

Harden Surgery

Quality Report

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Date of inspection visit: 23 May 2017
Date of publication: 27/07/2017

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	Requires improvement	
Are services safe?	Requires improvement	
Are services effective?	Good	
Are services well-led?	Inadequate	

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
What people who use the service say	6
Areas for improvement	6

Detailed findings from this inspection

Our inspection team	7
Background to Harden Surgery	7
Why we carried out this inspection	7
How we carried out this inspection	7
Detailed findings	9
Action we have told the provider to take	14

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Harden Surgery on 5 September 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the September 2016 inspection can be found by selecting the 'all reports' link for Harden Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 23 May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 5 September 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice continues to be rated as requires improvement.

Our key findings were as follows:

- Since the previous inspection systems for reporting and recording significant events had generally improved. Records showed that the practice had responded to significant events; however, evidence of shared learning with the wider team was limited.
- Previously systems for receiving and acting on alerts from the Medical and Healthcare products Regulatory Agency (MHRA) were not effective. At this inspection recording and distribution of alerts had improved. However, the practice did not operate an effective process to ensure appropriate actions were carried out.
- At our September 2016 inspection, we found that risk had not been formally assessed in the absence of some emergency medicines and a record of fire safety checks was not maintained. During this inspection we found the arrangements to respond to medical emergencies and recording of fire safety checks had been strengthened.
- When we carried out our previous inspection, staff we spoke with felt staffing levels was insufficient. During this inspection, we were told that there had been

Summary of findings

some improvement since the recruitment of extra non-clinical staff; however, we saw that some clinics had not been uploaded onto the practice system as GP cover had not been secured.

- Quality Outcomes Framework (QOF) data showed areas where the practice performance had improved since the previous inspection.
- The uptake of national screening such as breast and bowel cancer had increased since the September 2016 inspection.
- Since our previous inspection governance arrangements had improved in some areas. For example, processes for sharing evidence based guidance and outcomes from GP updates had improved. However, at this inspection, the practice was unable to evidence where they had carried out clinical audits to monitor quality improvements or demonstrate effective use of data to drive improvements. Arrangements to keep non-clinical staff informed about changes within the practice had not been established.

At our previous inspection on 5 September 2016, we rated the practice as requires improvement for providing safe services as the system for managing safety alerts, incidents and staffing levels needed improving. At this inspection we found some improvements; however, sharing learning following incidents, oversight of safety alerts and staffing levels required further improvement.

Consequently, the practice is still rated as requires improvement for providing safe services and as a result of this inspection the practice is rated inadequate for providing well-led services.

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure clinical performance initiatives such as clinical audits are carried out to monitor quality improvements.
- Establish effective communication systems to ensure that reviews about the quality and safety of the service and any actions required following reviews are shared throughout the practice.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

In addition the provider should:

- Continue to consider ways of encouraging the uptake of national screening programmes such as bowel and breast cancer.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

At our previous inspection, we rated the practice as requires improvement for providing safe services as some areas relating to safe care needed improving. These arrangements had improved in some areas when we undertook a follow up inspection on 23 May 2017. However found that some systems required further improvement. For example:

- Previously system for reporting and recording significant events did not demonstrate completion of a thorough analysis or evidence of shared learning. At this inspection, we saw processes had been strengthened; however, evidence of shared learning with the wider team was limited.
- When we carried out the previous inspection, we saw systems for monitoring and sharing safety alerts was not effective. At this inspection, the recording and distribution of alerts had improved. However, systems to ensure appropriate actions were carried out to ensure compliance was not effective.
- During our previous inspection, we saw that risks associated with the absence of some emergency medicines had not been carried out and a record of fire safety checks had not gained assurance from the property owners that appropriate checks had been completed. When we carried out this inspection, we saw improvements in the management of environmental risks.
- Since our previous inspection, the practice implemented systems for monitoring staffing levels. We saw that additional receptionists had been recruited and the practice was actively seeking to increase their GP capacity. However, a plan to ensure appropriate clinical cover during the recruitment process had not been established.

Requires improvement



Are services effective?

At our previous inspection, we rated the practice as requires improvement for providing effective services as areas relating to sharing evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) and some areas of Quality and Outcomes Framework performance needed improving. These arrangements had mainly improved when we undertook a follow up inspection on 23 May 2017. For example:

- Sharing of evidence based guidance and outcomes following of GP updates had improved since the previous inspection.

