Malthouse Surgery

Quality Report

The Charter
Abingdon
Oxfordshire
OX14 3JY
Tel: 01235 468860
Website: www. malthousesurgery.co.uk

Date of inspection visit: 15 July 2014
Date of publication: 24/10/2014

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.

Contents

Summary of findings

Overall summary

Malthouse Surgery is a general medical practice situated in the centre of Abingdon. Over 19,000 patients are registered with the practice. Around 25% of the registered patients are over the age of 65. The practice provides a range of services for patients which includes clinics for the management of long term conditions, family planning, travel and child health. Patients are signposted to and supported by other health care professionals who visit the practice and by local voluntary groups.

We spoke with 18 patients during our inspection and reviewed 27 comment cards completed by patients in the two weeks prior to our visit. Patients we spoke with complimented the care and support they received from the GPs and staff at the practice. We looked at the results of the last practice survey. This showed us that patients are pleased with the service they receive. We also spoke with the local team of NHS England, Healthwatch and the Oxfordshire Clinical Commissioning Group (CCG).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

The practice provided services that were safe. Current clinical guidelines were followed and referral systems operated efficiently. GPs and staff demonstrated a caring approach. Patients we spoke with told us they were treated with respect and with regard to their privacy. Services were responsive. A range of appointment times including evenings and every other weekend were offered. Systems were in place to respond to the needs of patients living in care homes. The practice was well led.

There were clear lines of accountability and management of patient data and security of data was robust. Policies and procedures were not always reviewed regularly and some quality monitoring processes were not followed up.

Quality and Outcomes Framework data showed us the practice performed well in delivering care and treatment for patients with long term conditions. The needs of working age patients were recognised. A range of appointment times were available and telephone consultations could be offered. Mothers, babies and young children received services including childhood immunisation clinics and mother and baby health checks. The practice provided GP services to six care homes. We spoke with some elderly patients. They told us they received care and support from the GPs that met their needs. Patients in vulnerable circumstances who may have difficulty accessing services were supported. The practice offered services for patients experiencing poor mental health. Including counselling services at the practice premises.

We found the provider was in breach of regulations relating to:

- Safeguarding patients who use the service from abuse and

- Requirements relating to workers.

Services are provided from:

Malthouse surgery, The Charter, Abingdon, Oxfordshire, OX14 3JY

and

Appleton Surgery, Appleton Village Hall, Oakesmere, Abingdon, OX13 5JS

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Some systems and processes relating to patient safety required improvement. The practice had comprehensive safeguarding policies and procedures in place to protect vulnerable patients. A safeguarding lead GP had been appointed and we found that most GPs had received appropriate levels of training. We saw that practice nursing staff had completed relevant safeguarding training. However, reception and administration staff were not aware of all the types of abuse they could encounter during the course of their duties and they had not received any training in safeguarding. Recording of recruitment checks that met legal requirements was not consistent. Photographic ID was not held on staff personnel files in all cases. Criminal record checks on practice nursing staff had not been undertaken. The practice did not have a risk assessment to identify which members of staff required criminal record checks. Procedures were not in place to ensure staff employed were of good character and fit to deliver services. The practice had regular team meetings involving the GPs, nurses administration and reception staff. Significant events were discussed in detail with the practice team. We found most systems to manage medicines were in place. Medicines were stored securely and could not be accessed by patients or visitors. However, the issue of medicines from stock was not recorded. The practice had a business continuity plan in place to deal with emergencies that could interrupt the smooth running of the practice. There were arrangements in place to deal with foreseeable medical emergencies.

Are services effective?

The practice was effective. Data we reviewed showed us the practice had achieved 99% of the care targets contained in the national quality and outcomes framework (QOF). The practice had an up to date recruitment policy in place that met the requirements of the Health and Social Care Act 2008. The practice had carried out clinical audits on a range of topics. End of life care was reviewed with the wider healthcare team. Staff received annual appraisals and told us that their training needs were being met. Information was exchanged between the practice and hospital departments. Data we reviewed showed us national targets for screening programmes such as cervical cytology and immunisations were being met. The practice worked with external services to ensure they were aware of the needs of their patients who were in vulnerable situations or had significant health problems.

Summary of findings

Are services caring?

The practice was caring. The GPs and staff we spoke with demonstrated a caring approach. Patients were extremely positive about the care they received. Patients told us staff were caring. This was detailed on comment cards CQC reviewed and by the patients we spoke with on the day of inspection. We saw that staff were caring and respectful in their interactions with patients. Patients we spoke with told us they were involved in making decisions about their care. They also told us they made the decision whether thy needed to be seen urgently or could wait. GPs and nurses were aware of their responsibilities in regard to the Mental Capacity Act 2005 and told us how they would apply it. We were given examples of how GPs and nurses ensured patients understood their care and treatment. The practice respected confidentiality of patient information by ensuring data was held securely. Calls from patients seeking advice or wishing to book an appointment were taken in an office away from reception to avoid the conversation being overheard.

Are services responsive to people's needs?

The practice was responsive to patient needs. There was a clear complaints policy and patients we spoke with told us they would feel able to offer comments about the service they received. Advice about how to make a complaint was available on the practice website and from the reception desk. The practice understood the different needs of the population it served and acted on these to ensure the service they provided offered appropriate support. The practice offered access for patients with mobility difficulties. All consulting and treatment rooms were on the ground floor. The practice did not have an induction loop and no specific provision was made for patients with hearing impairments. Written information about practice services and specific health conditions was able to be provided in large print for patients with visual impairment. There were a range of appointment options available to patients and evening and weekend clinics were held.

Are services well-led?

