Garston Family Health Centre

Inspection 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 location	Inspected but not rated
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Good

Overall summary

We carried out an announced comprehensive inspection at Garston Family Health Centre on 7 and 8 November 2023.

We have not rated this practice overall. This is because the provider had recently taken over the service and the majority of staff who provided care to patients were new and there was not enough evidence to rate effective, caring and responsive. The practice is rated requires improvement for safe and good for well-led.

The provider, Primary Care 24 (Merseyside) Limited (PC24) has the contract for the practice which was registered with CQC in June 2023. During the inspection process, the practice highlighted efforts they were making to improve outcomes and treatment for their population. These had only recently been implemented so at the time of inspection, and outcomes were still under review.

Why we carried out this inspection.

We carried out this inspection in line with our inspection priorities.

How we carried out the inspection/review

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 short 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:

- The practice had systems, practices, and processes to keep people safe and safeguarded from abuse. However, a number of the systems had only recently been developed at the time of inspection and were not fully implemented.
- The systems in place for monitoring medicines that require monitoring and clinical review prior to prescribing were not effective to ensure medicines were always prescribed in line with best practice guidance.
- There was a system for recording and acting on safety alerts, however the practice was unable to demonstrate that all relevant safety alerts had been acted upon.
- Patients with long-term conditions were not always receiving appropriate monitoring and reviews.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.

Overall summary

- During the inspection process, the practice highlighted efforts they were making to improve patient experience and in turn improve the feedback given by patients. An action plan was in place addressing the negative results received in patient surveys. Any changes put into place by the provider had only recently been implemented and the effect of these efforts was not yet reflected in verified outcomes data above.
- Patients could access care and treatment in a timely way.
- The provider had undertaken audits and reviews and identified a number of significant challenges for the practice. Short, medium and longer term actions plans were developed to address these challenges.

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

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

The provider **should**:

- Improve the uptake of cervical screening and children's immunisation.
- Take action to ensure that all Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) assessments are reviewed annually.
- Continue to develop and monitor safe systems and processors for safeguarding vulnerable patients.
- Take action to ensure records of vaccinations status for relevant staff are maintained.
- Monitor the staff vacancy rates, continue the recruitment processes for vacant positions to ensure there are enough staff to provide appointments and prevent staff from working excessive hours.
- Take action to ensure the workflow arrangements for patient test results are managed safely.
- Improve communication systems to ensure patients who may be digitally excluded have their needs equally met.
- Continue to monitor the governance and risk management processes which at the time of inspection were newly developed.

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 and second inspector who spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

Background to Garston Family Health Centre

This practice was registered with CQC on 23 June 2023. The provider is registered with CQC to deliver the Regulated Activities, diagnostic and screening procedures, maternity and midwifery services and treatment of disease and disorder or injury.

The practice is situated within the Liverpool Integrated Care System (ICS) and delivers General Medical Services (GMS) to a patient population of 8,251 patients. This is part of a contract held with NHS England.

Information published by the Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the lowest decile 1 (1 out 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 2% Asian, 94% White, 1% Black, 1% Mixed, and 0.8% Other.

The provider is currently registered with CQC as the out of hours provider across Merseyside and Cheshire. The provider also operates 11 GP practices across the Merseyside area.

The practice is supported by a full management team at Primary Care 24 (Merseyside) Limited (PC24) head office. The service is provided by a team of two GPs who work as salaried and associate GPs. The practice has a practice manager, a locum advanced nurse practitioner, a locum practices nurse and a health care assistant. The GPs are supported at the practice by a team of reception/administration staff. 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 and advance appointments.

Out of hours services are provided by Primary Care 24 (Merseyside) Limited (PC24).

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 Treatment of disease, disorder or injury Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The searches and review of the clinical records found care to service users was not always being delivered in line with best practice guidance. • The searches and review of a sample of the clinical records found that service users with a long-term condition had not always been identified and coded in the patient record system. Service users were overdue recall for monitoring checks, service users with asthma were not always being called for review, service users prescribed medicines that required monitoring were not always receiving this. • The system in place for recording and acting on historic safety alerts was not effective. This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.