

Hall Street Medical Centre

Inspection report

28-30 Hall Street
St. Helens
WA10 1DW
Tel: 01744733113
www.hallstreetmedicalcentre.nhs.uk

Date of inspection visit: 11 October 2023
Date of publication: 13/11/2023

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Requires Improvement 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Overall summary

We carried out an announced comprehensive inspection at Hall Street Medical Centre on 11 October 2023. Overall, the practice is rated as good.

The key question ratings are as follows:

Safe - Good

Effective – Requires Improvement

Caring - Good

Responsive - Good

Well-led – Good

This is the first inspection of Hall Street Medical Centre since it was registered under a new provider with CQC in July 2022 .

Why we carried out this inspection

We carried out this inspection in line with our inspection priorities. We inspected all of the key questions as part of this inspection.

How we carried out the inspection

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

This included:

- Conducting staff interviews using video conferencing.
- Completing clinical searches on the practice's patient records system (this was with consent from the provider and in line with all data protection and information governance requirements).
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A site visit.

Our findings

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We found that:

Overall summary

We rated the provider as **good** for providing safe services. This was because:

- The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.
- Staff had the information they needed to deliver safe care and treatment.

We rated the provider as **requires improvement** for providing effective services. This was because:

- Patients with long-term conditions were not always receiving appropriate monitoring or reviews.
- Do not attempt cardio pulmonary resuscitation records (DNACPR) were either incomplete or could not be located.
- The practice was not meeting the target for cervical screening uptake for eligible patients.

We rated the provider as **good** for providing caring services. This was because:

- Staff treated patients with kindness and respect.
- The practice respected patient's privacy and dignity.

We rated the provider as **good** for providing responsive services. This was because:

- The practice organised and delivered services to meet patient's needs.
- Patients could access care and treatment in a timely way.

We rated the provider as **good** for providing well-led services. This was because:

- There was compassionate and inclusive leadership at all levels.
- There was evidence of systems and processes for learning, continuous improvement and innovation.

We found one breach of regulations. The provider **must**:

- Ensure care and treatment is provided in a safe way to patients.

The provider **should**:

- Update training records to ensure gaps in training for staff such as infection, prevention and control are addressed.
- Improve the appraisal schedule to clarify the appraisers and appraisal dates for staff employed by the PCN in advanced clinical practice.
- Progress plans to improve the cervical screening uptake for eligible patients.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

Our inspection team was led by a CQC lead inspector who spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with the provider using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

Background to Hall Street Medical Centre

Hall Street Medical Centre is located in St Helens at:

28-30 Hall Street

St Helens

WA10 1DW

The provider is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, family planning, maternity and midwifery services, treatment of disease, disorder or injury and surgical procedures.

The practice is situated within Cheshire and Merseyside Integrated Care Board and delivers General Medical Services (GMS) to a patient population to approximately 5,426 patients. This is part of a contract held with NHS England.

Locally, the practice is part of a wider network of 8 GP practices called a primary care network (PCN) in the St Helens Central Primary Care Network.

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the second lowest decile (2 of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 98.1% White, 1.1% Asian, Mixed 0.6% and 0.1% Other. The age distribution of the practice population closely mirrors the local and national averages. There are approximately 2,463 female patients and 2,490 male patients registered at the practice. Life expectancy for females is 80 years and 75.7 years for males.

There is a team of 2 male and 1 female GPs who provide cover at the practice. This consists of the clinical lead/provider and 2 salaried GPs. The practice also has 1 male ST2 and 1 female ST3 junior doctors working at the practice. An ST2 and ST3 GP registrar is a qualified doctor and has now decided to pursue a career in general practice. They were in their second/third year of GP training and will have their own surgeries, but they will still be supervised by their GP trainer.

Additionally, the practice employs 1 advanced nurse practitioner, 1 trainee advanced clinical practitioner/practice nurse, 1 practice nurse, 1 clinical pharmacist, 1 trainee nurse associate and 1 health care assistant.

The clinical team is supported by a practice management team that consists of 1 practice manager, 1 assistant practice manager, 1 senior administrator/data officer, 5 medical receptionists and 1 apprentice medical receptionist.

The practice is open between 8am to 6.30 pm Monday to Friday. The practice offers a range of appointment types including book on the day, telephone consultations, online and advance appointments.

Extended access appointments are available via the PCN. Late evening and weekend appointments are offered at Lowe House Health Care Resource Centre on a Monday and Friday from 5.30pm to 8pm, Tuesday to Thursday from 5pm to 8.30pm and on Saturdays from 9am to 5pm.

Out of hours services are provided locally by Primary Care 24 Limited.

The Surgery is an approved training practice for the training of General Practice Registrars (GPRs).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury Maternity and midwifery services	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <ul style="list-style-type: none">• Our searches and review of the clinical records found care to patients was not always being delivered in line with best practice guidance.• The system for monitoring patients was not always effective as some patients were overdue recall for monitoring checks and patients prescribed medicines that required monitoring were not always receiving this on time.• Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care.• The system in place for recording and acting on historic safety alerts was not always effective.• Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were not made in line with relevant legislation.