The practice was well led. There was an ethos throughout the practice team to deliver accessible patient care of the highest quality. Staff were fully aware of their roles and what decisions they could make. Practice management and GPs demonstrated leadership and a commitment to their patients and staff. Development and improvement for the GPs and their staff was supported by a performance review process and by a visible commitment to training. Staff received annual appraisal and their training needs were being met. Governance structures were in place and the practice had completed a nationally recognised process to

Summary of findings

ensure safety and proper handling of confidential data. Some systems to monitor quality were not operated consistently. For example the monitoring of general cleaning standards and completing actions identified in the control of infection audit. The practice manager was made aware of the findings and told us they would take action to address the issues found.

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

Approximately 25% of the registered patients were over the age of 65. This was higher than the Oxfordshire average. The Quality and Outcomes Framework (QOF) data we reviewed showed good performance in managing long term medical conditions associated with patients over the age of 75. The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients.

Patients over the age of 75 were allocated a named GP. We were told that if a patient wished to change their named GP their request would be respected. The practice manager told us that some patients had already changed their named GP. Patients were offered choice of the GP they preferred to deliver their care and treatment.

GPs were aware of local support and community groups that worked with older people. Patients in this group were referred to these organisations for support and practical advice. One of the GPs we spoke with told us how they, and their colleagues, assisted older patients to make hospital appointments when a referral was made. This had been introduced because a number of older patients had commented that they found it difficult to use the hospital appointment booking system.

We saw that arrangements were in place to provide flu vaccinations and other vaccinations appropriate to this group of patients. If a patient was unable to attend a flu vaccination clinic they could attend at a time that was convenient to them. Where the patient was unable to attend the practice arrangements were made for them to receive their vaccinations in their own home.

There were systems in place to respond to requests to visit patients living in care homes. Patients living in care homes had a named GP. There was a separate telephone number for care home staff to call when they needed GP support for a patient. Home visits were arranged for the frail and elderly to avoid them having to make difficult journeys to the practice.

People with long-term conditions

The practice supported patients with long term conditions. Disease registers were maintained that identified this group of patients. There were recall systems in place to ensure patients received monitoring and support at appropriate intervals.

Summary of findings

We were told that when a GP first diagnosed a long term condition they made an entry in the patient record. A recall for annual review of the patient's health was then established in the patient's medical record. A system was also in place to include newly registered patients with a previous similar diagnosis on both the register and recall programme.

The GPs followed national guidance for reviewing all aspects of a patient's long term condition and recommended templates for review were in use. We saw that the practice achieved over 99% of the targets for care of this group of patients. If a patient who was recalled for an annual review of their health did not attend their appointment there was a system in place to remind them of the importance of attending the review. We saw that patients in this group were offered an annual flu vaccination.

The practice also held a central electronic record of good practice guidance which all GPs and nurses could access. The lead GP we spoke with during our inspection told us they accessed this information during consultations and could offer patients a copy of guidance to take home with them.

When appropriate GPs referred patients to specialist community staff for support with their long term medical conditions. This included referral to specialist nurses supporting patients with severe breathing problems and heart conditions.

The practice offered clinics for these patients. The clinics were run by practice nurses. We saw that the nurses who held these clinics had received additional training specific to the management of chronic diseases. For example training in diabetes management. If a patient was unable to attend the clinic they were able to book to see the relevant nurse or their own GP for their review at another time.

Mothers, babies, children and young people

The practice delivered services appropriate to the needs of mother, babies, children and young people. There was a child safeguarding policy in place. GPs and nurses were trained to spot signs of abuse and were aware of how to and who to report any concerns.

Systems were in place to invite parents or guardians to bring babies and young children for childhood immunisations. We saw that immunisation take up was over 90%. Childhood immunisation clinics were held and we heard that nurses received regular updates in the administration of childhood immunisations.

Expectant mothers were able to see their midwife at the practice. There were systems in place to support liaison between the GPs and midwives to ensure care for expectant mothers was co-ordinated.

Summary of findings

New mothers were invited to bring their babies for a health check six weeks after birth. There was a system in place to alert health visitors if the mother and baby did not attend for their appointment. Health visitors were based and held clinics at the practice. When an expectant mother made the choice to have a homebirth this was supported.

Sexual health advice and support was available for young patients.

The working-age population and those recently retired

The practice offered a range of services to patients of working age and those recently retired.

Counselling clinics were available and family planning advice was offered by practice nurses. Referrals to hospital were made efficiently and in consultation with the patient. Patients were able to progress the booking of their hospital appointments at times convenient to them.

Access to a variety of appointment types was available. Evening surgeries ran on two evenings a week and a fortnightly Saturday morning surgery took place. Telephone consultations were available on request. This supported patients who worked every weekday and found it difficult to attend the practice for an appointment. Appointments could be booked online.

When appropriate online advice and consultations with hospital specialists was used by GPs to avoid the need for the patient to attend a hospital clinic. For example, photographs of suspected skin complaints could be sent to the dermatologists for a diagnosis.

People in vulnerable circumstances who may have poor access to primary care

The practice recognised the needs of and offered services to patients in vulnerable circumstances. One of the GPs told us practice had an open registration policy and would not turn patients away who wished to register from within their area. Interpreter services were available for patients whose first language was not English.

Home visits were offered for patients with mobility problems.

Carers were identified on the practice computer system. We were told that the GPs supported carers to complete their claim for a carers grant. Carers were also provided with information regarding the local carers forum. The local carers forum offered advice and practical support to carers and the opportunity to meet other carers and share their experiences.

Summary of findings

There were patients with a learning disability registered with the practice. We were told these patients received an annual health check-up.

People experiencing poor mental health

The practice offered a range of services to patients experiencing mental health problems. Counselling services were referred to when appropriate. A range of leaflets detailing local self help and support groups were available.

The practice achieved all of the targets for managing mental health problems included within QOF.

