physiotherapists to discuss and plan the needs of patients. The manager of the care home confirmed that the practice worked with them in a supportive and helpful way. They said that the GPs were approachable and that staff at the home could talk to the GPs at any time.

The practice engaged fully with the South Warwickshire clinical commissioning group (CCG) and one of the partners was the chair. The practice managers were part of a local practice manager network which met each month to provide support and share information. Both managers had outside roles; one supporting another local practice one day a week and the other recently appointed as a director to a local GP federation and supporting local training practice assessment visits.

Information Sharing

Information was available for all staff to access on the shared drive of the practice's computer system. All of the staff we spoke with knew this and gave us examples of information they might look for such as policies and procedures and safeguarding information.

The practice had a system for making sure test results and other important communications about patients were dealt with. The system ensured that if the relevant GP was not at work when results arrived these were assigned to other GPs so that there were no delays in contacting patients if urgent action was needed. Administrative staff we spoke with understood the systems used by the practice and their individual role in making sure these worked smoothly. One of them told us that everyone worked hard to keep the workflow of results and tests up to date and that normally these were dealt with on the day they arrived. When GPs referred patients for tests in respect of suspected cancer they followed national and local guidelines in respect of the two week cancer referral targets. The administration team followed these referrals up to make sure patients received outpatient appointments. The practice also told patients to telephone if they did not hear from the hospital.

The practice had clear systems for making information available to the out of hours and ambulance services about patients with complex care needs, such as those receiving end of life care. Staff told us that one of the GPs was

responsible for updating this information at least weekly and that two other GPs, the practice managers and one of the administrative team were also familiar with how to do this if necessary.

The practice used the Choose and Book system which enables patients to choose which hospital they will be seen in and to book outpatients' appointments in discussion with their chosen hospital. We saw that during the last year the practice had made 95% of its referrals to secondary care using this system.

The practice recognised the importance of confidentiality and had a confidentiality policy. The practice had a poster in the waiting room and information on their website to inform patients about their rights regarding how their information was managed. This included information about summary care records and Care data and how patients could opt out of these if they wanted to. The summary care record (SCR) is an NHS computer system intended to help emergency doctors and nurses with patients' care when their GP practice is closed. This currently only contains information about medications and allergies. Care data is an NHS England initiative which can extract data from practice records for health research purposes.

Consent to care and treatment

The practice had a policy to support staff in fulfilling the requirements of the Mental Capacity Act 2005. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them.

The practice team understood the importance of considering the patients' ability to make informed decisions about their care and treatment and give consent for this. In October 2014 the practice arranged a talk for patients and carers by staff from the Office of the Public Guardian (OPG) about how to make a lasting power of attorney (LPA). This is a legal arrangement to assist people who lack capacity to make their own decisions to designate one or more named people to support them. Thirty five patients attended this talk. The practice provided information about the talk and how to contact the OPG in its winter 2014 newsletter so that those unable to attend the talk could also benefit from the information provided.

The GP with main responsibility for safeguarding and mental capacity related issues told us that they actively encouraged patients and their families to talk about the benefits of arranging a lasting power of attorney.

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence. The Gillick Test helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Staff we spoke with understood the importance of gaining informed consent and knew where the practice's consent forms were stored if they needed to use one. Members of the team could describe situations where they would need to consider whether or not a person had capacity to give consent to a procedure or treatment. A GP and a healthcare assistant described three situations where they had needed to take the principles of the MCA into account when decisions needed to be made about what course of action was in the best interests of the patients concerned. The manager of a local care home confirmed that the GPs understood the issues to be considered in respect of the MCA and worked with the staff at the home to deal with issues such as consent and decisions about end of life care in a sensitive way. The confirmed that they involved the right people in making decisions in patients best interests when they were too ill to be involved themselves.

GPs confirmed that they always obtained written consent for minor surgery.

Health Promotion & Prevention

The practice nurses, healthcare assistants and phlebotomist provided appointments for a range of health checks and conditions. These included blood tests, health checks, baby immunisations and health reviews for patients with long term conditions such as diabetes or respiratory problems. Patients were offered support to stop smoking by the practice nurses and HCAs who worked in partnership with a local smoking cessation co-ordinator. The practice also provided phlebotomy (taking blood samples), electrocardiograms (ECGs) and spirometry (a spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function).

