

Care Quality Commission

Inspection Evidence Table

Castle Health Centre (1-2196497839)

Inspection date: 14th and 16th September 2022

Date of data download: 07 September 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
The practice completed an annual safeguarding audit toolkit which enabled them to focus and assess how they were implementing and embedding safeguarding into the practice both in practical and cultural ways.	
The provider had not set the safeguarding training requirements for nursing staff for safeguarding level 3 as required. However, we were told all the trained nurses completed the Hot Topic Level 3 update on an annual basis which was provided by safeguarding locally. The new nurses had not yet completed this as new to role. This was planned for the near future to ensure they were working towards towards safeguarding level 3 training in line with The Royal College of Nursing published updated intercollegiate guidance.	

Safeguarding	Y/N/Partial
<p>Castle Health Centre was contracted to take patients allocated to the Special Allocation Scheme. These schemes ensure that patients who have been removed from a practice patient list following an incident that is reported to the police can continue to access healthcare services at an alternative, specific GP practice. The practice had clear arrangements in place in respect of ensuring staff and patient safety when patients on the scheme were allocated to the practice. All patients on the scheme had a set time when they could attend the practice to mitigate risk by ensuring more than one GP was present, and that security was at the practice. A security person was either present in the practice building, outside of the consultation room or in the consultation itself.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	P
<p>Explanation of any answers and additional evidence:</p> <p>The provider did not routinely maintain a record of all immunisations in relation to The UK Health Security Agency (UKHSA) guidance.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 26/01/22	Y
There was a fire procedure.	Y
Date of fire risk assessment: 10/12/2021	Y
Actions from fire risk assessment were identified and completed.	
<p>Explanation of any answers and additional evidence:</p> <p>A range of measures were in place to check fire safety on a regular basis. Fire evacuations were carried out every six months. The last fire evacuation took place on 12/11/2021.</p> <p>Legionella risk assessment completed 08/07/2022</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 26/01/2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Clinical and non-clinical staff had completed the providers mandatory infection prevention and control training.</p> <p>Specific time was allocated to the lead staff member to manage infection prevention control. Infection control meetings took place, and actions identified recorded and followed through to monitor completion.</p> <p>Robust infection prevention and control arrangements were clear during our visit to the practice.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <p>Sepsis training for staff was not included in the providers mandatory training requirements. Shortly following the inspection we were provided with evidence to demonstrate the provider was taking action to address this.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
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Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.</p> <p>The practice had a backlog of patient records to summarise. The practice re-summarised all new patient records to ensure that no information relating to that patient had been missed. A plan was in place to reduce the backlog.</p>	

Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.78	0.86	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	5.6%	7.0%	8.5%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.07	5.08	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	310.9‰	132.9‰	128.0‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	2.37	0.48	0.59	Significant Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	12.7‰	4.7‰	6.8‰	Tending towards variation (negative)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The practice was aware of the negative prescribing audits identified in the table above. For example Pregabalin and Hypnotics. They described in detail the challenges with the patient population in respect of the prescribing of certain medicines and the control measures they had in place, such as weekly prescribing and regular audits. For example, the practice had an audit in place in respect of Pregabalin prescribing (particularly in patient with active substance misuse problems) which was carried out every six months.</p> <p>Our clinical search of high-risk drug monitoring showed the following:</p> <p>Patients prescribed DOACs (Direct-acting Oral Anti-Coagulants - blood thinning medicines) identified that a system was in place for the recall of patients for blood monitoring. However, there did not appear to be an embedded system for ensuring that creatinine clearance check was undertaken to complete the required monitoring. The creatinine clearance test is a test used to check a person's kidney function. We</p>	