The practice took an active role in supporting patients with drug and alcohol addiction. Shared care agreements were in place with the local addiction team. Some of the GPs had specialist expertise in working with patients with mental health problems.

The care of patients experiencing poor mental health was subject to an audit in 2013. Recall systems were improved as a result to ensure both physical and mental health was reviewed at appropriate intervals for this group.

Summary of findings

What people who use the service say

We spoke with 18 patients on the day of our inspection. We reviewed 27 comment cards that patients had completed in the two weeks prior to inspection. We also looked at the results of a national patient survey conducted in 2013 and the practice patient survey conducted in early 2014. The comments patients' had posted on the NHS choices website were looked at before the inspection took place.

The patients we spoke with on the day of the inspection were very positive and complimentary of the care, treatment and support they received from GPs and practice nurses. They told us they could access a range of appointments and that they were treated with dignity and respect. A number of the patients we spoke with told us that they found the GPs explained care and treatment very well and that they felt involved in making decisions about their care. Similar comments were included in the comment cards we reviewed.

The results of the national patient survey showed us that 91% of 128 patients who responded said the GPs were good at explaining tests and treatments. 84% of the 128 patients who responded said their GP was good at involving them in decisions about their care. 83% of those who replied said their overall experience of the service was good or very good. However this rating is lower than the average for the Oxfordshire CCG.

Areas for improvement

Action the service MUST take to improve

- Improve systems, training and staff awareness of safeguarding patients from abuse and ensure reception and administration staff are aware of the reporting processes to follow if they suspect abuse has occurred.
- Take appropriate action to ensure staff are of good character and risk assess the requirement for criminal record checks.
- Staff carrying out chaperone duties must be trained in the role and have criminal records checks.

Action the service SHOULD take to improve

- Should improve the maintenance and refurbishment of the premises
- Apply the induction programme for all new staff.
- In respect of sharps bins the practice should comply with all requirements of the hazardous waste regulations.
- In respect of audit cycles the practice should operate quality monitoring systems consistently. Whilst there was evidence of clinical audits the practice should complete two full audit cycles to ensure clinical care has improved as a result.
- Consider the requirements of patients with a sensory impairment. An induction loop system was not available for patients with a hearing impairment and no plans were in place to install one.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice offered the working age population the opportunity to book appointments online and provided Saturday morning GP appointments every other week.

Malthouse Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor. The team included a practice manager advisor, a second CQC inspector and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to Malthouse Surgery

Malthouse surgery is located in the centre of Abingdon. The practice rent the premises from the local council and share the building with staff from a local NHS Trust. Patients are registered from the main town of Abingdon and from local villages and rural communities.

The practice premises had been considered by private companies for commercial development. The practice had hoped to move to a purpose built surgery as part of the development project. The project is subject to review and it is not yet known whether the practice will remain in the current premises. Consequently the practice is not investing in improving the premises as the future of the building is uncertain. A decision on the future of the premises is expected within the next two years.

Over 19,000 patients are registered with the practice. Approximately 25% of the registered patients are over the age of 65. This is above the Oxfordshire average. The practice performs well against nationally recognised quality standards. The Quality and Outcomes Framework data available to CQC shows over 99% of targets are met. A wide range of primary medical services are provided including clinics for patients with long term conditions and for child health.

Care and treatment is delivered by 12 GPs, a nurse practitioner, four practice nurses, two healthcare assistants and two phlebotomists (phlebotomists are staff trained to take blood tests). The GPs and nurses are supported by a practice manager, patient services manager and a team of administration and reception staff.

The practice is a member of Oxfordshire Clinical Commissioning Group (CCG) and the South West Oxford Locality sub group of the CCG. One of the GPs and the practice manager attend CCG meetings.

The feedback from the 18 patients we spoke with on the day of inspection and on the 27 comment cards we reviewed was positive. The practice patient survey conducted in early 2014 also showed patients' are positive about the care and treatment they receive.

The Malthouse Surgery, The Charter, Abingdon, Oxfordshire, OX14 3JY

and

Appleton Surgery, Appleton Village Hall, Oakesmere, Abingdon, OX13 5JS

We visited the Malthouse surgery but did not visit The Appleton Surgery as part of this inspection. The Appleton surgery is only open one morning each week and was not open on the day of our visit.

The practice had opted out of providing Out Of Hours services to their patients. There were arrangements in place for patients to access care from an out of hours provider.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Oxfordshire Clinical Commissioning Group (CCG). We carried out an announced visit on 15 July 2014. During our visit we spoke with a range of staff, including GPs, practice nurses, the practice manager and administration staff. We observed how patients were cared for and how staff interacted with patients. We also spoke with 18 patients who used the service. We reviewed management records.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Are services safe?

Our findings

Safe Track Record

The practice had a system in place to deal with alerts from national bodies. Information relating to withdrawal or a dose change for specific medicines was passed to the GPs for action. Patients affected were contacted and the necessary changes made in consultation with the patient and GP. If an alert related to medical equipment it was passed to either the senior nurse or dealt with by the practice manager. The practice manager kept an electronic log of the actions taken.

Any incidents that could have affected the safe treatment and care of patients were recorded as significant events.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events.

We saw that the practice carried out regular reviews of significant events. The records showed that full investigation of any significant event was carried out. Learning from the incident was shared with the practice team. Staff confirmed that the learning from incidents, relevant to their roles and responsibilities, was shared with them. The practice had systems in place to reduce the likelihood of significant events being repeated. The notes from significant event reviews were posted in the main administration office. This included the learning and action taken.

