Dr A Palmer & Dr J Gardner

Quality Report

Barlborough Medical Practice
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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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Key findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as good overall (at the previous inspection undertaken in June 2015 and January 2016, the practice received a good overall rating).

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Dr A Palmer and J Gardner (Barlborough Medical Practice) on 21 February 2018. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was 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.

At this inspection we found:

- There was a clear leadership structure and staff told us they felt well supported by the partners and practice manager. We observed the positive impact this had in establishing a well-integrated practice team with low staff turnover and high morale.
- GPs and practice staff worked effectively as a cohesive team and provided personalised and responsive care to their patients.
- There was an emphasis on a patient centred approach in all aspects of the practice's work. This was underpinned by the practice's mission statement.
- The practice directly employed a community matron and two part-time care coordinators. This impacted positively on patients from a clinical, caring and social

Summary of findings

perspective. We saw how these staff members helped to provide holistic support to patients and their families, and integrate them within the local community.

- Results from the latest national GP patient survey showed that the practice had performed either above or in line with local and national averages regarding patient experience. This was particularly evident in relation to continuity of care in being able to see a preferred clinician, and easy access in obtaining an appointment.
- The national GP survey showed that 89% of patients who responded would recommend the surgery to someone new to the area compared with the clinical commissioning group (CCG) average of 81% and the national average of 77%. This was reinforced by the Care Quality Commission (CQC) comment cards completed by patients prior to our inspection, which reflected that patients strongly valued the practice and were extremely satisfied with the care they had received.
- The practice regularly dispensed medicines to approximately 250 patients. On the day of the inspection, we found that some processes within the dispensary required strengthening to fully comply with legal requirements and recommended guidance.
- The procedure for issuing repeat prescriptions did not always comply with best practice. The number of repeat issues for patients receiving high risk medicines needed review. This was to ensure that patients were compliant with attending for regular blood checks before receiving further supplies of their medicine.
- We found that the procedure for checking medicines within the practice was not sufficiently robust and we discovered a small number of medicines and consumables that had exceeded their expiry date.
- The practice encouraged and supported staff to report incidents. We found that the procedure to apply learning from incidents was not always sufficient and required improvements to be made. The practice acknowledged this and agreed to review their process.
- The practice had a strategy and forward vision. They worked with their local CCG and practices to maximise improvements in primary care for local patients. For example, the practice were seeking a solution to NHS England's requirementto ensure that everyone would be able to access easier and more convenient GP services, including appointments at evenings and weekends via an 8-8 service.
- We spoke with community based health, social and care home staff who overwhelmingly provided us with positive feedback about their interactions with the practice team.
- There was a focus on continuous learning and improvement at all levels of the organisation. Staff training records were mostly up to date, and regular appraisals encouraged development at all levels.
- The practice had an established quality improvement programme. This included an audit programme which demonstrated improvements in outcomes for patients.

We saw the following areas of outstanding practice:

- Weekly multi-disciplinary (Community Support Team) meetings took place which were attended by members of the practice team with community health staff, social care and voluntary sector representatives. This was supported by the analysis of current activity data, for example, from out of hours contacts and accident and emergency attendees to determine where additional support may be required for patients. The practice provided an example of a patient who was shown to be making repeated contacts with the 111 service. When this was identified, the patient was assessed and provided with a care package to suit their needs, and this resulted in a marked decrease in 111 contacts by this individual. A social care representative informed us how this helped establish appropriate care packages at the earliest opportunity to keep patients at home. This was supported by lower levels of access to acute care. The integration between practice and community teams had created an excellent understanding of respective roles and how these could work in collaboration to benefit patient care. The meetings had received recognition from the CCG as a good model for other practices to develop.
- The practice manager developed templates on the computer system to enhance accurate data collection and maximise the collation of essential patient information. These were made available to colleagues across the county to share best practice. This included a template to develop individualised care plans for patients with a long-term condition; a template to

Key findings

record a patient's specific communication and access needs for sharing with other services; and a template to capture an accurate records of vaccinations and immunisations.

Importantly, the provider **must** make improvements to the following areas of practice:

- Ensure care and treatment is provided in a safe way to patients. For example, by reviewing procedures within the dispensary to ensure they are in line with the practice's own standard operating procedures; establish effective internal monitoring of the expiry dates of medicines and consumables; ensuring that patients prescribed high risk medicines receive regular monitoring; and reviewing the number of issues for repeat prescriptions.

The areas where the provider **should** make improvements are:

- Review the procedure for incident reporting to provide improved assurance that investigations have identified the key contributory factors, and that these have been appropriately acted upon to keep patients safe.

