Barnsley Healthcare Federation CIC Woodland Drive Medical Cenre (also known as i-HEART Barnsley 365)

Quality Report

The Oaks Park Primary Care Centre,
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Key findings

Contents

Letter from the Chief Inspector of General Practice

This service is rated as inadequate overall. (Not previously inspected)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Inadequate

Are services well-led? – Inadequate

Overall the service is rated as inadequate.

We carried out an announced comprehensive inspection at Barnsley Healthcare Federation CIC on 13 and 14 February 2018 as part of our inspection programme. We inspected three registered locations where regulated activities are carried out.

Our key findings were as follows:

- There was no open and transparent approach to safety and no effective system in place for recording, reporting and learning from significant events.
- Risks to patients were not adequately assessed or acted upon.
- Patients were at risk of harm because systems and processes were not always in place to keep them safe. For example, the telephone triage process in the extended hours service and the out of hours service was judged unsafe. This was because clinicians were undertaking tasks without the support of triage protocols and guidance or evidence of appropriate training
- Patients care needs were not always assessed and delivered in a timely way according to need. The service had not met all the National and Local Quality Requirements used to monitor safe, clinically effective and responsive care.
- There was a system in place that enabled staff access to patient records, and information was shared with the patients GP following contact with patients using the service.
- The service could not demonstrate that it ensured care and treatment was delivered according to evidence-based guidelines. For example, we saw in one patients record incorrect prescribing of some medicine.
- Staff involved patients in their care and treated people with compassion, kindness, dignity and respect. Patients told us through CQC questionnaires, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- There was a lack of overarching clinical governance arrangements in place that meant patients were not kept safe from avoidable harm.

Summary of findings

- There was limited audited clinical oversight; the recording in patient records was poor and baseline observations were not recorded consistently in the patient records we viewed.
- There was a leadership structure but communication between some staff and management was limited and some staff felt unsupported by managers. Following the recruitment of a new manager in December 17 some staff told us that they felt more confident in approaching leaders and felt more supported to do their jobs.
- Significant issues that threatened the delivery of safe and effective care were not adequately identified or managed by leaders within the organisation.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure the competence and skill of clinical staff is assessed.
- Implement an effective processes for assessing patients who attend the GP streaming and out of hours service.
- Ensure a system is in place and staff have been trained, understand and follow the system at all times with regard to sepsis management.
- Implement effective and sustainable clinical governance systems and processes and ensure managerial oversight at all times.
- Ensure that staff who are employed at the service receive the appropriate support, training and professional development necessary to enable them to carry out their duties.
- Ensure that there is an accessible system for identifying, handling, investigating and responding to complaints made about the service.

As a result of these failures we have concluded patients are at serious risk of receiving unsafe care or treatment.

Due to the serious concerns we found regarding the safety of patients we immediately wrote to the provider following the inspection under Section 31 of the Health and Social Care Act 2008. We asked them to provide us with assurance that they would take action immediately to mitigate identified risks to patient safety in terms of patient care, treatment and welfare. We also informed the provider that we would be issuing a notice to impose some restrictions on the providers registration in order to keep patients who used the service safe.

Special measures statement

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any, key question, we will take further action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Barnsley Healthcare Federation CIC Woodland Drive Medical Cenre (also known as i-HEART Barnsley 365)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a CQC Inspection Manager, a GP specialist adviser, a nurse specialist adviser and two further CQC inspectors.

Background to Barnsley Healthcare Federation CIC Woodland Drive Medical Cenre (also known as i-HEART Barnsley 365)

Barnsley Healthcare Federation CIC provides an Extended Hours service, an Out of Hours service and a GP streaming service to a population of approximately 250,000 in the Barnsley area. Barnsley Healthcare Federation CIC are contracted by Barnsley Clinical Commissioning Group to provide these services.

The provider operates a GP extended hours service – this service provides a four-hour extension to GP services across Barnsley that is delivered from Woodlands Drive and Chapelfield Medical Centres from 6pm to10pm daily and Barnsley Hospital NHS Foundation Trust (BHNFT) 7pm to 11pm daily. This service offers pre-bookable appointment at these locations.