Reliable safety systems and processes including safeguarding

Children and vulnerable adults were not adequately protected from the risk of abuse because the practice had not taken all reasonable steps to identify and prevent abuse from happening. Most of the GPs were trained to an appropriate level in safeguarding. We were told that at least one GP had not completed the appropriate level of training. We could not evidence that all GPs were trained to level 3. Practice nursing staff were trained appropriately in safeguarding. The GPs and nurses we spoke with were knowledgeable about how to report safeguarding incidents.

We spoke with five members of the practice administrative and reception staff. They were unable to tell us about all of the forms of abuse they might encounter during their duties and how they would report any concerns. We saw from the monthly training timetable and personnel files that administrative and reception staff had not received training in safeguarding of either children or vulnerable adults. There was no evidence of safeguarding being discussed with the full practice team and one of the GPs we spoke with recognised the need for seminars to be held on this topic. We found administrative and reception staff did not access online training material relating to safeguarding.

The local safeguarding procedures for Oxfordshire County Council were displayed on the staff notice board in the main administration office. The reporting process including telephone contact numbers for the safeguarding authority were displayed alongside the policy. Some of the reception and administrative staff we spoke with were not aware this information was available to them.

The practice had a chaperone policy. We were told that either a nurse or health care assistant was called to undertake chaperone duties. However, the health care assistant and nurse we spoke with had not received chaperone training and had not had criminal record checks carried out. The opportunity to request a chaperone was promoted via a poster in the waiting room. The GPs told us they recorded when a chaperone had been present in the patient's medical record.

Monitoring Safety & Responding to Risk

The lead GP and the practice manager told us that they were aware some of the partners could retire in the next few years. Two unsuccessful attempts to recruit a new partner had been made. The partners and manager kept the GP establishment under review in order to respond if a partner decided to retire.

We saw that the mix of appointments types was adjusted to meet expected peaks in demand. For example, there were more telephone slots and on the day appointments available on a Monday morning. There was recognition that more staff were needed in the morning to receive phone calls from patients wishing to book appointments. We saw that there were more staff on duty in the morning than in the afternoon.

Medicines Management

We saw that medicines were stored securely. Prescription pads were stored safely in a locked room. When boxes of prescriptions were delivered they were signed for and taken to secure storage immediately. We saw that the practice was the highest user of electronic prescribing in

Are services safe?

Oxfordshire. There was a system in place for reviewing repeat prescriptions and we were told that patients who failed to attend for their prescription review were followed up and reminded to attend their review.

Separate fridges were used to store vaccines. We saw that a vaccine stock control system was operated. Fridge temperatures were monitored and there was a procedure in place to follow if a temperature reading fell outside the safe range. The vaccine fridges were located in a locked room only accessible to staff. We noted one of the vaccine fridges did not have a lock.

Cleanliness & Infection Control

The practice had a cleaning schedule. The schedule was displayed and described each cleaning task and how often it should be carried out. Monitoring of the cleaning was the responsibility of the senior member of cleaning staff. We were told there was a checklist used to confirm cleaning had been completed. Copies of the checklist could not be located on the day of our visit. Treatment rooms and most common areas were clean and tidy. Some of the cupboards, window blinds and work surfaces in GPs consultation rooms were visibly dusty. The floor in one patient toilet was not clean around a service duct cover and there was dirt behind a toilet cistern in another toilet.

There was an infection control policy and a member of the nursing team was the infection control lead. Nursing staff undertook annual refresher training in infection control processes. We saw that clinical rooms had supplies of hand gel and paper towels and hand washing guidance was displayed. A control of infection audit had been carried out in May 2014. There were actions identified from the audit had been taken or were in progress. For example GPs and administration staff were taking training in infection control. Some actions had not been progressed or given a date of when they should be completed. For example, an examination couch had a tear in the covering and this had not been repaired or replaced. We could not see a date for the job to be carried out. This presented a risk of cross infection because the couch covering was not intact and could not be cleaned properly.

We looked at the contract for disposal of clinical waste and at the documentation confirming that clinical waste had been collected by the approved contractor at regular intervals. Bags of clinical waste were dealt with appropriately and stored safely awaiting collection.

However, the sharps bins we looked at were not labelled with the practice name or date they were first used. Sharps bins should be identified to the practice to provide an audit trail which can trace infections to their source.

A risk assessment for legionella had been completed. Appropriate water testing was carried out. Certificates confirming that water tests had been completed were held on record.

Staffing & Recruitment

There was an up-to-date documented recruitment and selection policy. This met current legal requirements. The practice manager told us that this policy was now in use. Staff turnover was very low and only two staff had been appointed in the last 18 months. One member of staff had a criminal record check through the Disclosure and Barring Service (DBS) (previously Criminal Records Bureau (CRB)). The second member of staff recruited had not been subject to a risk assessment to decide whether a DBS check was required.

Practice nurses told us they had not been subject to a DBS check and we found no evidence of the checks being undertaken in the personnel files of the nurse and healthcare assistants we reviewed. There was no risk assessment in place to inform which members of staff required a DBS and which members did not. The practice had not operated processes to ensure all staff were of good character to carry out their roles or put systems in place to safeguard patients from the risk of abuse.

We looked at eight personnel files. All contained a CV and two did not have a job description. Only three of the files held photographic proof of identification. One of the personnel files where photographic ID was absent was for a member of staff recruited in the last 18 months. The information we reviewed in staff files did not meet the requirements of legislation. The practice had not obtained all evidence to confirm staff were of good character and fit to carry out their roles.

Dealing with Emergencies

Appropriate equipment, medicines and oxygen was available for use in a medical emergency. We saw that the emergency equipment was checked regularly and the check was recorded. We saw evidence of these checks and

that when a check identified a need for repair or replacement this had been carried out. All the staff at the practice received annual training in basic life support. Records of the training received were in personnel files.