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice had an informative website which could be set to display the information provided in 90 languages. The website provided information about a wide range of health and care topics arranged according the gender and age of patients to help people find the information they needed.

To provide flexibility for working parents appointments for childhood immunisations were available throughout the week rather than on specific days.

One of the practice nurses was responsible for the practice's cervical screening programme. The data available showed that the take up of screening at the practice was in line with the national average. Patients could also have long acting contraceptive devices and implants provided at the practice at appointment times to suit them.

The practice held an annual flu vaccination clinic where a national charity provided teas by donation. The practice actively targeted older patients so they had the option to receive relevant vaccinations. This included calling patients for flu and pneumonia vaccinations and for shingles vaccination on a rolling programme for those between the ages of 70 and 80. National data showed that the practice had achieved higher than the national average figures for providing flu vaccinations to patients aged 65 or over (84% compared with 73%) and for those in high risk groups (62% compared to 53%).

Travel health information was available on the practice website and the practice was a yellow fever vaccination centre so patients were able to receive this vaccine on site in addition to the more usual travel vaccinations. Evening appointments were available for this to benefit patients who could not visit the practice during the day.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered patients view by looking at 15 Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with four patients one of whom was a member of the Castle Medical Centre Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. Data available from the NHS England GP patient survey results during 2014 showed that the patients had reported positive views about the practice. The practice matched the national average score in respect of patients' overall satisfaction with the care they received (85.39% compared to 85.01%).

Results from the GP patient survey during 2014 showed that 88% of patients confirmed that they felt their GP was very good or good at treating them with care and concern compared to the national average of 85%. Responses for the care and concern shown by the practice nurses were also positive with 89% being happy with this compared with the national average of 90%.

Information written by patients in the comment cards gave a positive picture of patients' experiences. Patients used words such as brilliant, superb, caring and considerate to describe the team and confirmed that they were treated with dignity and respect.

A patient who was a member of the PPG spoke with us and described the staff as caring and compassionate. They confirmed that they had never heard staff discussing anyone's care where other patients might be able to overhear and that staff always knocked and waited to be asked in if they needed to go into a room during a consultation.

We spoke with the manager of a local care home where some of the practice's patients lived. They told us that the GPs took their time to sit and speak with patients they visited, were approachable and provided a personalised service.

Care planning and involvement in decisions about care and treatment

Patients told us they were very happy with the service they received and included all staff groups at the practice in their praise. Some patients described specific examples of how the care the practice had provided care and treatment to them or members of their family. They described receiving swift and effective treatment. In one case this had been in response to a medical emergency which a GP had responded to during their lunch break. The GP then followed this up to make sure the patient received the care they needed subsequently. The managers of local care homes told us that the GPs involved patients and their families appropriately in discussions about their care. As an example of this one described a situation where two of the GPs provided sensitive and supportive information to help a family reach a decision about a patient's future care needs.

One aspect of the practice's new appointment system which started in February 2015 was that it gave patients more control over which GP they saw. Some patients commented that they had been pleased that they were able to see or speak with the GP who knew them best. Patients told us their GP gave them the time and attention they needed and several mentioned feeling well supported over the years or during extended periods of treatment.

Results from the GP patient survey during 2014 showed that in response to a question about trust and confidence in their GP 94% of patients who responded said that they trusted their GP. Eighty three percent felt that their GP was very good or good at involving them in decisions about their care compared to the national average of 81%. Most other survey results were in line with the national average although the results for patient satisfaction with the nursing team were slightly lower than the national average.

The practice had identified 200 of their patients with the highest level of need who were most likely to require urgent medical assistance or have an unplanned hospital admission. The practice confirmed that they had developed care plans for all of these patients and we saw evidence that these were comprehensive. Patients needing care at the end of their lives also had advanced care plans.