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

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	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Dr A Palmer & Dr J Gardner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist advisor, and a pharmacist specialist advisor.

Background to Dr A Palmer & Dr J Gardner

Dr A Palmer and J Gardner are also known as Barlborough Medical Practice (www.barlboroughmedicalpractice.co.uk). It is registered with the CQC as a GP partnership with two GP partners. The partnership has been established since 1993. The practice has a population of approximately 7,175 registered patients, and the list size has increased by over 10% since our previous inspection in June 2015. The practice has a higher proportion of patients aged under 50, and a smaller number of patients aged 65 and above in comparison with local averages. However, the figures generally align with national averages.

The surgery provides primary care medical services commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The practice covers a semi-rural area and lies within the Bolsover district of North East Derbyshire. The practice serves a predominantly white British population with 3.2% of registered patients from Black and Minority Ethic (BME) groups population. It is ranked in the fourth lowest decile for deprivation.

The premises include a main site within Barlborough and a branch surgery situated in the nearby village of Renishaw, approximately 2½ miles away. The premises at Barlborough are approximately 20 years old, and the branch surgery shares a building with another GP practice which is part of the neighbouring CCG.

The addresses for the main location and branch surgery are:

- Barlborough Medical Practice, The Old Malthouse, 7 Worksop Road, Barlborough, Chesterfield, Derbyshire. S43 4TY.
- Renishaw, Emmett Carr Surgery, Abbey Place, Renishaw, Sheffield. S21 3TY.

As part of our inspection, we visited the main site at Barlborough. The practice offers dispensing services from the main site to 572 patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy. Approximately 250 of these patients were currently prescribed repeat medicines at the time of our inspection.

The practice team consists of the two GP partners and two salaried GPs (one male and three females). There is one nurse practitioner and two practice nurses, one of whom works predominantly as the community matron. The practice employs three health care assistants and two care coordinators, most of whom have combined roles with other duties due to the small nature of the practice and the necessity to cover roles. A full-time practice manager is in post and there are four other staff undertaking dual roles in respect of secretarial and administrative tasks as well as dispensing duties. There is one caretaker/cleaner who is directly employed by the practice.

The Barlborough practice is open between 8am until 6.30pm on Monday, Wednesday and Friday; 8am to 4pm on Tuesday and Thursday; and provides extended opening hours for pre-bookable appointments on a Saturday morning from 8am until 11.30am.

Detailed findings

The Renishaw surgery opens from 8.30am to 6pm on a Monday; 8.30am until 6.30pm on a Tuesday and Thursday; and 8am to 1pm on a Wednesday and Friday.

The surgery closes for one afternoon a month on nine months of the year. This is to facilitate staff training. When the practice is closed, patients are directed to the out of hours provider via the 111 service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

Requires improvement

Are services safe?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments, including those for fire, Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings), and general health and safety issues. It had a range of safety policies which were regularly reviewed and staff received safety information as part of their induction and ongoing training programme.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. All staff received up-to-date safeguarding training appropriate to their role. Members of the practice team knew how to identify and report concerns.
- The practice team worked with other agencies to support and protect patients from abuse, neglect, discrimination and breaches of their dignity and respect. We saw clear evidence of effective working with community based health and social care staff to achieve this aim.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. The nurse practitioner and the lead GP partner were identified as the infection control leads for the practice. Annual audits were undertaken and any follow up actions that were identified were addressed promptly. Some issues, such as access to elbow-operated taps in treatment areas had been identified and earmarked for action as part of any future refurbishment work. There were systems in place to support the safe management of healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction programme for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Reception staff had access to urgent care guidelines for patients who may be presenting with chest pain. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. GPs had attended a course on early recognition, diagnosis & management for sepsis, and this learning was cascaded to the practice clinicians. The practice also used the GP sepsis screening and action tool, which is an automated protocol triggered during consultations when relevant text is entered.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. Information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.
- The practice had systems to ensure that any urgent incoming patient documents and pathology results were reviewed and actioned appropriately.

Safe and appropriate use of medicines

- The systems for managing medicines, including emergency medicines and equipment did not always

minimise risks. There was no documented process for checking emergency medicines and we found out of date medicines available for use. The practice told us they had introduced a new process following our inspection to minimise this risk.