There was a comprehensive plan in place to deal with situations that might affect delivery of patient care. This business continuity plan included what to do if the building became unusable for any reason. Staff we spoke with were aware of this plan and their role in dealing with situations that might arise that interrupted services to patients.

The business continuity plan was displayed on the staff notice board and the telephone numbers for emergency services and contractors were included. This enabled staff to access the plan and take appropriate action if the practice manager or patient services manager were not in the practice.

Equipment

Records confirmed essential equipment had been serviced and maintained in accordance with manufacturer's instructions. The records also showed us that where equipment required regular calibration this had been carried out. Medical equipment was safe to use and gave accurate readings.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Care and treatment was delivered in line with recognised best practice standards and guidelines. There was evidence the practice kept up to date with new guidance and legislation. GPs and nurses followed the relevant National Institute for Health and Care Excellence (NICE) guidelines in the management of patients with long term medical conditions. Good practice protocols were contained in the practice database. Additional guidance was held in a shared file on the practice computer system.

GPs and nurses were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

Management, monitoring and improving outcomes for people

The practice participated in benchmarking programmes nationally and locally including the Quality and Outcomes Framework (QOF). The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice achieved high results in 2012/2013 against the national quality and outcomes framework (QOF). These included the clinical, organisational and patient experience domains. We saw that prescribing audits were undertaken that formed part of a Clinical Commissioning Group (CCG) wide audit programme.

We saw that the practice had conducted an audit of all aspects of care received by housebound patients with diabetes. The GPs had used the data to ensure all the support required by housebound diabetics was delivered. We also heard about an audit that covered the range of care and support received by patients with mental health problems. This had resulted in the practice introducing more robust recall systems to ensure this group of patients received both review of their mental and physical health. We did not find continuous audit cycles in operation. Audits carried out were focused on specific topics and were not revisited.

The practice worked with other professionals to co-ordinate the care of patients with specific conditions. For example, shared care agreements were in place for both patients with a substance addiction and with rheumatology problems. The GPs were able to make changes to prescriptions for this group of patients thus avoiding the need for them to attend the hospital.

GPs in the surgery undertook minor surgical procedures in line with their registration and National Institute for Health and Care Excellence (NICE) guidance.

Effective Staffing, equipment and facilities

We found there was an inconsistent application of the staff induction programme. We were told by staff we spoke with that shadowing of experienced staff took place and that new staff were made aware of important policies and procedures. However, an induction checklist had not been used to ensure every aspect of induction had been completed. We saw a revised induction programme was available. This included signing off competencies as they were achieved. We were told by the practice manager that the new induction system would be used when staff were appointed in the future.

Training and professional development was in place. There was a record of training undertaken by staff and a programme for future training of individual staff. For example, we saw the next basic life support training was timetabled for all staff. The staff we spoke with told us that when they identified training needs this was made available. Nursing staff held records of the training and development they completed to maintain their professional registration. We were told by the practice manager that the senior nurse checked that nurses' professional registration was up-to-date.

GPs and nurses held regular meetings and we saw that training was on the agenda. The GPs also took part in shared learning events with another practice in the Abingdon area. These were held every month. Staff received an annual appraisal. We saw records of appraisals in the staff files we reviewed. GPs were actively involved in professional revalidation and one of the GPs held responsibility as the lead for training.

There were systems in place to disseminate relevant learning through a structure of team meetings. For example, updates in clinical treatments and protocols were shared with the nursing team on a monthly basis. We saw

Are services effective?

(for example, treatment is effective)

minutes of the various team meetings. All staff groups took part in the quarterly review of significant events. We saw that the minutes of the meeting, including the learning points were circulated to all staff.

Working with other services

The practice worked with the district nursing team, health visitors and midwifes. GPs told us there was a clinical meeting every month and the community team was invited. This included the district nurses and palliative care nurses. The minutes of the meetings showed us that care of patients that required the input from various staff was discussed to ensure co-ordinated care was given. For example, the support required by patients in receipt of palliative care was discussed and co-ordinated.

There was evidence of working with other healthcare professionals and voluntary bodies. Clinics were held at the practice by counsellors. Patients and carers were informed about local community groups including support groups for the elderly and the carers forum.

Technology was used to support working with the local hospital. For example e-mails and photographs could be exchanged with dermatologists at the hospital to obtain advice about and diagnosis of skin conditions. Patients could receive a diagnosis and treatment without the need to attend hospital clinics.

The practice operated a system of reviewing discharge letters within three days of their receipt. The lead GP told us this improved the support they gave patients who an in-patient stay. For example, if a hospital doctor asked the GP to change a prescription this was able to be followed up within three days.

Health Promotion & Prevention

GPs told us of a range of health promotion services they were able to access for their patients. For example, smoking cessation counselling was available in the practice. The GPs were able to refer patients to a dietician for weight management advice. Patients with alcohol misuse problems were referred to local support services. Patients seeking support for drug misuse problems were referred to the local team and shared care agreements were entered into when appropriate.

Health information was made available during consultation and GPs used literature available from online services to support the advice they gave patients. A range of health promotion information was available in both the main waiting area and in clinical rooms.

The practice website also contained health promotion advice and links to other relevant websites. For example 'Lifecheck' (Lifecheck is a free NHS service advising patients and their families on how to improve their health.)

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 18 patients on the day of our inspection. Patients told us they had been listened to by both GPs and nurses and that their care and treatment met their needs. Patients also told us that staff were professional and friendly. We were also told patients found the GPs and nurses to be caring. We saw staff interaction with patients was carried out with respect and kindness. Waiting areas were located close to treatment rooms.

The GPs consultation rooms were suitably equipped and laid out to protect patient's privacy and dignity. For example, there were curtains that could be drawn around examination couches. Consultations were carried out in a way which protected dignity and privacy. Long queues were avoided at the reception desk, which reduced conversations being overheard. There was a separate area with a member of staff present for patients to request and collect their repeat prescriptions.