Patient/carer support to cope emotionally with care and treatment

The information contained in the comment cards showed that patients felt supported by the practice. One patient commented that they and their family had been well supported over the years and another told us that the practice had been very supportive towards them following

Good

Are services caring?

the death of a close family member. A family member described how one of the GPs had telephoned to say they were running late when they were expected at the home of a patient who was very ill so they knew when to expect them.

Staff at the practice had attended local training about meeting the needs of patients at the end of life. The practice had clear information available for staff to make them aware of patients nearing the end of their lives where a rapid response may be needed to provide the necessary care or emotional support.

Information about local health and social care organisations and sources of support and guidance was available on the practice website and at the practice. This included details of various support groups and organisations for carers and families. Patients who were carers were encouraged to register so that the practice were aware of their role and could direct them to local carers' organisations for practical support and advice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Information we obtained before the inspection from the NHS England Area team and South Warwickshire Clinical Commissioning Group (CCG) provided a picture of GPs who engaged positively with these organisations so that they had a good understanding of the wider picture of health provision in the local area. One of the practice GPs was actively involved as the chair of the CCG.

The practice had a register of people with mental health support and care needs. Each person on the register was invited for an annual review of their overall health with the GP they preferred and at a time to suit them. The team were alert to the complex needs of people who were living with dementia and had a dementia register. GPs told us that they reviewed these patients' needs at least annually and invited carers to take part in this so that they could contribute and have their needs as a carer recognised. Longer appointments of 30 to 40 minutes were booked for patients to ensure there was time to talk about their care adequately and the GPs did home visits for patients with dementia if this was easier for them and their carers.

The practice provided GP care to older people living in three local care homes. At one of these they provided care to patients living at the home permanently and for patients benefitting from a scheme called 'Discharge to access' (D2A). Under this scheme the home was contracted to provide 12 beds for patients discharged from Warwick hospital with a planned length of stay of six weeks. The aim was to support patients to achieve the best recovery they could and to assess their future care needs. The commitment for the practice included a daily visit to the nursing home to see patients and attendance at a weekly multi-disciplinary meeting with other professionals (hospital discharge team, social services and occupational therapists and physiotherapists. Whilst they did not yet have hard data for this the practice believed that the initiative had reduced hospital readmission rates and improved the experience of hospital discharge for patients. The practice considered that this provided a more dignified and personalised approach to care in a setting where it was also easier for families and friends to visit. The practice told us that as an additional consequence of the initiative Warwick hospital's four hour target for seeing patients in the accident and emergency department had improved as a result of the hospital having access to these beds, therefore improving patient flows through the hospital. We spoke with the manager of this care home who told us that the practice provided patients there with a responsive and personalised service. They confirmed that the GPs worked in partnership with them and responded in a helpful way when staff felt a person needed to see a doctor. The practice received some funding for the scheme but this did not cover the cost of the daily visits or weekly meetings. The practice had accepted the cost to them because they recognised the value of the scheme and the benefits to individual patients and their families. The managers from the other two homes were also positive about the service provided by the practice.

The practice provided a case study about a patient who had benefitted from the D2A scheme. The patient had been very weak when they were admitted to the care home but was assessed as no longer needing hospital care. The care provided by the nursing home staff in liaison with the GPs from Castle Medical Centre resulted in the patient improving over a period of just under six weeks. They gained weight, their mobility improved and their family noted an improvement in their mental and physical wellbeing. While the person needed to move to a care home long term rather than returning home they did so in improved health and without a long stay in hospital while they waited for a place to be available for them.

Longer appointments were arranged to review older patients' health. These were for 30 minutes to an hour depending on individual circumstances and the complexity of a patient's needs.

The practice used a locally agreed alternative to the gold standard framework for end of life care and had a register of patients receiving palliative care. The practice took part in two monthly meetings with other professionals involved in caring for patients in these circumstances. They had a clear system for making sure members of the team, including reception staff and those who answered the telephones, were aware of patients who were at the end of their lives and might need an urgent response from the team.

One of the GPs was trained to use a dermascope, equipment used to assist improved accuracy of diagnosis of melanoma, the most serious type of skin cancer. The GP had established through their minor surgery audits that their use of this equipment had improved the practice's

Are services responsive to people's needs?