- Patients receiving high risk medicines were not always monitored appropriately to ensure it remained safe to continue their prescriptions. A significant event in the practice had highlighted this risk but appropriate changes in process had not been adopted to reduce the risk of recurrence. The practice told us that following our inspection a new process had been implemented to ensure clinicians checked monitoring results prior to prescribing these medicines.
- Standard Operating Procedures (SOPs) were in place to govern procedures within the dispensary. We saw that these were not always followed and staff were reminded of these during our visit.
- The practice had a process for identifying and reviewing significant events which included those within the dispensary. There was no process for ensuring near misses were identified and actions taken tominimise risks of recurrence. The practice addressed this following our inspection.
- Vaccines and medical gases were effectively managed.

Lessons learned and improvements made

- There was a system for recording and acting on significant events, incidents and near misses. Twelve significant events had been recorded during 2017.
- Staff understood their duty to raise concerns and report incidents. Leaders and managers supported them when they did so, and encouraged reporting.
- Learning outcomes and actions were documented but we found that these were not always effective in reducing the likelihood of a future recurrence. For example, we saw that a significant event documented that a flu vaccination had been administered to the same patient twice in September 2017. There was a limited review of learning and documented system changes, and we saw that the same incident recurred with a different patient the following month. Following the inspection, the practice told us that they understood the need to review the process and would address this to improve the application of learning from incidents.
- An annual review of incidents was undertaken in discussion with the practice team to review any themes and discuss the outcomes achieved collectively.
- There was a system for receiving and acting on patient and medicine safety alerts. We saw evidence that when medicines alerts were received, searches were undertaken to identify patients this might affect, and these were then followed up and reviewed accordingly. Minutes of a recent clinical meeting included an update on a MHRA alert issued in August 2017 recommending that patients were prescribed two adrenaline auto-injectors which should be carried with them at all times. Medicine alerts which were relevant to stocks held within the dispensary were also followed up appropriately. The practice informed us that they had established a MHRA log following our inspection to keep an effective audit trail of the responses made to each relevant alert.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clinical pathways and protocols. Clinicians were able to describe examples of recent discussions held in relation to new or updated guidance.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs, including a review of their prescribed medicines.
- The practice employed a community matron and two care coordinators, who cared for frail and older people with complex conditions to keep them safe and well in their own home. They also followed up on older patients discharged from hospital and ensured that their care plans and prescriptions were updated to reflect any new or additional needs.
- Many of the patients aged over 65 had a care plan in place to document their individual requirements. The plans were shared with the out of hours service as necessary to coordinate patient centered care.
- The practice supported approximately 70 residents in two local care homes. A named GP visited each home every fortnight, but responded to any urgent requests as required. The practice had invited care home staff to attend relevant training events held at the practice, and delivered impromptu training to staff within the care home environment. Regular management meetings were held with the homes to review and continually improve the service delivered. We spoke to representatives at both care homes who told us that they received a responsive and caring service from the practice. They told us that the GPs interacted well with their staff, and treated patients with dignity and respect.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. The practice provided information that showed they had achieved a good uptake for annual reviews with 84% of patients on the long-term conditions register having received one in the last 12 months.
- Interim reviews were conducted as appropriate, for example, patients with poorly controlled diabetes were seen at three or six monthly reviews. Patients with breathing difficulties were reviewed a month later if their treatment was stepped up due to an exacerbation of their condition. Telephone follow ups were often made to patients in order to check that any agreed follow up actions had been completed.
- Although the practice was located in a region of average deprivation, it had accommodated a number of new patients from an adjacent area who sought a more responsive service. This had impacted upon the practice, as some of these patients had multiple pathologies and required additional time upon registration to stabilise their condition.
- The practice manager had created a data entry template to create a personalised care plan for patients with a long-term condition. Individual care plans were then produced by clinicians in collaboration with the patient to address their specific needs. This was given to the patient and included goals, details of support services and emergency contacts, and healthy lifestyle discussions. Care management plans were in place for 90% of patients on the practice long-term condition registers.
- For patients with the most complex needs, the practice team worked with other health and care professionals, including specialist nurses, to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training in support of this.

Families, children and young people

Good

Are services effective?

(for example, treatment is effective)

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice provided emergency contraception, and offered family planning services.
- The health visitor offered child development reviews on site every two weeks, and the midwife provided a weekly clinic at the practice. The clinics also ensured regular liaison with the practice team regarding expectant and new mothers and their infants.
- Meetings were held with the health visitor every six weeks to review any children where there were any known safeguarding concerns.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 89%, which was above the local average of 84% and national average of 81%. This was achieved with a lower exception reporting rate, below the local and national averages. This outcome contributed to the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74.