Medicines management	Y/N/Partial
<p>identified fifty-five out of the 71 patients had not had the completed required monitoring. We checked in detail the records of five of these patients which confirmed the findings but despite this they were on the correct dose of medicine. The practice informed us there was a process in place and it appeared to be that a certain check was not being recorded in the system to complete the process.</p> <p>Patients prescribed Methotrexate showed a good recall process was in place with varying means of contacting the patient at various times when the patient did not attend for monitoring. Methotrexate is a type of medicine called an immunosuppressant. It slows down the body's immune system and helps reduce inflammation. We identified two out of the 16 patients had not had the required monitoring. We looked in detail at both of these patients records and found multiple attempts had been made to invite the patients for review and noted to discuss with patient opportunistically but in one case in particular active discussion with the patient was not evident considering the length of time since they had last been reviewed. One patient may have been having their monitoring undertaken in secondary care due to the medicine they were receiving but this was not clear. Links to the shared care pathway notes were not evident in the two patient records.</p> <p>Our clinical search of patients prescribed Disease-modifying anti-rheumatic drugs (DMARDs) identified a high number of patients being prescribed 10 or more benzodiazepines (prescribed sedative-hypnotic medications) and Zdrugs (approved for insomnia). However, all appeared to be managed and many of the patients listed were under the care of the Substance Misuse Team. We discussed this with the practice who described this as being representative of the patient demographic. They described how they worked closely with the Substance Misuse Team and tightly managed the issuing of prescriptions to give the practice a higher level of control in terms of the way the patient received the medicine.</p> <p>Our clinical searches identified that medicine reviews were primarily carried out by the GP's. There was evidence that some of these reviews were starting to be completed by a Pharmacist. It was not always clear from the reviews we looked at that every single item and areas that required monitoring had always been considered.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	6
Number of events that required action:	6
Explanation of any answers and additional evidence:	
Significant event processes and procedures were in place at both practice and provider level.	
Feedback provided by staff demonstrated they were aware of their responsibilities to raise concerns and knew how to do this.	

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

Event	Specific action taken
A patient referral was not tasked to the administration team by a clinician. In addition, the administration safety netting systems had not been actioned	Safety netting procedures embedded within the administration team and extra support given to new members of staff. Discussion with clinician involved.
A patient was given a nasal flu vaccine that was out of date by four days.	Professional advice sought, vaccine manufacturer contacted, and guidelines followed. Patient was contacted and given a second vaccine as per the manufacturers protocol and discussion with family.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	

We saw examples of actions taken on past Medicines and Healthcare products Regulatory Agency (MHRA) alerts.

We also looked at a single drug alert relating to Teratogenic Drugs for women of childbearing age. It appeared that patients on specific well-known teratogenic medicines such as sodium valproate had embedded systems to ensure that patients were warned of teratogenicity risk. A teratogen is any agent that causes an abnormality following foetal exposure during pregnancy. We looked in detail at five patients and found three of the patients were prescribed the medicine pregabalin which has increased in use in this age group. We were told the practice had recently written to such patients to make them aware of this risk.

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	

Effective care for the practice population

Findings
<ul style="list-style-type: none">Multi-disciplinary and safeguarding meetings were evident for the practice population.A wide range of opportunities to engage with patients was evident and where this was not reciprocated the practice staff used any contacts to try and opportunistically review patients.The practice actively managed and encouraged patient engagement with the practice and with other services, particularly for those with poor mental health, taking a holistic approach to their health and well-being.

- The practice proactively worked with patients and other services to assist and support patients with the management of substance misuse issues. The lead GP was a GP with special interest (GPWSI) in substance misuse.
- The practice was contracted to deliver primary care services to homeless patients in the Scarborough and part of Ryedale area. Most of the patients were registered with Castle Health Centre but could be registered elsewhere in the area. A specific nurse was allocated to this role and had recently been recruited to after a period of the post being vacant. They reviewed all patients who attended. The nurse attended local centres such as the Rainbow Centre and undertook clinical assessments there and made use of their bicycle to try and engage and seek out patients in the community who may be homeless. They attended regular safeguarding meetings which included representatives from the Police and housing department. In previous times the nurse had delivered vaccines in the community and was planning to restart this service.
- 3.5% of the practice population were over 75 years of age. The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. The practice contacted patients over 75 years who had not attended the practice for over 12 months to check on their well-being.
- A wide range of vaccinations were offered to patients.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. 459 patients who were eligible had been invited on more than one occasion for a check and 68 had attended.
- All patients with a learning disability were offered an annual health check. At the time of the inspection all 40 patients on the learning disability register had been invited for a health check with 17 having received the check. Further invites had been made to those who had not attended for a check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Hospice at Home was available in the area.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