(for example, to feedback?)

diagnostic accuracy and resulted in fewer referrals to secondary care dermatology services for skin cancer. This was because they were able to carry out procedures within the practice as a first step which also meant patients had a shorter wait for treatment. We looked at the minor surgery audits for 2013 and 2014 and noted that over the last two years waiting times at the practice for procedures had reduced from an average of 23.55 days to 19.56 days.

The practice was planning to provide a programme of patient education evenings each year and had held the first of these in October 2014. This was about how to make a lasting power of attorney (LPA). This is a legal arrangement to assist people who lack capacity to make their own decisions to designated one or more named people to support them. The practice had invited a member of staff from the Office of the Public Guardian (OPG) to lead this evening which 35 patients attended. The practice provided information about the talk and how to contact the OPG in its winter 2014 newsletter so that those unable to attend the talk could also benefit from the information provided. The practice told us this had resulted in an increased number of patients with LPAs. The practice had carried out a survey of patients who attended the meeting. The results indicated that 96% of them intended to arrange an LPA and six had already done so. Practice staff were following this up with the remaining patients to ensure that the practice had up to date information. The practice had also scheduled a talk by the Alzheimer's Society for patients and carers regarding dementia in March 2015. The GPs were attending dementia friends training provided by the Alzheimer's Society to increase their knowledge and awareness of dementia and become a dementia friendly organisation.

Tackling inequity and promoting equality

The practice building was purpose built on three floors with a passenger lift for patients unable to use the stairs to the consulting rooms upstairs. There were automatic entrance doors to make it easier for patients with mobility difficulties and families with prams and pushchairs to get in and out of the building. Staff told us that although there was a lift they often arranged appointments in the ground floor rooms for patients who found the lift difficult to use. Although the practice had limited parking there were public and supermarket car parks within walking distance and there were two disabled parking spaces at the front of the building. We saw that the practice had a wheelchair available for patients to use.

The practice nurses and GPs visited patients at home if their health or mobility meant they were unable to go to the practice so that they were not disadvantaged by this. A practice nurse explained that when they visited patients at home for specific things such as blood tests and monitoring of anti-coagulant (blood thinning medicines) they also offered flu vaccinations and reviews for long term conditions at the same time to make best use of the visits.

Staff told us that the practice did not have any homeless patients or traveller families registered with them but would respond as needed if approached by patients who needed to be seen.

The practice used a telephone interpreting service for any patients who were unable to converse in English. Staff knew about the service and how to access it if a patient needed support. The practice website had a translation service offering 90 languages which patients could use to translate the content into the one they used. GPs also had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this. Staff explained that the practice population was not culturally diverse and so whilst interpreting and translation services were available they only needed to use them occasionally. One member of the reception team described an occasion when they had arranged an interpreter for a patient. They initially used the telephone service to speak with the patient and then arranged with them to come to the practice to support the patient during their appointment.

The practice had a portable induction loop to assist people who use hearing aids. The practice leaflet explained that they added an alert to the records of patients who found it difficult to speak to reception staff on the telephone due to hearing loss. Those patients could come to the practice to request an appointment and they could wait to see a GP in person although they might need to wait.

We did not identify any indication of discrimination on any grounds during the inspection.

Access to the service

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice's main opening hours were 8am to 6.30pm Monday to Friday and from 8am to 11am on Saturdays. Results from the GP patient survey during 2014 showed that the practice's scores for opening hours and getting through on the telephone were slightly lower than the national average. The practice had recognised this as an area to improve and had recently introduced a new telephone and appointment system which was receiving a positive response from patients. Several patients specifically told us about this improvement in their comment cards and gave examples of how well the new system had worked for them. We spoke with some of the reception staff about the new system and they were also positive. They told us patients appeared happy with it and that it had reduced pressure on the GPs. We saw that the practice had produced a leaflet to explain the new system to patients. This information was also available on the practice website. The information was detailed and included a frequently asked questions section.