The provider also operates an Out of Hours service. This service provides home visits and telephone advice to patients outside core service hours. Patients access the service through NHS 111. The hours of operation are 6.30pm to 8am daily Monday to Thursday and 6.30pm Friday to Monday 8am.

The service also operates a GP Streaming at Barnsley Hospital NHS Trust. This service provides a “walk in navigational service” at the A&E department in Barnsley Hospital. This service is provided between the hours of 10am and10pm 365 days a year. Its purpose is to reduce pressure on the A&E department and provide a more effective clinical pathway for patients.

Detailed findings

The service employs both male and female GP's, nursing staff, clinical advisors, and qualified healthcare professionals from the existing healthcare providers. The clinicians are supported by an administration/call handling team, receptionists, drivers and a management team who are responsible for the day-to-day running of the service. The Oaks Park Medical centre is where the provider is based and all head office functions are carried out from this location.

We carried out an inspection of all three locations on the 13 & 14 February 2018.

Inadequate

Are services safe?

Our findings

We rated the practice as inadequate for providing safe services.

Safety systems and processes:

Systems, processes and services were inadequate and did not keep patients and staff safe at all times.

- There was an incident recording form available on the service's computer system that staff could access. However, staff told us they would verbally report incidents to the service lead and not routinely complete the incident form. This process was not in line with the provider's policy and procedure for recording incidents.
- During the inspection, staff told us of two incidents that were significant events. Although senior leaders were aware of these events they had not been recorded as such and therefore no investigation had been carried out.
- Staff could demonstrate they understood 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). However, we saw evidence that when things went wrong with care and treatment that reviews and investigations were not thorough enough to support improvement.
- A serious incident had taken place at the service in which a patient had died. The provider had not taken action to issue any revised guidance or identify and deliver specific training to all staff regarding this incident. In addition this event had not triggered any review of clinical skills, competencies or judgements made by clinicians at the service. We asked the provider to take immediate action to ensure that the failings that led to the incident were addressed and that all staff were appropriately skilled, competent and trained to deliver safe care and treatment to patients.
- Communication with staff was ineffective. Where learning was identified from events this was not disseminated with staff in an appropriate or timely manner.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, on the evening of our inspection inspectors observed that a SMART card (a unique user system for accessing electronic patient records) was left in a computer in an unlocked clinical room, which was contrary to the provider's information governance policy.
- The service had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to staff. They outlined who to go to for further guidance. All staff during the inspection were aware of who the safeguarding lead was for the organisation and who to contact if they suspected abuse was taking place.
- The provider carried out staff checks at the time of recruitment. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, we saw a DBS check that had a conviction recorded on it. Whilst this would not preclude the person from being employed at the service there was no documented evidence that a risk assessment had been undertaken to ensure that this person was safe to work in the role they were employed to undertake.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

We saw during the inspection that there were gaps in mandatory training for all staff, and induction for locum GPs was limited. Some staff transferred their employment from the previous provider of the service when the contract was changed to the new service provider. We found that the new service provider had not undertaken the necessary actions to assure themselves that staff who transferred were trained and competent to carry out the role they were employed to do when transferring employment.

- There was a documented induction programme for newly appointed staff. However, locum GPs told us that they did not receive an induction other than a list of useful telephone numbers and a check to see if their SMART card was functional.
- There were gaps in permanent staff training records shown to us at the inspection. We saw that 13 out of 30

members of staff (43%) had received or had planned training regarding safeguarding vulnerable adults, and 14 members of staff out of 30 (46%) had received or had planned training in basic life support.

Information to deliver safe care and treatment

The provider had arrangements in place with all GP practices in Barnsley to allow access to the primary patient record whilst providing care and treatment at their service. A summary of consultation, any prescribed medication or onward referral was also sent to the patients GP**.**

Staff said that they did not receive regular up-to-date guidance from the provider. We saw no evidence to suggest that there was a system in place to keep staff up to date with safety alerts or guidelines from the National Institute for Health and Care Excellence (NICE).