Our search of clinical records in respect of patients with certain long-term conditions such as diabetes, asthma and hypothyroidism showed a good level of care provided. A small number of minor issues with potential for risk were identified but most of these patients were under secondary care and receiving regular contact from the practice. For example, we identified of the 115 patients identified with hypothyroidism that seven had not had a thyroid function test monitoring for 18 months. We looked in detail at five of these patients and found that they were either under secondary care or in contact with the practice.

Our search of clinical records identified 26 patients with a potentially missed diagnosis of chronic kidney disease (CKD). We looked in detail at five patient records and found all five patients should have been coded/diagnosed with CKD. As a younger population then there can be a greater impact on CKD prevention work as CKD can be a sign of underlying poorer metabolic health. The provider informed us they would review such patients immediately and review the process in place.

Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. GPs followed up patients who had received treatment in hospital or through out of hours services.

Staff who were responsible for reviews of patients with long-term conditions had received specific training. Two new nurses were shortly joining the practice team who specialised in respiratory and diabetes.

The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Adults with newly diagnosed cardio-vascular disease were offered statins.

Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

Patients with COPD were offered rescue packs.

Patients with asthma were offered an asthma management plan.

The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	37	45	82.2%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation	44	54	81.5%	Below 90% minimum

for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	44	54	81.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	44	54	81.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	33	38	86.8%	Below 90% minimum

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

Any additional evidence or comments

Patients not brought for their immunisations are flagged within the practice and with the appropriate professional such as the health visitor for follow-up. This is recorded on the patient record and any contact used to raise awareness of the importance of immunisations.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	53.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	48.6%	69.9%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	51.1%	72.8%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	37.5%	58.5%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
<p>The practice was acutely aware of the challenges it faced regarding uptake of cervical screening and childhood immunisations. They had recently met with Public Health England who acknowledged the practice was doing everything they could in respect of cervical screening to try and increase uptake but was severely challenged by the patient demographic. This area was kept under regular review.</p>

Monitoring care and treatment

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

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

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

Xhantines monitoring August 2021 – August 2022

Xhantines (Aminophylline and Theophylline) are medications used for the management of complicated asthma. Its effectiveness depends on plasma concentrations, and levels above the recommended can cause toxicity hence the importance of assuring the blood levels of these medicines are adequate. In the absence of clear guidance, it is commonly accepted to be good practice to monitor every six to 12 months once a stable dosage is achieved. An opportunistic catch of a patient that had not been monitored highlighted the practice did not have a recall system in place for patients being treated with these medicines. Of the total population of patients registered at the practice it was identified that two were currently on treatment with these medicines. Of the two patients one had not been monitored at all (compliance with medication was variable) and the other patient had not been monitored for the last four years. The non-monitored patient was invited to attend an appointment for bloods and a recall system for yearly reviews for both patients created. On auditing data, a year after it was identified that both patients were being correctly monitored. Re-audit set for one year.

Diabetes: patients with HbA1c above 58 mmol/mol August 2021 to August 2022

Current guidelines recommend a HbA1c target between 48mmol/mol to 58mmol/mol, depending on the patient. For the purpose of the audit the practice tried to identify those patients with HbA1c above 58mmol/mol. Of the total practice population diagnosed with diabetes 84 had a HbA1c above 58 (oscillating from 59 up to 120 and above). A recall system was already in place to invite patients for six monthly or yearly monitoring. The practice agreed that due to the absence of a specialist diabetic nurse that those patients who were found to have HbA1c above target (meaning that above 58mmol/mol) would be reviewed with the GP in the practice with more experience and understanding in diabetes management. The data was re-audited after a year. 82 patients were found to have HbA1c levels above 58. The changes in practice implementing the action upon abnormal HbA1c results had worked well in terms of patients being directed to discuss their results with the designated GP, but this did not seem to translate to a significant improvement in diabetes control overall. Limitations to that expected improvement could be due to resistance from patients to lifestyle modifications and low awareness of illness as not being symptomatic.

