

# Chapel Street

## Inspection report

Chapel Street  
Royton  
Oldham  
OL2 5QL  
Tel: 01616526336

Date of inspection visit: 7 September 2022  
Date of publication: 02/11/2022

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		Requires Improvement	
Are services safe?		Requires Improvement	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Requires Improvement	
Are services well-led?		Inadequate	

# Overall summary

We carried out an announced comprehensive Chapel Street (also known as Royton Medical Centre) on 7 September 2022. Overall, the practice is rated as requires improvement, with the following key question ratings:

Safe - requires improvement

Effective - good

Caring - good

Responsive - requires improvement

Well-led - inadequate

## Why we carried out this inspection

We carried out this inspection in line with our inspection priorities. This was the first inspection to this location following it registering with the Care Quality Commission (CQC) on 2 November 2021. The provider – Royton Medical Centre – has been registered since 2015 and had one location, also called Royton Medical Centre. In June 2021 the practice moved to a new building that registered under the name Chapel Street.

As this was the first inspection to the location all the key questions were inspected.

The full reports for this inspection can be found by selecting the 'all reports' link for Chapel Street on our website at [www.cqc.org.uk](http://www.cqc.org.uk)

## 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.

# Overall summary

We rated the practice **requires improvement** for providing safe services:

- The system for obtaining Disclosure and Barring Service (DBS) checks was not effective.
- The process for authorising nursing staff to administer medicines was not effective.
- Medicine reviews were completed without patient involvement and without all the required checks being carried out.
- The process for checking emergency medicines was not effective.
- The system for learning and making improvements when things went wrong was not effective.
- The systems to manage safety alerts were not fully effective.

We rated the practice **good** for providing effective services:

- Patients received effective care and treatment that met their needs.

We rated the practice **good** for providing caring services:

- Staff dealt with patients with kindness and respect and involved them in decisions about their care.

We rated the practice **requires improvement** for providing responsive services:

- Complaints were not used to improve the quality of care.
- Although we could see appointments were available at the time of the inspection, patient feedback around access was poor.

We rated the practice **inadequate** for providing well-led services:

- Leaders could not demonstrate they had the capacity to deliver high quality care.
- Most of the staff we asked were not aware they had a Freedom to Speak Up Guardian.
- We saw examples of policies being inaccurate and not being followed.
- We saw examples of systems and processes that were not effective, including the process for requesting Disclosure and Barring Service (DBS) checks, the process for checking emergency medicines and the process to manage significant events and complaints.
- The website was difficult to navigate and included incorrect information.

We found two breaches of regulation. The provider **must**:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

In addition, the provider **should**:

- Work towards improving levels of cervical screening.
- Monitor patient satisfaction with a view to improving all below average areas of the GP Patient Survey.

# Overall summary

If a service is rated as inadequate for one of the five key questions it will have usually have six months to improve. We will inspect this service again within six months, and if at that time service is rated as inadequate for a key question, it will be placed in special measures.

**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 Hospitals and Interim Chief Inspector of Primary Medical Services

## 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 staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location, and a second CQC inspector who attended the site visit.

## Background to Chapel Street

Chapel Street is located in Oldham at:

Royton Medical Centre

Chapel Street

Royton

Oldham

OL2 5QL

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

The practice delivers a General Medical Services (GMS) contract to a patient population of 5915 at the time of inspection. This is part of a contract held with NHS England. The practice is part of the Oldham locality of the Greater Manchester Integrated Care Board.

Information published by Public Health England shows that deprivation within the practice population group is in the fourth decile 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 89% White, 9% Asian and 2% Mixed, Black or Other.

There is a team of two GP partners (both male) and two salaried GPs (one male and one female). There are two practice nurses and a healthcare assistant. There is a Registered Manager (who works as a manager in this practice and other practices), an Operations Manager and a senior team leader, and they are supported by a team of administrative staff.

A company called Beacon GP Care Ltd provides corporate and clinical governance for the practice. Beacon GP Care is a not-for-profit organisation that supports individual GP practices. Beacon GP Care Ltd is not a CQC registered provider, and Chapel Street is a separate legal entity to Beacon GP Care Ltd.

The practice is located in a new purpose-built building which opened in June 2021. There are five GP consulting rooms and two nurse treatments rooms, with a reception/waiting area and administrative staff are located on the ground floor. The first floor has a large meeting room and staff kitchen/dining room, and also offices for Beacon GP Care Ltd.

The practice is open from 8am until 6.30pm on Monday and 7am until 6.30pm on Tuesday to Friday. Monday to Friday. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments.

Patients requiring a GP outside of normal working hours are advised to contact the surgery and they will be directed to the local out of hours service which is provided through NHS 111. Additionally, patients can access GP services in the evening and on Saturdays and Sundays through the Oldham seven day access scheme.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Family planning services	The registered person had not carried out assessments of the risks to the health and safety of service users of receiving care or treatment. In particular:
Maternity and midwifery services	<ul style="list-style-type: none"><li>Practice nurses were not appropriately authorised to administer medicines.</li><li>The five medicine reviews we examined had been completed without patient involvement. Three of these had been coded without all the repeat medicines being reviewed. Some ongoing monitoring processes had not been checked.</li></ul>
Surgical procedures	The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:
Treatment of disease, disorder or injury	<ul style="list-style-type: none"><li>A patient safety alert had not been actioned so patients were not informed of the possible risks from taking a medicine.</li></ul>
	This was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Enforcement actions

### Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:</p> <ul style="list-style-type: none"><li>• The system for learning and making improvements when things went wrong was not effective. The practice's significant event policy was not being followed.</li><li>• Complaints were not used to improve the quality of care.</li><li>• Leaders could not demonstrate capacity to deliver high quality care.</li><li>• Most staff we asked were unaware they had a Freedom to Speak Up Guardian.</li><li>• There were examples of policies being inaccurate or not being followed.</li><li>• The website contained inaccurate information and other information, such as practice staff, was not included.</li></ul> <p>The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk:</p> <ul style="list-style-type: none"><li>• The system for requesting Disclosure and Barring Service (DBS) checks was not effective and did not follow the 'Internal DBS Process' supplied to us as part of their recruitment procedures.</li><li>• The process for authorising clinicians to administer certain medicines was not effective and not understood. The practice nurses were routinely not included in the practice's Patient Group Directions (PGDs), and authorisation was not correctly given when they were included.</li></ul>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

## Enforcement actions

- The process for checking emergency medicines was not effective.
- The process of issuing GPs with a box containing all the equipment they may need for their surgery was not effective.
- The system for managing safety alerts was not fully effective. We saw an example of a safety alert not being actioned.

This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.