The new system meant that patients wanting an appointment could telephone the practice on the day they wished to be seen. The reception team took their details and a GP called them back to discuss their needs and if necessary book a time for them to come to the practice. Patients could also book their telephone call from a GP online. If their need was not urgent they could make their initial telephone call at any time up until 4.30pm and receive a call back from a GP that day. Patients with an urgent need could call after 4.30pm and be dealt with that day. Patients could ask to speak with a specific GP and this was accommodated as far as possible. The practice provided information about the days of the week each of the GPs worked so that for non-urgent issues patients could phone on the day their preferred GP would be available. Staff told us that the GPs aimed to speak with patients who telephoned in the morning by 1pm and those who telephoned in the afternoon by 6pm. Reception staff asked patients for brief details to assist the GPs when they called patients back but if a patient preferred not to share information they would still be added to the list for a GP to telephone them.

One patient told us that the new system did not work very well for them due to working a distance from the practice which made it difficult to travel back to see a GP once they had spoken with them by telephone. It also meant they could not arrange time out of work in advance. We noted that the practice leaflet highlighted that the practice was open late one evening a week and that appointments were available on Saturday mornings. The practice information explained that patients could agree a mutually convenient date and time for their appointment when they spoke with the GP on the telephone.

The system did not provide for patients to book appointments in advance except for some specific appointments such as planned minor surgery, contraceptive coil fittings and contraceptive implants. Patients requesting appointments with the practice nurse or HCA could pre-book in advance, with provision for urgent patients to be seen on the day. There was also a provision should a patient speak to the GP and need to see the nurse, to accommodate them the same day. In addition the practice provided some late evening and Saturday morning nursing appointments.

Staff highlighted to us that if patients concerned about skin lesions telephoned on the day the GP who carried out minor surgery worked they could usually be seen that day. This reduced the anxiety of having to wait for an appointment. This GP told us that since the introduction of the new appointment system they often saw patients to assess moles on the day they first telephoned and carried out such procedures on most days they worked. This was confirmed by a patient in a comment card who said they were seen by this GP within an hour of phoning the practice.

The practice provided information about out of hours arrangements on their website and in a leaflet available in the practice. The out of hours service in Warwickshire was run by an organisation called Care UK and was based at Warwick Hospital.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns including a comprehensive complaints procedure to provide guidance to help staff deal with all concerns and complaints in a helpful and constructive way. The practice managers held the lead responsibility for complaints handling. The complaints policy provided the names and contact details of the practice managers and informed patients that if they did not wish to contact the practice direct they could complain direct to NHS England. Staff told us they always tried to resolve patients' concerns at an early stage so they did not develop into more serious complaints.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We saw evidence to show that the practice discussed concerns and complaints at team meetings and used these to help them improve the service. The practice audited any complaints they received and the results were discussed at practice meetings. A GP spoke with us about a complaint which the practice had logged as a significant event and already looked at in detail but would be discussing again at the next significant event meeting to ensure that any learning from this was identified and followed up. This GP also explained to us that any complaints relating to the care or treatment by one of the GPs or nurses were peer reviewed by colleagues.

We met a patient during the inspection who was not satisfied with the care of their relative. They had not made a complaint to the practice. They gave us their permission to tell the practice they had spoken with us. The practice manager said they would note the information as a complaint and contact the family to arrange to discuss their concerns with them.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and Strategy

The practice team showed a strong commitment to providing patients with a safe, high quality and caring service. They were clear about the practice's values and aims which they described as providing good quality care, teamwork, teaching and training, improvement and involvement in local, regional and national decision making. All of the staff we met were enthusiastic, enjoyed working at the practice and confirmed that their experience of working at Castle Medical Centre fitted with these values. Throughout the day we saw examples of staff working together as a team and the practice managers told us that the team had all worked together to support the partners in respect of the inspection.

The practice leadership team were aware of the importance of forward planning to ensure that the quality of the service they provided could continue to develop. They viewed their involvement in GP education as an important part of this bringing with it the prospect of encouraging newly qualified doctors to consider careers in general practice.