The audit also identified that during COVID-19 glycaemic control in diabetic patients had suffered a decline in general. Implemented changes to continue and re-audit in one year.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
<p>The practice had access to a range of services which may help patients lead a healthier life. For example, the local diabetes prevention team, ability to refer patients to the weight management service and the lifestyle intervention team.</p> <p>The practice had well established links with local well-being practitioners who could support a range of patients such as those with potential social isolation, low mood, lifestyle concerns and those making use of food banks. It was anticipated that the recent introduction of a primary care network social prescriber and the two new care coordinators to the practice would enhance this area of work. This was particularly important for the practice's patient demographic. The practice staff demonstrated an acute awareness of their patient population and the recognition that for many patients the patient was reactive rather than proactive in respect of their health. This was demonstrated by the level of attempts at engagement we saw in patient records. Every opportunity was taken by the practice to try and support patients to proactively manage their health and well-being.</p> <p>A wide range of literature was available on the practice information board which detailed the different services and support groups available to patients. For example, sexual health, mental health and wellbeing, healthy eating drop-in centres and support groups.</p>	

Consent to care and treatment

The practice was able to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
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Responsive

Rating: Not Rated

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y

Explanation of any answers and additional evidence:

- The practice was open 8am to 8pm seven days a week excluding Bank Holidays which was of significant benefit to the practice population with 61% being age 40 years and under and 21% being under 18 years of age.
- The practice offered a range of different appointments for patients, these included face to face, telephone and video consultations. A specific appointment was allocated each day for Afghan patients to attend as the practice had assessed there was a need for this.
- All patients under 16 years of age were triaged and seen on the day.
- The appointment system viewed at the time of the inspection showed patients could access routine appointments with a GP or a nurse within a couple of days. On the day appointments for patients assessed as needing to be seen that day were also available.
- Face-to-face appointments were 15 minutes.
- The practice had access to an interpreter service when needed if the patients first language was not English.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The leaders we met with during the inspection process demonstrated they were knowledgeable about issues and priorities for the quality and sustainability of services and that they understood what the challenges were and acted to address them. For example, vacancies had remained open for some time until the practice staff were satisfied they had found the right people for the roles. Compassion was abundant when staff were spoken too. We heard examples of how staff supported patients in a compassionate way. One example was provided where the GP had gone into the community where a member of staff had found an injured patient. The GP provided care and support in the community and the practice for over two hours until the ambulance arrived. We received positive feedback from staff regarding the support they received by the provider Intrahealth.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: During the inspection leaders demonstrated they encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported. There were processes to support staff and promote their positive wellbeing.	

Candour, openness, honesty, transparency and challenges to poor practice were the norm. There was evidence that concerns were investigated, and lessons shared and acted on. For example, one member of staff told us they had visited a patient at home to discuss concerns they had raised with the practice.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	P
<p>Explanation of any answers and additional evidence:</p> <p>There were high levels of satisfaction across all staff. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns. A wide range of examples were provided by staff about the positive way they were treated and the positive culture that emanated throughout the practice. An example of this was in the non-clinical protected learning time the team had decided with staff to focus on care and support of the reception team as they often had to deal with difficult situations which caused low morale. The management employed the services of a Clinical Psychologist who ran a session for staff focusing on how staff were feeling and mechanisms to support them in their lives. The feedback from staff was extremely positive. The management recognised the importance and success of this and was planning to fund a similar session for the clinical staff. Staff told us they had been provided with gift hampers and advent calendars at Christmas and Easter eggs at Easter. From the beginning of December, the practice manager organised a range a weekly event for staff such as buffets and Christmas games.</p> <p>Not all staff were aware of who the Freedom to speak up guardian was.</p> <p>Staff were required to complete annual Equality and Diversity training. All but one member of permanent staff was up to date with this.</p>	

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

Source	Feedback
Staff member	Two more receptionists employed following additional hours being requested following feedback from staff.