People whose circumstances make them vulnerable:

- The practice worked with voluntary services, including the Red Cross, to enhance the support available to their most vulnerable patients.
- End of life care was delivered in a coordinated way with extensive collaboration from the multi-disciplinary team via weekly meetings and regular communication in-between. The care provided took into account individual needs such as the patients preferred place of care.
- The practice conducted an 'after death analysis' of all patients and reviewed this annually to consider any learning. A review of deaths over a 12 month period up to December 2017 showed that 60% of expected deaths occurred in the patient's preferred place. An identified learning point from the last review was to increase the use of the anticipatory drug box for patients at the end of life.
- The practice held a register of patients with a learning disability. The practice had completed annual health reviews for 96% of their 27 patients on this register. Reviews were offered in patient's homes in recognition of high rates of non-attendance, and this had improved uptake.
- We were shown a report produced by the local learning disability lead strategic health facilitator following a practice visit in November 2017. This was very positive and highlighted many positive approaches taken by the practice to support their patients with learning disabilities. This included consistency in seeing a named clinician; receiving appropriate follow-up care where this was indicated; the recording of consent; and the promotion of cancer screening.
- The practice could refer patients to a local high impact user programme, commissioned by Hardwick CCG. This helped to support some of the most vulnerable patients who required extensive support in terms of health, social, housing and financial needs. The practice was able to provide examples of how this had been used to positively impact on patients' lives and well-being.
- The practice had identified a high number of patients as carers. The carers were offered advice and could be signposted to sources of additional support if they consented to this.

People experiencing poor mental health (including people with dementia):

- 97% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher than the local average of 83% and national average of 84%. Exception reporting rates were in alignment with averages.
- 82% of patients with a new diagnosis of dementia recorded in the preceding year had a record of recommended investigations recorded between 12 months before, or 6 months after, entry onto the practice register. This was above the CCG average (73%) and national average (76%), although exception reporting rates were significantly higher at 35% which was 17% more than the CCG rate and 13% above the national average.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was above the local and national averages of 95% and 90% respectively.

Good

Are services effective?

(for example, treatment is effective)

Exception reporting rates were higher at 20% (4% above the CCG average, and 7% above the national average), but this was due to the small number of patients this indicator applied to.

- The practice considered the physical health needs of patients with poor mental health and those living with dementia. For example, 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption in the last 12 months (CCG 94%; national 91%).
- A community psychiatric nurse would often attend multi-disciplinary meetings to discuss patients requiring mental health support.

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. For example, there was a documented clinical audit plan which included the monitoring of some high risk medicines, and for reviews of patients with conditions such as diabetes, osteoporosis and dementia.

The most recent published Quality Outcome Framework (QOF) results for 2016-17 were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 99% and national average of 96%. The overall exception reporting rate at almost 13% was marginally higher than the local average, and approximately 3% above the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). The practice provided data (subject to verification) that they were on target to achieve highly on QOF for 2017-18 with current performance showing an 81% achievement at the beginning of February 2018 (the final result being determined by the end of March 2018).

We noted that exception reporting rates for some individual indicators relating to mental health, cancer and diabetes were generally higher than local and national averages. The practice told us this was in part accountable to the high number of care home patients on some registers, where inclusion in QOF tests was not appropriate due to their general frailty or challenging behaviour.

- The practice was involved in quality improvement activity and provide a timetable of their internal audit programme. The practice provided us with examples of two recently completed full cycle clinical audits which included an audit monitoring patients prescribed a particular anticoagulation medicine to help prevent blood clots. The initial audit in February 2017 identified that 72% of the identified 58 patients had received the recommended blood tests within the previous 12 months. Following this result being highlighted to clinicians and the recall of patients to complete the recommended testing, a repeat audit was undertaken in February 2018. This demonstrated that 93% of 63 patients had received the appropriate blood tests 12 months later.
- The practice participated in local projects to benefit patient care. For example, the practice was involved in a commissioning project aimed at patients with diabetes who were not achieving three recommended target levels in accordance with NICE guidance.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Records of training were maintained and monitored via a practice training matrix, which included defined recommended intervals for further update training. We saw that the majority of staff were up to date with training and all essential training had been completed. Staff were encouraged and given opportunities to develop.
- The practice had protected learning time events once a month on nine months of the year, avoiding Christmas and summer holidays when the demand for appointments was at its highest. Some of these afternoons involved attendance at a CCG led learning event, whilst the rest were held in house and included time for a full practice team meeting to take place.
- In house training events were organised at the practice, this included a recent presentation on suicide awareness and prevention.

Good

Are services effective?