Telephone calls from patients booking appointments were taken in a back office to avoid the call being overheard by patients attending the reception desk. We observed that this enabled staff to take detailed information confidentially. For example, the details of the location for a home visit could be read back and confirmed to a patient without this being overheard by others.

A room was available for patients who wished to speak with reception staff in private. The design and layout of the practice meant patient records could not be viewed by those attending the practice, and records were maintained securely and confidentially. The practice complied with data protection and confidentiality.

The lead GP told us the confidentiality policy had been reviewed in the last year. They told us that the revised policy had been communicated to all staff. Staff we spoke with were very aware of their responsibilities in maintaining confidentiality at all times. Some of the patients we spoke with told us they had never been asked for personal medical information when calling to make an appointment or at reception. We saw that the confidentiality policy had been updated.

Involvement in decisions and consent

Patients told us staff took time to listen to them and respect their wishes. Patients said they were involved in the decisions about their treatment and care. There was information available on specific treatments that patients could take away to assist them in understanding their treatment and condition. The GPs and nurses we spoke with told us they always sought patient consent to treatment. There was a consent policy. Patients we spoke with told us the GPs explained treatments proposed and asked them if they wanted to pursue the treatment.

Most of the patients we spoke with and who completed comment cards said they were able to decide the urgency of their appointment need.

Patients we spoke with told us that they were involved in planning their care. Patients who had been referred to hospital for treatment said they had the reason for the referral explained to their satisfaction. We heard how patients who found it difficult to use the hospital clinic booking system were assisted by their GP. A member of staff we spoke with gave us examples of how they had helped patients to book their hospital appointments.

GPs and nurses we spoke with were aware of their responsibilities in relation to applying the Mental Capacity Act 2005 (MCA). We were given an example by a nurse who did not proceed with a treatment because the patient had not understood the description of the treatment. They told us that they stopped and gave a second explanation more slowly to ensure the patient understood the treatment before they proceeded. Staff were aware that relatives and advocates were to be involved when they felt a patient was unable to make a decision about their care and treatment.

Patients were told about the out of hours arrangements. The surgery website and information leaflets described how to contact a GP in the event of an emergency outside of the opening hours.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The lead GP told us that no one from within the practice area wishing to register would be turned away. GPs from the practice visited patients in local care and nursing homes and links had been built with these homes. Patients living in these homes had a named GP to support continuity of care. However, arrangements were in place to ensure that patients were seen when their own GP was not available.

The practice was sensitive to meeting patients' needs. The consulting rooms were situated on the ground floor of the surgery. We saw access to the practice was suitable for patients who used a wheelchair and for children in prams. Parking for patients with mobility difficulties was available in the public car park next door to the practice. An induction loop (system for voice amplification) was not available. There was no specific provision for patients with hearing impairments. Written material about either the practice or specific medical conditions could be produced in large print to support patients with a visual impairment.

A range of clinics and services were offered to patients, which included family planning, antenatal, children's immunisation, and nurse specialist clinics for patients with long-term conditions.

The practice had a system in place with secondary care providers to ensure information was exchanged when a referral was made or when results where available. Any action requested by the hospital or Out of Hours (OOH) service was communicated to the practice. Information relating to end of life care was communicated to the OOH using special notes.

The practice sought and acted upon feedback from patients. A patient representative group (PRG) was in place and were involved in annual patient satisfaction surveys. A PRG is formed of a group of patients who have agreed to contribute, usually via e-mail, their views on practice services and possible developments. The practice had changed the telephone system because patients had commented that their calls were taking a long time to be answered. A notice board had been introduced which carried information about which GPs were on duty and whether their clinics were running late. The notice board had been installed following comments from patients about their appointments running late.

Access to the service

Alternative methods of booking appointments were available. Patients could book by telephone, in person or online. We heard that the online booking facility had been introduced in the last year in response to patient feedback. Appointments were available on two evenings each week and on every other Saturday morning. Telephone consultations were also available. Double appointments could be booked upon request or on the advice of the GP.

Patients told us they did not have problems accessing appointments. Patients were very positive about being able to obtain an appointment on the day they called the practice. The patients we spoke with were very positive about obtaining an appointment on the day they called. We saw that the practice adjusted the mix of pre bookable and on the day appointments to meet demand.

The hours when medical support was available were clearly displayed at the practice and on the website. When the practice was closed there was a message on the answering machine which directed patients to the Out Of Hours service. There was information on the website and in the practice regarding the availability of the minor injuries unit at the local hospital.

There was a patient information leaflet available at reception and this was given to all new patients. It contained details of practice opening times and the services that were on offer in the practice. Further Information was also included about the members of the practice team and how to make an appointment. The website provided information such as the different clinics and services offered by the practice. Patients who used the service were given appropriate information and support regarding their care or treatment.

Meeting people's needs

When a decision was made to refer a patient for specialist advice or treatment the referral was processed promptly. We were told by members of staff that patients who were encountering difficulties in obtaining a hospital appointment were assisted in this process. Staff called the relevant hospital department and helped the patient make the appointment. Follow up care arrangements were in

Are services responsive to people's needs?

(for example, to feedback?)

place. GPs reviewed all hospital letters within three days of receipt. The information needed to support patients who had attended hospital was known to the GP before the patient returned to see them. Patients we spoke with confirmed they knew the reason why they were being referred and what process to follow to obtain their appointment. Advice could be sought to assist patients who found it difficult to attend hospital. For example, e-mail exchange with hospital doctors was used.