The partners and practice managers held an annual general meeting to consider the business plan for the forthcoming year and develop and action plan. The practice managers told us that they shared a summary of the action plan with the patient participation group (PPG) to enable them to contribute if appropriate. A PPG is made up of a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The partners were committed to improving primary healthcare and recognised the value of research. They told us this was because the majority of NHS clinical encounters took place in GP practices. They had been a host practice for the Primary Care Research network (PCPR) since 2011 and a research nurse was based there for two days a week. The practice told us they were only involved in university based research and not that led by medicines manufacturers. A primary care research nurse had recently started work at the practice for two days a week. The practice had provided patients with information about this so that they were aware that they may be contacted to be invited to take part in research projects based at the practice.

Work was in progress to plan and implement alterations to the building. The practice had identified that although purpose built the practice building needed to be upgraded and extended to help them keep pace with increased future demand and provide care in the best possible environment.

Governance Arrangements

The five GP partners all had lead roles and specific areas of interest and expertise. These roles included specific lead roles at the practice such as safeguarding, GP trainee and medical student training, Care Quality Commission lead, and cancer and palliative care lead. The practice also had a lead for the Quality and Outcomes Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. They also all had roles in the wider local medical community such as the South Warwickshire Clinical Commissioning Group and local GP Federation and in education and training.

It was evident that the practice managers worked closely together to ensure that all aspects of governance were well organised. This included the policies and procedures that were available to support the effective management of the practice. These were available for all staff on the practice's computer system, something that most staff referred to at some stage during our discussions with them about a range of subjects. All members of the team we met understood their roles and responsibilities.

The practice was developing the use of information technology to assist in the day to day management of the practice. They had already introduced an application that staff could use on smart phones and tablets to check rotas and staff meeting dates and in the future were looking at remote electronic prescribing for GPs on home visits. We saw that the practice managers were able to monitor which staff had read the practice's policies and procedures because the computer system was set up to provide an audit trail.

The practice held a variety of regular meetings and events to provide opportunities for communication, team building and shared education and learning. These included monthly evening meetings used for educational purposes

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to which the practice often invited external trainers and speakers. In the previous year topics covered in these meetings included dementia care, mental health and addiction and QOF.

The practice held a variety of meetings to support the management of the practice and the ongoing education of the staff team. These included business meetings every two weeks attended by partners, managers and a representative from the salaried GPs and staff training/ information meetings every month which were open to all staff. These were used to deliver mandatory staff training as well as talks and training about clinical practice and other relevant topics. The practice nurses and healthcare team met every two months with the practice managers. The practice was 'buddied' with another practice in the town and met with them quarterly to share good practice.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. One of the GP partners was the lead for QOF. They told us they had achieved good QOF results because of their proactive assessment and recall arrangements which ensured patients who needed to be reviewed were seen.

We saw examples of clinical audit cycles and a summary of completed audit cycles over a five year period which demonstrated that the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had well organised management arrangements to support the GP partners in the running of the practice. The practice had two practice managers who job shared this role and during the inspection demonstrated that they worked effectively as a team. They had both been employed by the practice since 1989 and had master's degrees in primary health care management . Both undertook other NHS related roles outside the practice. The practice also had a reception manager who was responsible for leading the team of reception staff. The practice introduced this role in September 2014 having recognised the benefit of providing direct leadership and support to the reception team. Staff told us that this helped to ensure that any difficulties in reception or on the telephones could be dealt with promptly.

The practice spent time together outside practice hours to help them build and develop their relationships as a team. For example, in September 2014 staff and members of their families took part in a local charity dragon boat race.

Staff told us that the practice was a friendly and supportive workplace and that there was an open door policy. The practice had a whistleblowing policy which included information about the rights and responsibilities of staff. Staff knew this was available on the computer system and told us that the team had discussed whistleblowing at staff meetings. Staff told us they would not hesitate to report concerns because they knew they would be well supported by the practice.

The GP trainees we spoke with described an open and flexible working environment where they felt supported by the partners and were always able to ask for advice. This view was echoed by a salaried GP who had recently joined the practice who told us that all of the partners worked hard to make the practice work well.