Following a significant event regarding a patient with sepsis that had gone unrecognised the provider had not issued staff with any updated guidance or protocols, only an e-mail to all staff reminding them to be vigilant about patients who may present with symptoms of sepsis. There was no information in the reception areas or consultation rooms in respect of sepsis for clinicians or patients to refer to. Staff had not been routinely trained in diagnosing or in the treatment of sepsis.

Safe and appropriate use of medicines

- Arrangements for managing medicines were checked at the service.
- Emergency medicines were easily accessible to staff in secure areas and all staff knew of their location. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were in date and stored securely.
- The service had a stock list that set out which medicines they should stock. We checked medicines stocks at the Oak Park Surgery site and found that systems were in place to ensure that medicines were available in suitable quantities
- We checked medicines and equipment in one of the transport vehicles. Vehicles used to take clinicians to patients' homes for consultations were well maintained, clean and contained appropriate emergency medical equipment and medicines. Medicines were removed from the vehicle to safe storage when not in use.
- The service kept prescription stationery securely and monitored its use.
- A system was in place for disseminating national safety alerts (which included alerts such as equipment, devices and medicines) that needed to be actioned to protect people from harm. However, there was a lack of evidence to provide assurance that once distributed to staff that alerts were always acted on by staff.
- We viewed a patient record which showed the patient had not been prescribed an appropriate course of antibiotics for treatment of tonsillitis in line with national guidance.

Lessons learned and improvements made

- From September 2017, when the service was first registered with the Commission, we saw six significant events had been documented. Inspectors saw evidence that lessons were not analysed or shared and action was not being taken to improve safety in the service.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as inadequate for providing effective services.

Effective needs assessment, care and treatment

The provider could not demonstrate that they had an effective process for assessing patients who used the service. Process flowcharts commonly used to direct clinical staff to provide evidence based care and effective clinical decision making were not used to triage calls. Staff told us that they had to use their own clinical judgement. This meant that staff were at risk of missing vital information needed to provide safe patient care. There was no documented evidence to show that clinical staff competence was assessed by audit of their clinical decision making. We asked the provider to take immediate action to make sure that clinicians were skilled and competent to make clinical decisions regarding the appropriate care and treatment for patients using the service.

- During the inspection we looked at seven patient records. Documented entries regarding patient consultations were poor and baseline observations were not recorded in four of the records viewed.
- We saw one example whereby the clinician did not use appropriate protocols or up to date evidence-based guidance. For example in one patient record reviewed it was reported a child had a raised temperature for two days. The patient record showed no pulse, respiratory rate, capillary refill time and pulse oximetry as having been recorded. These observations should have been recorded to check for signs of particular conditions such as sepsis and to inform diagnosis. This demonstrated that national guidance had not been followed on this occasion.
- Staff told us that patients who presented at the GP streaming service had a 30 second assessment carried out by a clinical advisor (an advanced nurse practitioner of emergency care practitioner) to determine whether they needed to be seen at Accident & Emergency (A&E) or at the GP streaming service. This assessment was carried out at the reception desk and did not afford patients any privacy. This assessment did not include any time to take an adequate history or any patient observations such as pulse rate, respiratory rate, temperature or blood pressure, which could identify red flag symptoms indicating sepsis. With the time constraint and the absence of any baseline observations, it would be difficult to safely determine the most appropriate course of action in terms of referral to A&E or to the GP Streaming service which put patients at risk.

Monitoring care and treatment

From 1 January 2005, all providers of out-of-hours services have been required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group (CCG) on their performance against standards which includes audits, whether face-to-face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

We looked at the NQRs, which provide a clear and consistent way of assessing performance as they help inform our decisions about the quality of care. In particular we looked at the indicator for the National Quality Requirement (NQR) 4 which stated that providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. We found that the provider had not undertaking any sampling of patient records since September 2017 when the service was first registered with the Commission. The provider had not put actions in place to improve performance in this area. There was no evidence that information about patients' outcomes was used to make improvements to services, and no system in place to check the competence and skills of the GPs. No audits of the consultation notes of Out Of Hours (OOHs) clinicians had been undertaken. We also looked at NQR 12. This stated that face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed; emergency within one hour; urgent within two hours and less urgent within six hours. The data for October and November 2017 showed the provider's performance was below the 90% minimum target for clinical assessment for 'Walk-in Services', face to face consultations for urgent and for emergency cases, and face-to-face consultations (visits) for urgent and for emergency cases.