If medical tests were needed prior to referring a patient for specialist care these were carried out and the results were included in the information sent with the referral. Patients we spoke with understood the systems in place to receive results of medical tests and how to obtain their repeat prescriptions. Patients we spoke with told us the repeat prescription system worked well.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. A designated responsible person handled all complaints in the practice. Information on how to lodge a complaint was available on the website. Some of the patients we spoke with were aware of the complaints procedure. Others told us they would not know how to make a complaint. However, patients told us they were pleased with the services they received and had not felt the need to raise any concerns or complaints.

We reviewed the summary of complaints received in since 2013. All complaints received had been investigated in full and responses made to the complainant in accordance with the practice policy. We were given examples by staff of how the practice manager made themselves available immediately when a patient raised a concern. We also heard how anyone who raised a verbal complaint by telephone was called back as soon as possible. The practice was proactive in dealing with concerns and complaints.

We saw notes of meetings that showed us complaints were reviewed by the GPs and lessons learnt from complaints were discussed and recorded. Learning from complaints was shared with the wider practice team.

Are services well-led?

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

Our findings

Leadership & Culture

All the staff we spoke with were focussed on ensuring patients could access timely medical advice and support. GPs were committed to delivering good quality care and meeting the needs of all groups of patients. We saw the GPs and management had recognised the current situation of working from premises with an uncertain future. The uncertainty was preventing any investment to improve the surroundings. There were minutes of meetings showing the GPs and management had discussed the topic of moving to new premises. We were told that until a decision was made about tenure of the present practice premises no investment would be made to improve them.

We saw the practice had a strategic plan covering the years 2013 to 2015. The strategic plan included the vision of the practice and a mission statement and it had been shared with staff. The practice had a succession plan.

Governance Arrangements

Meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. Significant events were shared with the practice team to ensure they learnt from them and received advice on how to avoid similar incidents in the future. GPs led on specific areas of clinical management and staff we spoke with were aware of which GP was responsible for which area.

The practice manager delegated certain responsibilities to team leaders and staff clearly identified with their team manager. The practice had a range of policies and procedures. For example, confidentiality, infection control and complaints handling.

There was an information governance policy in place and we saw that the practice had quality assured the processes in operation for use and storage of patient data. One of the GPs took responsibility for information governance.

Systems to monitor and improve quality & improvement (leadership)

We looked at a range of clinical audits that had been undertaken in the last year. For example, an audit of care for diabetic patients who were housebound had been carried out. The practice had adopted a protocol to review all discharge letters for patients who had been in hospital within three days of receipt. We were told this target was being met and had improved the follow up of care for this group of patients. Some of the patients we spoke with told us they had attended hospital for operations or as in patients. They said the GPs were fully briefed on the support they needed when they left hospital. We also saw that the practice had improved the service for patients with mental health problems following an audit of care for this group. This included making the recall system more robust to ensure patients were called in for regular health checks.

Patient Experience & Involvement

The practice undertook an annual patient satisfaction survey. We saw the results of the last survey were displayed on the practice website. The feedback was generally positive. There was an action plan in place to respond to the findings of the survey. It was evident that the practice took feedback seriously and responded to it. For example, one action identified was to avoid keeping patients waiting on the phone for more than two minutes before the call was answered. The practice manager told us how the new telephone system enabled tracking of calls. They told us the majority of calls were answered within the two minute target.

Complaints were investigated and responded to by the practice. We saw that detailed responses to complaints were offered and that apologies were made when appropriate. We heard how the practice manager made sure they were available very quickly when a patient advised they wished to lodge a complaint.

Practice seeks and acts on feedback from users, public and staff

Staff we spoke with told us they were able to access GPs and managers for advice and support when they needed to. There were a range of staff meetings held and staff said they were able to contribute to them. Staff felt they were listened to and their ideas and suggestions were considered.

The practice had a patient reference group (PRG). (A PRG is a group of patients who have volunteered to be in electronic communication with the practice because they take an interest in service developments). We saw that PRG members had taken part in the patient survey conducted in January 2014. The results of the practice survey showed that the majority of patients were happy with the services they received. 80 % of the 200 patients who took part rated their consultation with their GP as very good and 79% rated

Are services well-led?

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

their consultation with a nurse as very good. 93% of the responders said the GP was good at involving them in decisions about their care and treatment. We saw that an action plan had been developed to address the comments received during the survey. The practice had introduced a system to keep patients informed if the GP was running late in surgery. This was an issue identified from the survey.

Management lead through learning & improvement

GPs were active in the process of revalidation and this was supported by audits carried out either individually or as a practice. Clinical updates were supported by monthly clinical meetings held with a neighbouring practice. Nurses held their own training records and we were told that professional registration was checked by the senior nurse. Staff received annual appraisals and there was a central record of the training undertaken month by month.

The objectives for the practice were set out in the strategic plan which was subject to annual review. For example there was recognition the practice needed to work closely with other health care providers locally and across the county of Oxfordshire. The practice had identified increasing demand on services required more co-ordination of services between providers of health care.

Identification & Management of Risk

The practice had taken measures to identify, assess and manage risk. However, some improvements were required in the monitoring of risks. There was a health and safety policy. This had not been reviewed in the last year. The building risk assessment was not available to us on the day of inspection. This was held by the building owners. There was a fire risk policy and a professionally completed fire risk assessment. The control of infection audit carried out in May 2014 identified action to be taken to further reduce risk of infection. For example develop a cleaning schedule for ECG machines. The actions identified who was responsible but, did not set a deadline for when the action should be completed. Monitoring checklists for the quality of general cleaning were not available. We found areas of the practice, for example window blinds in consultation rooms, where cleaning was not adequate. Monitoring systems had not identified this risk. We advised the practice manager of our findings. They told us they would review safety policies as a matter of urgency and would improve monitoring of cleaning standards.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Approximately 25% of the registered patients were over the age of 65. This was higher than the Oxfordshire average. The Quality and Outcomes Framework (QOF) data we reviewed showed good performance in managing long term medical conditions associated with patients over the age of 75. The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients.