(for example, treatment is effective)

- The practice provided staff with ongoing support. This included an induction process, regular meetings, appraisals, and support for revalidation. The nurse practitioner informed us that they met the lead GP regularly and would discuss case studies for clinical supervision and mentorship.
- There was an approach for supporting and managing staff when their performance was poor or variable. Staff were aware of the whistleblowing process.
- Locums were rarely used and when they were they would be sourced from those who had previously worked at the practice. This ensured familiarity with systems and continuity for patients and staff. The practice generally used the same GP and nurse practitioner to cover any available locum sessions.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. The practice team worked effectively with community based staff as part of an integrated approach to care. Weekly multi-disciplinary meetings (Community Support Team meetings) reviewed the ongoing care and support for patients who were at risk of hospital admission or had complex health and care needs. Data, including out of hours' activity and accident and emergency department attendances, was proactively reviewed to inform planning at this meeting. We were shown an example, in which 111 data presented at one of the meetings showed a significant increase in demand for one month. This was found to be attributable to one patient, but with input from the community matron and care coordinators, they were able to provide the patients with the care they required and this resolved the issue within the month.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice employed two part-time care co-ordinators to help facilitate this. Information was shared appropriately with out of hours' and other relevant providers to ensure a smooth transition across services for patients.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Patients with end of life care needs were reviewed at the weekly multi-disciplinary meetings which usually included attendees from the local hospice and Macmillan nurses. The practice undertook an annual after death analysis to review any learning. The most recent review included outcomes including increasing the use of anticipatory medicines in patients' homes where applicable; and discussions around documenting the patients preferred place of death and bereavement visits.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of 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.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, there was access to smoking cessation and weight management advice on site. The practice offered advice on smoking cessation although the funding for this service at practice level had been de-commissioned. The practice told us they had continued this in line with their ethos of patient centred care and providing a holistic approach.
- Referrals were made to other services such as the Live Life Better Derbyshire service to access a range of services and support to promote healthy lifestyles.
- NHS Health checks were available for patients aged 40-74 years old.
- Uptake rates for breast and bowel cancer screening was above national averages and slightly higher than local rates. For example, three year coverage breast screening rates for females aged 50-70 was 80% (CCG 75%; national 70%), and two and a half year coverage for bowel cancer screening in 60-69 year olds was 66% (CCG 63%; national 55%)

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

Good

Are services effective?

(for example, treatment is effective)

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. A care home manager told us that GPs had assisted in best interest assessments for their residents when this was appropriate.
- The practice monitored the process for seeking consent appropriately. For example, we viewed an audit of minor surgery that demonstrated 100% compliance with written consent

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Patients told us that staff treated them with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 53 Care Quality Commission patient comment cards we received were positive about the service experienced. Patients praised individual staff at all levels for providing exceptional care and support. They said they were proud to have the surgery within their community, and told us that staff went the extra mile to provide them with the care and support they needed. Three of these cards also included a negative comment relating to poor interactions with individual members of the practice team, but this was balanced with an overall positive view of the surgery.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 246 surveys were sent out and 120 were returned. This represented about 1.7% of the practice population. The practice was in alignment with CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 100% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 88% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 88% of patients who responded said the GP gave them enough time; CCG - 88%; national average - 86%.
- 88% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 89%; national average - 86%.
- 92% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 92% of patients who responded said the nurse gave them enough time; CCG – 94%; national average - 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 90% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 94%; national average - 91%.
- 94% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

The practice provided us with many positive examples of situations in which staff had demonstrated a commitment to offer kind and compassionate care, beyond the parameters of the consultation. This included helping patients with personal care when carers agencies had not attended as planned to assist the patient; shopping for drinks with high sugar content to help a patient with unstable diabetes who had no relatives living nearby to support them; transporting patients home from the surgery when they were unwell; and intervention in a disagreement between two patients in the street to help calm the situation.

As a small practice, the team knew their patients well. Reception staff would recognise if individuals were struggling and would pass this information to clinicians so that they were able to review those patients.

The caring aspect extended beyond the practice's own patients with participation in fund raising events. For example, staff donated money to the local hospice in lieu of sending Christmas cards, and a coffee morning had raised money for the Macmillan service.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.

Good

Are services caring?

- Staff communicated with patients in a way that they could understand, for example, communication aids (such as a hearing loop) and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers, and the list was reviewed on a regular basis to ensure it was kept updated. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 233 patients as carers, which was 3.2% of the practice list.