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

The practice had a well-established patient participation group (PPG) which started in July 2011 and held its first meeting in November 2011. During the inspection we met a member of the PPG. They gave a positive picture of the practice and gave us numerous examples from their own experience of ways the practice team worked to provide patients with good quality care.

We saw a copy of the PPG report for 2013/2014 based on meetings between June 2013 and March 2014. We saw that the PPG held five meetings with the practice during this period each of which was preceded by a meeting for PPG members only. The PPG viewed this as an opportunity to discuss priorities before meeting with the practice team. The PPG had identified that some population groups were under represented on the group. They and the practice team were addressing this by raising patient awareness. Information was available in the practice to advertise the PPG, members attended flu clinics to tell patients about it and GPs were speaking with patients from underrepresented groups during appointments to encourage them to consider taking part.

The report included an action plan based on the results of a patient survey during 2013/14. The action plan detailed numerous actions agreed by the practice in response to the

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survey results. These included increasing surgery opening times and the hours when the phone lines were open, employing an additional nurse and healthcare assistant to improve capacity and flexibility for appointments, exploring alternative appointment systems and developing ways of communicating with patients. The report also provided an update about the actions resulting from the 2012/13 surveys. The practice had recently introduced a new telephone and appointment system in response to patient views about access to appointments and getting through on the telephone. The practice carried out extensive research and involved multi-disciplinary stakeholders, the PPG and independent audit to help them decide what changes to make. The new system had been operating for four weeks when we inspected and was receiving a positive response from patients. Several patients specifically told us about this improvement in their comment cards and gave examples of how well the new system had worked for them. The reception manager was responsible for monitoring how the new system was working and told us that the practice planned to carry out a formal review after three months.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. This was well publicised in the practice newsletter and in the building with posters, comment cards and boxes prominently displayed together with information about recent results. The comment cards asked whether patients would recommend the practice using text and smiling, neutral and frowning faces so that patients who were unable to read the text would be able to use them too.

Throughout the inspection members of the team we spoke with told us they felt supported and that the partners and practice management team were approachable. Staff said they felt they could raise any concerns they might have and felt valued and listened to.

Management lead through learning & improvement

We saw evidence that the practice valued the importance of quality, improvement and learning. There was a well-established staff development programme for all staff within the practice, whatever their role. The practice had an annual training timetable and this detailed the planned training for the team and which roles each course was aimed at. We saw that the timetable for 2014/15 included topics aimed at the GPs and practice nurses such as diabetes and asthma updates, a talk by an external speaker about general adult and addiction psychiatry and training by the Alzheimer's Society. There had been training for the whole team about a range of topics which included fire safety, the practice computer system, chaperoning, the Friends and Family test and consultation skills.

Castle Medical Centre had been a training practice since 1982 and GP education was a significant aspect of the practice's work. One of the GPs was a programme director for the local GP Speciality Training Programme, the route for qualified doctors to train to become GPs. The practice valued the contribution that their involvement in GP education made to the learning and development of the practice overall. They provided GP training places for up to two GP trainees. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. Two of the partners at Castle Medical Centre were GP trainers. We met the current GP trainees during the inspection.

The practice was also a teaching practice and had provided placements for medical students for 30 years and had four GPs who were trained to support them. The practice had a structured induction programme for all medical students and GP trainees. One of the GPs was the local training support lead for Coventry and Warwickshire and several of the GPs had fulfilled other education and support roles. These included supporting GPs to return to practice after suspension and retraining a GP following a career break which led to them being successful in obtaining a GP post.

The practice told us they were in discussion with the local school of nursing to provide placements for student nurses to provide a tailored practice nursing qualification. The practice viewed this as a way to contribute to the recruitment and retention of practice nurses for whom opportunities for specialist training for this branch of nursing were limited.

The practice managers were involved in a local network with colleagues from other practices which held meetings every month. Because there were two of them 'job-sharing' they were also able to provide support to each other.

The staff we spoke with confirmed that they received structured support and an annual appraisal during which

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training needs were identified and discussed. For example, a practice nurse had identified the benefits for the practice of them completing training in the management of chronic kidney disease because they would be able to support an additional group of patients with this long term condition.