Good



Summary of findings

- Quality Outcomes Framework (QOF) data showed areas where the practice performance had improved since the previous inspection. However, exception reporting for COPD and cervical screening remained above local and national averages. The practice were aware of this and demonstrated that they were taking action to engage patients in appropriate reviews of care.
- Processes to ensure reviews of people whose circumstances may make them vulnerable were routinely carried out had improved since our previous inspection. For example, care plans and health reviews for patients with a learning disability and patients diagnosed with dementia were carried out.
- The uptake of national screening such as breast and bowel cancer had increased since the September 2016 inspection.

Are services well-led?

At our previous inspection, we rated the practice as requires improvement for providing well-led services as some governance arrangements needed improving. These arrangements had improved in some areas when we undertook a follow up inspection on 23 May 2017. However, we identified actions had not been effective in mitigating all identified risks. For example:

- Previously some risks and governance arrangements was not effective. At this inspection, arrangements to respond to medical emergencies had been developed. However, communication within the practice was not effective in some areas.
- Oversight of clinical capacity and management of clinical cover was not operated effectively.
- When we carried out our previous inspection, a programme of continuous clinical audits was used to monitor quality and make improvements. During this inspection, we identified that some areas of prescribing were not in line with local and national averages. The practice did not demonstrate how they were monitoring quality or using data in order to establish an effective plan to improve performance.
- At our previous inspection, we found leadership was not effective in some areas. During this inspection, we saw some improvements. For example, staffing levels had been addressed in some areas; however, management of GP cover was not operated effectively.

Inadequate



Summary of findings

What people who use the service say

Areas for improvement

Action the service **MUST** take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure clinical performance initiatives such as clinical audits are carried out to monitor quality improvements.
- Establish effective communication systems to ensure that reviews about the quality and safety of the service and any actions required following reviews are shared throughout the practice.

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

Action the service **SHOULD** take to improve

- Continue to consider ways of encouraging the uptake of national screening programmes such as bowel and breast cancer.

Harden Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC), Lead Inspector. The team included a GP specialist adviser and a practice nurse specialist advisor.

Background to Harden Surgery

Harden Surgery is located in Walsall, West Midlands situated in a multipurpose modern built NHS building, providing NHS services to the local community. Harden Surgery is part of Phoenix Primary Care, which is a general medical service provider comprising of 12 GP practices operating in the Midlands, Bedfordshire and Herefordshire. Since the April 2016 inspection, Phoenix Primary Care joined The Practice Group in May 2016.

Based on data available from Public Health England, the levels of deprivation in the area served by Harden Surgery are below the national average, ranked at one out of 10, with 10 being the least deprived. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The practice serves a higher than average patient population aged between zero to 29 and 40 to 49. The practice has a below average of patients aged 55 to 85 plus.

The patient list is approximately 2,600 of various ages registered and cared for at the practice. Services to patients are provided under a General Medical Services (GMS) contract with the Clinical Commissioning Group (CCG). GMS is a contract between general practices and the CCG for delivering primary care services to local communities.

The surgery has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The practice is situated on the ground floor of a multipurpose building with two other practices. On-site parking is available with designated parking for cyclists and patients who display a disabled blue badge. The practice has automatic entrance doors and is accessible to patients using a wheelchair.

The practice staffing consists of two female GPs and one long-term male locum GP. One part time advance nurse practitioner, two part time practice nurses, one health care assistant, a practice manager and a team of administrative staff.

The practice is open between 8am and 8pm Mondays and Tuesdays, 8am and 1pm Wednesdays, 8am and 6.30pm Thursdays and Fridays. The practice is also open on Saturdays between 9am and 12pm.

GP consulting hours are from 9.30am to 3.40pm and 5pm to 7.40pm Mondays. Tuesdays consulting times are from 9.30am to 4.20pm and 5pm to 7.20pm; Wednesdays' are from 9am to 12.20pm; Thursdays from 9am to 11.40am, 12.30pm to 2.40pm and 3.30pm to 5.40pm; Fridays 9.30am to 1.30pm and 3pm to 5.40pm. In addition the practice provides extended opening for appointments on a Saturday morning between 9am and 11.30am. The practice has opted out of providing cover to patients in their out of hours period. During this time services are provided by Primecare. In-hours service closures are covered by WALDOC (Walsall doctors on call).