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- A practice Carers Protocol had been developed. This included the identification of carers by incorporating this into the new patient questionnaire.
- Carers were provided with details of the local Carers' Association, and the practice referred carers (with their agreement) to the Carers Association, and to social services for a carer's assessment where this was appropriate.
- The community matron included carers as part of a holistic assessment when new patients were added to their caseload. The carer would be signposted to support services or advised to see the GP, for example, if they presented with issues such as anxiety. The carer was offered a flu vaccination at home when the patient received their own. The Citizen's Advice Bureau representative who attended the practice each week had also seen patients and carers at home if travelling into the surgery was difficult for them.
- Staff told us that if families had experienced bereavement, a member of the practice team would usually try and contact the family or carer. This call may either be followed by a patient consultation (if required) and/or by giving them advice on how to find a support service. In the last practice annual death analysis review, 15 bereavement visits or family contacts were made in relation to the 86 deaths of registered patients. This amounted to 17% of deaths, but the practice told us that 52% of these deaths occurred in care homes, and interactions with family members of the residents was not always possible.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 92% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 85% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 85%; national average - 82%.
- 92% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 93%; national average - 90%.
- 88% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

Feedback on some patient comment cards received on the day of the inspection included specific reference to clinicians explaining test results, whilst providing sufficient time to discuss these matters with patients.

Privacy and dignity

- Staff recognised the importance of patients' dignity and respect and promoted this through all aspects of their work. This was integral within the practice culture and reflected within the practice values.
- The practice complied with the Data Protection Act 1998, and all staff were up to date with training in information governance.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups

Responding to and meeting people's needs

- The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.
- The facilities and premises were appropriate for the services delivered. All patient services were delivered from the ground floor which were easily accessible by wheelchair.
- The practice understood the needs of its population and tailored services in response to those needs. For example, extended opening hours were available on a Saturday morning; online services were offered such as repeat prescription requests; and advanced booking of appointments could be made up to nine months ahead.
- The practice had almost 1,000 patients signed up to summary care records (SCRs) and additional information. SCRs enable healthcare professionals working in different care settings to access an electronic summary of key information from a patient's GP record. SCRs are widely used across NHS urgent and emergency care, such as NHS 111, 999 and Accident & Emergency Departments; and can also be used in planned care to provide up to date clinical information. Additional information includes information about communication needs because of a disability or sensory loss, which can be added to the SCR. This is a requirement of the Accessible Information Standard and means other health staff can see information about specific communication needs, and take steps to meet those needs.
- The practice made reasonable adjustments when patients found it hard to access services. The practice provided patients with information they required in the format that they required, for example, in larger print.
- The practice provided a wide range of information leaflets for patients. This included information that had been produced by the practice, for example, a comprehensive patient information booklet on insulin initiation.
- The Citizens Advice service provided a weekly session on site and this was well utilised by patients.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Longer appointments were available.
- The practice care coordinators had researched the services that were available locally to support patients in their own homes, and these were well utilised by the practice team. For example, patients were referred to the voluntary sector to access services such as befriending to help support isolation, and Sight Support offered help to those patients with visual impairment.
- If patients received their medicines from the practice dispensary, these had been delivered to the patient's home on occasions, if the patient (or a relative or friend) had been unable to collect them.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- Data demonstrated that the practice was below average for the emergency admission of patients into hospital and referrals to secondary care. This reflected that patients' conditions were being managed effectively by the practice.
- The practice held regular meetings and worked with community based teams to discuss and manage the needs of patients with complex medical issues.
- The practice provided insulin initiation on site for appropriate patients with diabetes.
- Any out of range test results received by the practice were reviewed by a GP. A safety net procedure had been introduced to pass these results onto the nurse practitioner who would then ensure appropriate follow up was undertaken to keep patients safe.
- The practice worked closely with specialist nurses, for example, the heart failure specialist nurses, to provide expert advice for those patients that required it.

Families, children and young people:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Care was targeted at teenage patients. For example, when attending the practice, health issues were discussed opportunistically with teenagers, and information packs were available on conditions that would be important to them. The practice had produced two different 'teen packs' which contained information on teenage sexual health and drugs/substance misuse. The material was specifically aimed towards a teenage audience and provided advice and details of different types of confidential support available to them. The practice website included a link to teenage health information through the NHS Choices website.
- Staff actively promoted and provided copies of a booklet called 'When Should I Worry?' developed by researchers at Cardiff University. This provided information for parents about the management of respiratory tract infections (coughs, colds, sore throats, and ear aches) in children, and was designed to be used in primary care consultations. Its use was evaluated in a randomised controlled trial, where it was shown that use of the booklet could result in a two-thirds reduction in antibiotic prescribing without impacting on parental satisfaction.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All children were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours pre-bookable appointments were available on a Saturday morning at the Barlborough site.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours. Telephone consultations were also being increasingly used for acute problems.
- The practice offered a range of services which included travel advice, contraceptive services and family planning, blood tests including an anticoagulation monitoring clinic, 24 hour blood pressure monitoring, spirometry (a test used to help diagnose and monitor certain lung conditions), minor surgery, and electrocardiogram (an ECG is a simple test that can be used to check a patient's heart's rhythm and electrical activity).