Staff member	Raised the option of allowing staff to work at a standing desk. Desk risers now provided so staff can have the option to work standing or sitting down.
Staff member	Safety concerns addressed regarding the security arrangements when patients on the Special Allocation Scheme attended the practice.
Staff member	Information given to management about the tone of some communication – this was brought to the attention of all staff with a request to be thoughtful about how communication to other staff was worded.
Staff member	A suggestion by a member of staff has led to the practice commencing undergraduate teaching for Hull and York Medical which commenced in January 2022.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Governance structures were mostly in place at Provider and practice level to allow the practice to function effectively. We identified a small number of areas, clinical and non-clinical where gaps were identified which should be considered.</p> <p>There was a systematic approach to working with other organisations to improve care outcomes. For example, the practice held and minuted a range of multi-disciplinary meetings including meetings with safeguarding, district nurses and social workers to monitor vulnerable patients. Regular staff and individual meetings were held and minuted.</p> <p>A small number of staff told us they would like to see a more shared understanding of roles and responsibilities across clinical and non-clinical staff groups.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
A wide range of audits both clinical and non-clinical were programmed for completion. Leaders demonstrated a clear understanding of risk and had systems and processes in place to mitigate such risks.	

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

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

During the pandemic and beyond the practice continued to deliver services. The use of telephone appointments proved favourable for the practice population with a large number of patients continuing to opt for telephone appointments rather than face-to-face. Practice staff were acutely aware of their population and used any contact with patients to try and review any outstanding issues the patient had previously declined to attend for.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: The practice monitored closely the increase in the practice list size which had increased significantly over the past couple of years. Staff capacity levels and access was kept under review and with the support of the provider, staffing adjusted accordingly to enable the practice to continue to meet the increasing practice population.	

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	P
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
At the time of the inspection the PPG had not yet been established. Three new patients had been recruited and the first meeting scheduled for the end of September 2022.	
The practice provided clear evidence that they worked with a wide range of stakeholders to fully support, understand and support the needs of the practice population as well as those from other practices as part of the additional contractual services Castle Health Centre provided. We received letters of commendation from North Yorkshire Clinical Group/Integrated Care Board for the work the staff at Castle Health Centre had provided, stepping up at short notice to provide primary medical services to a group of Afghan nationals arriving in the area as part of the Afghan relocation scheme (ARAP) for families evacuated under the Operation Pitting programme in August 2021. The CCG/ICB said they were impressed by the commitment and professionalism shown in ensuring a very high-quality clinical service in very difficult circumstances. Castle Health Centre continue to provide a service for this group equating to over 200 patients. Other letters of praise were also received and described staff at the practice as developing a constructive working relationship with other agencies including North Yorkshire County Council and the Refugee Council (integration provider). Castle Health Centre had previously registered all the Syrian refugee families in Scarborough.	

Feedback from Patient Participation Group.

Feedback
Not available as no active PPG in place.

Any additional evidence

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>All staff were encouraged to use information and allocated time to review performance which led to improvements. A wide range of meetings, audits and reviews were embedded and used as a tool to learn and improve. Staff members described the positive culture of learning and improvement and provided examples to support this.</p>	

Examples of continuous learning and improvement

A member of staff identified that pregnant women were not always being informed by their midwife of a vaccine in a timely way, so the practice had created an alert system as a failsafe if the midwife did not share the information.

The way patients were offered appointments was kept under constant review and adjusted accordingly. A GP had suggested that as COVID-19 regulations had been lifted that consideration should be given to increasing the face to face appointment time to 15 minute to improve the patient experience. This was discussed and agreed.

Clinical meeting minutes showed external data such as that from NHS North of England Commissioning Support (NECS) was considered and reviewed in a bid to learn and drive improvement. NECS supports health and social care customers in meeting strategic and operational challenges, to improve outcome and improve efficiency.

The practice was in the process of conducting an in-house patient survey which focused on the areas which scored low in the National GP patient survey for July 2022 for them to better understand what needed to improve.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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