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of Harden Surgery on 5 September 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. This was because the provider did not operate an effective system for managing incidents, risk assessments in the absence of some emergency medicines had not been carried out and a formal system for managing safety alerts had not been established.

The full comprehensive report following the inspection on September 2016 can be found by selecting the 'all reports' link for Harden Surgery on our website at www.cqc.org.uk.

How we carried out this inspection

We carried out a focused inspection of Harden Surgery 23 May 2017. During our visit we:

- Spoke with a range of staff such as a GP, practice nurse, health care assistant receptionists and practice manager.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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.

Are services safe?

Our findings

At our previous inspection on 5 September 2016, we rated the practice as requires improvement for providing safe services as the systems in respect of managing significant events, some arrangement for managing risks dealing with medical emergencies; safety alerts and staffing levels were not effective.

These arrangements had improved in some areas when we undertook a follow up inspection on 23 May 2017. The practice continues to be rated as requires improvement for providing safe services.

Safe track record and learning

At our previous inspection we saw that the practice had systems in place for reporting and recording significant events; however, evidence of a thorough analysis involving clinical incidents was limited. Staff we spoke with during our previous inspection explained that although clinical incidents had been raised with senior management, staff were unaware of any actions taken to address identified issues. During our follow up inspection documentations showed that systems for investigating and monitoring significant events had improved in some areas. For example:

- The practice recorded 11 incidents since the previous inspection. We viewed three of these incidents which showed a detailed analysis of the incident and actions to reduce the risk of the same thing happening again.
- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information and a written response regarding actions taken by the practice.
- Staff were able to provide examples of incidents, which had been recorded using the incident recording form. For example, staff explained learning outcomes

regarding a clinical incident and we saw that discussions with the individuals involved had been carried out. However, staff we spoke with were unable to demonstrate whether learning outcomes had been shared with the wider team.

- There was a designated GP lead responsible for reviewing safety alerts, such as medical device alerts and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Previously we were told sharing alerts with the wider clinical team was taking place informally and not routinely discussed during clinical meetings. As a result, we saw that guidance around interaction between two particular medicines if prescribed in combination had not been widely shared amongst GPs. At this inspection we were told that a designated person monitored incoming safety alerts and we saw systems in place for tracking distribution with the wider team. However, oversight of actions required to ensure compliance with required guidance was not effective. As a result, we saw that an alert relating to medicines that posed a risk to women of childbearing age had been distributed to clinicians. However, appropriate actions to identify patients at risk had not been taken and appropriate reviews had not been carried out to ensure compliance with recommended guidelines. Following the inspection, members of the management team explained that the medicines management team had carried out a search and contacted identified patients; however, this information had not been fed back to clinicians.

Monitoring risks to patients

When we carried out the September 2016 inspection the practice was not maintaining an up to date record of fire safety checks. During this inspection, we saw documentation, which showed fire safety, checks which the property owners had carried out.

Previously we saw a rota system in place for all staffing groups to ensure sufficient staff was on duty. However, staff we spoke with during the previous inspection felt staffing levels were insufficient. For example, staff explained that they had to cover roles such as incoming referral letters while covering front desk duties as well as covering other partnership practices, which affected their workload. At this inspection members of the management team explained that systems developed since the last inspection enabled the practice to identify numbers of staff required to run the

Are services safe?

practice effectively. As a result, the practice recruited additional receptionists and were actively seeking to increase their GP capacity. However, some staff we spoke with felt that clinical staffing levels were not sufficient. For example, although on the day of the inspection we saw that correspondence from secondary care had been actioned; some staff explained that there were times where correspondence had not been acted on for over three weeks. We also saw some clinics had not been uploaded onto the practice system, as GP cover had not been secured. Staff we spoke with during the inspection, explained that although locums were used to fill two

sessions per week they felt that this level of cover was not sufficient to meet the demands. As a result, clinical staff explained that at times they felt overwhelmed with the workload.