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice provided care to a local residential rehabilitation service for women with a personality disorder and complex needs, who were registered with the practice. In response to meet the needs of this group more effectively, the practice had arranged for representatives at the unit to deliver a presentation to the practice team in March 2018.
- The practice had a named GP for each of the two care homes they were allocated. The named GP visited the home every fortnight, and the practice responded to any urgent issues as required.
- The practice welcomed people living in vulnerable circumstances, such as homeless people to register with the practice.

People experiencing poor mental health (including people with dementia):

- Patients with symptoms of anxiety and depression had access to information on self-referral to the Improving Access to Psychological Therapies(IAPT) programmes to provide evidence based treatment and support.
- The practice team had an received a dementia training session in 2015, and were up to date with dementia awareness training on the online learning and development system they used.
- The practice utilised the "This Is Me" booklet recommended by the Alzheimer's Society. 'This is me' is a tool for people with dementia that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use. The practice offered pre-bookable appointments for non-urgent cases. Each day some appointments were released as 'book on the day' to accommodate those patients who felt they needed to be seen and could not wait for the next available appointment. When the day's appointments were fully booked, a telephone triage was used to review patients and when necessary, arrangements were made to see them in person that day.
- Telephone consultations were also used for advice, and patients could book these directly.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment were above local and national averages. A total of 246 surveys were sent out and 120 were returned. This represented 1.7% of the practice population.

- 78% of patients who responded said they usually got to see or speak to their preferred GP; CCG - 57%; national average - 56%. On the day of our inspection, we saw that a routine appointment with a GP of the patient's choice could be booked within one week.
- 85% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 87% of patients who responded said they could get through easily to the practice by phone; CCG – 72%; national average - 71%.
- 91% of patients who responded said that the last time they wanted to speak or see a GP or nurse; they were able to get an appointment; CCG - 86%; national average - 84%.
- 80% of patients who responded said they usually waited 15 minutes or less after their appointment time to be seen; CCG - 71%; national average - 64%.
- 86% of patients who responded described their experience of making an appointment as good; CCG - 73%; national average - 73%.

These results were supported by patient feedback received via completed comment cards. Out of the 53 cards we received, all included positive comments about individual patient experience. Two of the cards included an additional negative remark about appointments, one stating that appointments ran late and one suggesting that more GP appointments were needed. However, the overwhelming consensus was that access worked very well for patients, and many patients commented on this as a very positive aspect of the practice.

We saw that the practice manager prepared monthly reports on access to consider any emerging challenges. Minutes of a recent team meeting also made reference to the increasing demand for appointments and included a plan to address this, showing that the practice kept this under constant review. The recent appointment of a new salaried GP had contributed to the achievement of good access for patients.

We were informed that the rate of wasted appointments when patients did not attend was only 4%. However, the practice was still hoping to reduce this further and wrote to patients who repeatedly did not attend with the support of their PPG. A text reminder service was well used and over 173,000 reminders had been sent to patients since its introduction at the practice.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The practice's complaint policy and procedure was in line with recognised guidance. Five complaints were received over the preceding 12 months. We reviewed three of these and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual complaints and also from analysis of trends via an annual practice complaints review. It acted as a result to improve the quality of care.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience and skills to deliver the practice strategy.
- The Partners and practice manager were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges, for example, the increasing number of patients and the impact this had in terms of maintaining good access. One of the ways the practice were addressing this was through active involvement with some other local practices to develop an 8am-8pm advice and treatment hub.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The two GP partners and nurse practitioner undertook specific lead responsibilities such as prescribing, QOF and safeguarding.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The practice had developed its mission statement with a clear focus on delivering high quality patient care. Partners and managers portrayed their commitment to achieve this. They told us that they had worked hard to produce a relevant and sincere statement which patients could understand and believe in.
- Staff were aware of and understood the vision, the mission statement and future strategy and their role in achieving them.
- The practice held business planning meetings and partnership meetings.
- Barlborough Medical Practice was one of three North Derbyshire CCG GP practices grouped with six practices from the neighbouring CCG in their 'Community/PLACE' grouping. This created some difficulties due to conflicting priorities and ways of working across the two CCGs, but the practice tried to plan its services to meet the needs of the practice population as demonstrated by the ongoing discussions around the 8-8 service.

Culture

The practice had a culture of high-quality sustainable care.