Patients over the age of 75 were allocated a named GP. We were told that if a patient wished to change their named GP their request would be respected. The practice manager told us that some patients had already changed their named GP. Patients were offered choice of the GP they preferred to deliver their care and treatment.

GPs were aware of local support and community groups that worked with older people. Patients in this group were referred to these organisations for support and practical advice. One of the GPs we spoke with told us how they, and their colleagues, assisted older patients to make hospital appointments when a referral was made. This had been introduced because a number of older patients had commented that they found it difficult to use the hospital appointment booking system.

We saw that arrangements were in place to provide flu vaccinations and other vaccinations appropriate to this group of patients. If a patient was unable to attend a flu vaccination clinic they could attend at a time that was convenient to them. Where the patient was unable to attend the practice arrangements were made for them to receive their vaccinations in their own home.

There were systems in place to respond to requests to visit patients living in care homes. Patients living in care homes had a named GP. There was a separate telephone number for care home staff to call when they needed GP support for a patient. Home visits were arranged for the frail and elderly to avoid them having to make difficult journeys to the practice.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice supported patients with long term conditions. Disease registers were maintained that identified this group of patients. There were recall systems in place to ensure patients received monitoring and support at appropriate intervals.

We were told that when a GP first diagnosed a long term condition they made an entry in the patient record. A recall for annual review of the patient's health was then established in the patient's medical record. A system was also in place to include newly registered patients with a previous similar diagnosis on both the register and recall programme.

The GPs followed national guidance for reviewing all aspects of a patient's long term condition and recommended templates for review were in use. We saw that the practice achieved over 99% of the targets for care of this group of patients. If a patient who was recalled for an annual review of their health did not attend their appointment there was a system in place to remind them of the importance of attending the review. We saw that patients in this group were offered an annual flu vaccination.

The practice also held a central electronic record of good practice guidance which all GPs and nurses could access. The lead GP we spoke with during our inspection told us they accessed this information during consultations and could offer patients a copy of guidance to take home with them.

When appropriate GPs referred patients to specialist community staff for support with their long term medical conditions. This included referral to specialist nurses supporting patients with severe breathing problems and heart conditions.

The practice offered clinics for these patients. The clinics were run by practice nurses. We saw that the nurses who held these clinics had received additional training specific to the management of chronic diseases. For example training in diabetes management. If a patient was unable to attend the clinic they were able to book to see the relevant nurse or their own GP for their review at another time.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice delivered services appropriate to the needs of mother, babies, children and young people. There was a child safeguarding policy in place. GPs and nurses were trained to spot signs of abuse and were aware of how to and who to report any concerns.

Systems were in place to invite parents or guardians to bring babies and young children for childhood immunisations. We saw that immunisation take up was over 90%. Childhood immunisation clinics were held and we heard that nurses received regular updates in the administration of childhood immunisations.

Expectant mothers were able to see their midwife at the practice. There were systems in place to support liaison between the GPs and midwives to ensure care for expectant mothers was co-ordinated.

New mothers were invited to bring their babies for a health check six weeks after birth. There was a system in place to alert health visitors if the mother and baby did not attend for their appointment. Health visitors were based and held clinics at the practice. When an expectant mother made the choice to have a homebirth this was supported.

Sexual health advice and support was available for young patients.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice offered a range of services to patients of working age and those recently retired.

Counselling clinics were available and family planning advice was offered by practice nurses. Referrals to hospital were made efficiently and in consultation with the patient. Patients were able to progress the booking of their hospital appointments at times convenient to them.

Access to a variety of appointment types was available. Evening surgeries ran on two evenings a week and a fortnightly Saturday morning surgery took place. Telephone consultations were available on request. This supported patients who worked every weekday and found it difficult to attend the practice for an appointment. Appointments could be booked online.

When appropriate online advice and consultations with hospital specialists was used by GPs to avoid the need for the patient to attend a hospital clinic. For example, photographs of suspected skin complaints could be sent to the dermatologists for a diagnosis.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice recognised the needs of and offered services to patients in vulnerable circumstances. One of the GPs told us practice had an open registration policy and would not turn patients away who wished to register from within their area. Interpreter services were available for patients whose first language was not English.

Home visits were offered for patients with mobility problems.

Carers were identified on the practice computer system. We were told that the GPs supported carers to complete their claim for a carers grant. Carers were also provided with information regarding the local carers forum. The local carers forum offered advice and practical support to carers and the opportunity to meet other carers and share their experiences.

There were patients with a learning disability registered with the practice. We were told these patients received an annual health check-up.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice offered a range of services to patients experiencing mental health problems. Counselling services were referred to when appropriate. A range of leaflets detailing local self help and support groups were available.

The practice achieved all of the targets for managing mental health problems included within QOF.

The practice took an active role in supporting patients with drug and alcohol addiction. Shared care agreements were in place with the local addiction team. Some of the GPs had specialist expertise in working with patients with mental health problems.

The care of patients experiencing poor mental health was subject to an audit in 2013. Recall systems were improved as a result to ensure both physical and mental health was reviewed at appropriate intervals for this group.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had failed to make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of –** 1. Taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and 2. Responding appropriately to any allegation of abuse. **Regulation 11(1) (a) and (b)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person had failed to –** 1. Operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person – (i) is of good character and 2. Ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate. **Regulation 21 (a) (i) and (b).<Provide**

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had failed to make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of –** 1. Taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and 2. Responding appropriately to any allegation of abuse. **Regulation 11(1) (a) and (b)**