Arrangements to deal with emergencies and major incidents

At our previous inspection, we saw that arrangements to respond to clinical emergencies such as epileptic fits had not been established and risk assessments to mitigate anticipated risks had not been carried out. At this inspection we saw that the practice had reviewed anticipated risks and had access to adequate medicines.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 5 September 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of sharing knowledge gained from GP update events and evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) needed improving. There were areas of the Quality and Outcomes Framework where the practice was performing below local and national averages.

These arrangements had improved in some areas when we undertook a follow up inspection on 23 May 2017. The practice is now rated as good for providing effective services.

Effective needs assessment

When we previously inspected the practice we saw that clinical meetings were taking place; however, there were no recording of discussions around sharing best practice. Staff we spoke with told us that there were a lack of communication and the practice had not adopted a specific approach to sharing knowledge gained from GP update days. At this inspection staff we spoke with explained that sharing of guideline updates within the practice had improved since the September 2016 inspection.

Previously the practice did not establish an effective process to ensure reviews for people whose circumstances may make them vulnerable were routinely carried out. At this inspection we saw significant improvements. For example, care plans and health reviews for patients with a learning disability and patients diagnosed with dementia had been carried out.

Management, monitoring and improving outcomes for people

Data from the 2014/15 Quality and Outcomes Framework (QOF is a system intended to improve the quality of general practice and reward good practice) showed that some exception reporting domains were significantly higher than Clinical Commissioning Group (CCG) and national averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). For example, exception

reporting rate for patients diagnosed with diabetes who had influenza immunisation was 36%, compared to CCG average of 22% and national 18%. Exception reporting rate for the uptake of cervical screening programme was 13%, compared to a CCG average of 7% and national average of 6%.

Data from 2015/16 QOF showed that exception reporting for some clinical domains remained above CCG and national averages. However, the practice provided unverified data from the 2016/17 QOF year which showed exception reporting for most clinical domains fell below local and national averages. For example:

- The percentage of patients with diabetes, on the register whom had a blood sugar reading which showed that the condition was being controlled appropriately improved from 81% to 84%, compared to CCG average of 79% and national average of 78%. With an exception reporting rate of 22%, compared to CCG average of 10% and national average of 13%. Additional unverified data provided by the practice showed one exception.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using recognised methods, was 89%, compared to CCG and national average of 76%. With a 23% exception reporting rate, compared to CCG average of 3% and national average of 8%. Additional unverified data provided by the practice showed 0% exception reporting.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using recognised methods in the preceding 12 months was 100%, compared to CCG average of 91% and national average of 90%. With a 44% exception reporting rate, compared to CCG average of 9% and national average of 12%. Additional unverified data provided by the practice showed 17% exception reporting.
- Overall exception reporting rate for patients diagnosed with dementia was 23%, compared to CCG average of 14% and national average of 13%. Additional unverified data provided by the practice showed 0% exception reporting.

Staff we spoke with as part of the follow up inspection explained that they were aware of the high exception

Are services effective?

(for example, treatment is effective)

reporting rates and since the previous inspection clinicians were now overseeing QOF performance. Staff were following established protocols for managing exception reporting. For example, staff explained that lead GPs made decisions regarding when to exception report patients. We were told that rather than simply sending three invitation letters, staff were now required to discuss non-compliant patients with GPs. Staff explained that they contacted patients via phone where possible as a final attempt to engage with them.

Supporting patients to live healthier lives

During our previous inspection, data highlighted that the practice's uptake for the cervical screening programme was in line with local and national averages. Data from 2015/16 showed that the practice achieved 82%, compared to CCG average of 81% and national average of 82%. Exception reporting rate increased from 13% to 17%, compared to CCG and national average of 7%. Additional unverified data provided by the practice showed 15% exception reporting. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. Staff explained that patients were signposted to the mobile screening unit, which was accessible via the practice and they flagged non-attenders on the practice clinical record for further discussion. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The

practice carried out audits to assess the rate of inadequate tests (the rate of patients who have been required to have a repeat test because the first one could not be read properly).