- The practice focused on the needs of patients.
- Staff stated they felt respected, supported and valued, and told us that they enjoyed their work and were proud to work in the practice. This was reflected by low levels of staff turnover. More than half of the 18 members of the practice team had worked at the practice for over ten years.
- There were positive relationships between practice staff and community based teams.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. We saw evidence to confirm this when reviewing incident reports
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. A salaried GP was identified as the 'freedom to speak' champion for the practice.
- There were processes for providing all staff with the development they need. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was an emphasis on the safety and well-being of all staff.
- There was a practice equal opportunities policy and staff were encouraged to undertake equality and diversity training. Staff we spoke with on the day of the inspection all felt that they were treated equally.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.

Are services well-led?

Good

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There was a schedule of regular in-house meetings, including quarterly clinical meetings and full staff meetings which usually took place each month.
- Some of the GP partners held strategic lead roles within the clinical commissioning group (CCG) which helped influence and drive improvement in the delivery of patient care within the locality. For example, one GP attended the prescribing leads committee. The practice manager attended several workgroups with CCG colleagues and representatives from other local GP practices

Managing risks, issues and performance

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

- There was mostly an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance.
- Practice leaders had oversight of MHRA alerts, incidents, and complaints, although the practice were aware that they needed to strengthen the learning outcomes following the investigation of incidents
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- The practice used performance information from a variety of sources, included CCG benchmarking data and CQC insight reports. We observed that the practice analysed information and took steps to address any identified weaknesses. Data demonstrated that the practice was performing well within the CCG and showed positive variations for three of the indicators within the CQC insight report (indicating a much higher performance in these specific areas).
- The practice used information technology systems to monitor and improve the quality of care. The practice had developed their intranet system to assist with operational and managerial issues. The practice manager developed and wrote data entry templates on the practice computer system to capture essential information, and these were published and shared with colleagues across the county to disseminate best practice.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active virtual patient participation group consisting of 44 members. The group was contacted frequently by the practice manager, for example to participate in surveys. In addition, there was an open door ethos to communication with the group and face to face meetings did take place when these were required. We spoke with a member of the PPG who informed us that the group was treated respectfully and was listened to by the practice. The practice was open with them when things had gone wrong and discussed complaints with them when this was appropriate. The PPG helped to influence issues that impacted upon patients, for example the installation of additional telephone lines. PPG members had taken an active role in patient surveys and helped to evaluate the outcomes.
- The practice analysed patient survey data and considered any areas that could be improved. The practice undertook their own annual patient survey which included 13 questions. In response to the 2015

Are services well-led?

Good

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

survey, the practice achieved an 85% positive response to a question about the ease of contacting the practice by telephone. Whilst this was a good outcome, the practice wanted to improve the situation for the 15% of patients who did not find this a good experience. The practice therefore invested £7500 in a new phone system and tripled the number of incoming lines to six in total. This resulted in the satisfaction increasing by 10% in the latest survey completed in 2017. The 2017 survey was returned by 120 patients and showed generally positive outcomes. The results were made available for patients to see in the practice and were available on the practice website.

- Patient satisfaction surveys were also done in respect of the dispensary service. The 2017 survey showed very high satisfaction levels with the service. There were 37 responses which represented approximately 15% of regular dispensing patients.
- A "you said, we listened, we did" notice board was used to inform patients about survey results and the actions the practice had taken in response.
- The results of the NHS Friends and Family Test were consistently positive and we reviewed returns over the preceding three months which showed that the majority of patients would be 'extremely likely' or 'likely' to recommend the service to others.
- A themed notice board helped promote health campaigns such as cervical screening. At the time of our inspection, the practice was highlighting the impact of medicines waste and how patients could help this by ordering only the medicines that were required. The local primary school were displaying some of their project work to help foster links across the wider community and engage younger people with healthcare.
- A monthly newsletter was available to staff.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- The practice was working in partnership with two other local practices to bid for improved access for patients via a seven day 8am-8pm service. The plan was for this to be launched in October 2018. The scheme involved working across two CCG areas. The practice were committed to this development to ensure the best service for their patients.
- The development of templates on the practice computer system was undertaken by the practice manager, and then published for wider sharing across all of the Derbyshire GP practices. For example, a vaccinations and immunisations template developed in response to coding problems on the computer system. The template ensured that absent coding was captured ensuring accurate data collection, and that payments could be claimed correctly.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met** We found that the registered provider had not ensured safe systems were in place to review the expiry dates of medicines; patients receiving high risk medicines were not always monitored appropriately to ensure it remained safe to continue their prescriptions; and we saw that Standard Operating Procedures (SOPs) were not always followed within the dispensary. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.