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. Data we viewed since the last inspection showed that some areas of performance had improved. For example:

- Females, aged 50 to 70, screened for breast cancer in last 36 months (3 year coverage, %) improved from 57% to 64% compared to CCG average of 72% and national average of 73%.
- Females, aged 50 to 70, screened for breast cancer in last six months of invitation remained at 0% compared to CCG average of 75% and national average of 74%.
- Patients aged between 60 to 69, screened for bowel cancer in last 30 months had remained at 37% compared to CCG average of 52% and national average of 58%.
- Patients aged between 60 to 69, screened for bowel cancer within six months of invitation increased from 40% to 46%, compared to CCG average of 50% and national average of 56%.

Staff we spoke with explained that the practice was actively engaging with the screening service and opportunistically encouraging patients to engage in testing. Patients who missed their screening appointments were contacted and a follow up appointment arranged. The practice scheduled a screening awareness day for May 2017 and were actively advising identified patients of the dates when the screening service was in the area. We saw informational leaflets in patient waiting areas.

Are services well-led?

Inadequate 

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

Our findings

At our previous inspection on 5 September 2016, we rated the practice as requires improvement for providing well-led services as some governance arrangements needed improving. These arrangements had improved in some areas when we undertook a follow up inspection on 23 May 2017. However some actions had not been effective in mitigating risks.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy. However, during our previous inspection we saw the recording and monitoring of some risks required strengthening. During this inspection, we saw some improvements in systems and processes. However, there were areas that required further attention. For example:

- Arrangements for identifying, recording and managing risks such as medical emergencies and fire safety had improved. However, oversight of safety alerts was not effective and evidence of shared learning from incidents with the wider team was limited.
- At our previous inspection the practice were able to demonstrate an understanding of the practice performance. However, during this inspection, the practice were unable to demonstrate how they were monitoring areas such as prescribing of antibacterial medicines and hypnotics where performance was below local and national averages or demonstrate effective use of data to drive improvement. Following the inspection, evidence and documentation were submitted to show the practice was taking appropriate actions to address the issues.
- Although, the practice was aware of their high exception reporting rates, exception reporting for some clinical domains remained above CCG and national averages and the practice did not establish an effective targeted plan to encourage patients to attend annual reviews.
- When we inspected the practice in September 2016, staff we spoke with felt that staffing levels were not

sufficient. At this inspection, we were told that the practice had recruited additional staff to join the reception team and nursing team. Staff explained that the practice were actively seeking to recruit a GP. However, oversight of clinical capacity and management of clinical cover was not operated effectively. As a result, we saw that cover for some clinical sessions had not been confirmed.

Leadership and culture

At our previous inspection, we found GPs and the provider's leadership was not effective in some areas. For example, there was a lack of consistency and oversight at a provider level in relation to areas of clinical management within the practice. There were some areas where we found appropriate action had not been taken in relation to learning from significant events and we were told by staff that some staffing issue were not being addressed to reduce the risk of reoccurrence. Since the previous inspection, the provider merged with the Practice Group. As a result, at this inspection, we saw evidence of where investigations had been carried out and actions taken to address staff concerns in some areas.

We saw evidence of meetings which had been carried out, however these were generally attended by clinical staff and members of the management team. Non-clinical staff explained that due to workloads they were not able to attend practice meetings, therefore felt communication of changes and updates within the practice was not always effective. Members of the management team explained that they were actively looking into this and provided evidence of a staff engagement survey which they requested staff to complete. Members of the management team identified areas for improvement such as setting monthly dates for practice meetings, actively inviting staff and distributing meeting minutes more effectively. We were told that the practice was gaining staff feedback, which would help them to improve communication and team working. Staff explained that the provider appointed a support practice manager to assist the practice with strengthening their governance framework.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing How the regulation was not being met: The registered person did not ensure sufficient numbers of staff were deployed in order to meet peoples care and treatment needs. This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. 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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance How the regulation was not being met: The registered person did not establish or operate effective systems or processes. For example, the practice did not implement an effective system to ensure recommendations received from the Medicines and Healthcare products Regulatory Agency (MHRA) were appropriately actioned and monitored to ensure compliance with guideline recommendations. The registered person did not establish or operate effective systems or processes to improve quality or effectively use information gathered to make improvements. For example, the practice did not effectively use clinical performance initiatives such as clinical audits or review data to monitor quality improvements. The registered person did not establish an effective communication systems to ensure that reviews about the quality and safety of the service and any actions required following reviews are shared throughout the practice. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.