Inadequate

Are services effective?

(for example, treatment is effective)

However, it is acknowledged that this was during a time of unprecedented national winter pressures which affected services nationally.

Effective staffing

Processes were not in place to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.

- The provider did not have a process to provide staff with ongoing support; this included appraisal and clinical competence. We were told by the provider that five out of thirty staff appraisals had been undertaken. However, no coaching and mentoring, appraisal or supervision for clinicians had taken place since the service began operating.
- The provider could not demonstrate how they ensured the competence of staff employed in advanced roles by audit of their clinical decision making.
- The clinical skills of locum GPs and competency had not been assessed by the provider to ensure that they were making sound clinical judgements when working for them at the service.
- Up to date records of skills, qualifications and training were not easily corroborated. For example, the provider's training system did not did not correlate with evidence held within staff files such as certification or confirmation of attendance at training.

Coordinating care and treatment

Staff worked together, and worked with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. Staff communicated promptly with patients' registered GPs so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. An electronic record of all consultations was sent to patients' own GPs.

Helping patients to live healthier lives

Staff supported patients to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

Some staff understood the requirements of legislation and guidance when considering consent and decision making. Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. However, during the inspection two out of four clinicians that we spoke with had limited understanding of the Mental Capacity Act.

Good

Are services caring?

Our findings

We rated the practice as Good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.
- There were arrangements in place to respond to those with specific health care needs such as end-of-life care and those who had mental health needs.
- We received feedback from 44 patients in the form of completed Care Quality Commission questionnaires. All but three were positive about the service experienced. This was in line with the provider's own feedback from patients they had surveyed each month.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language, via Language Line - a telephone system of interpretation.
- Patients told us through CQC questionnaires, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Privacy and dignity

The service did not always respect and promote patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. However, patients who attended the GP streaming service had a 30-second assessment carried out at the reception desk and did not afford patients any privacy.
- Privacy screens were used in consultation rooms and patients conversations could not be overheard in the waiting areas of the service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the provider as Inadequate for providing responsive services.

Responding to and meeting people's needs

- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service; this was done through electronic codes on the computer system. Care pathways were available for patients with specific needs, for example those at the end of their life.
- The facilities and premises were appropriate for the services delivered.
- The provider improved services where possible in response to unmet needs, for example, by providing the GP streaming service to the population of Barnsley. We saw a letter from Barnsley CCG thanking the provider for their proactive support in responding at short notice through the GP streaming services to see more patients, relieving some of the pressure from A&E where there were increased numbers of patient attendance over the winter months.

Timely access to the service

On some occasions we saw that there were delays where people had to wait for care or advice.

- Patients could access the service via the NHS 111 service or by referral from a healthcare professional. Patients were also seen by booked appointment via their own GP practice.
- Waiting times and delays were not always managed appropriately. We identified a number of examples where people had had to wait for subsequent care or advice. For example, one complaint to the service documented a seven hour wait by a patient to be called back by the service.
- Patients who attended the service in person were often not seen in a timely manner in particular the GP out-of-hours service where some patients reported waiting for long periods of time to see the GP.

Listening and learning from concerns and complaints

- There was no information or guidance on display at any of the locations to inform patients how to complain. Verbal complaints were not recorded. Staff told us that people who wished to complain were sent a complaints pack.
- No evidence was found that the registered provider monitored or looked for trends within complaints, or areas of risk that may have needed to be addressed.
- Appropriate action was not taken to respond to any failures identified by a complaint or the investigation of a complaint. Records showed some complaints were not investigated in a timely manner.
- The provider documented that they had received seven complaints within the past nine months. We found that the complaints records had very limited information of any outcomes and actions taken in response to the complaints.
- There was no evidence that complainants were kept informed of the status of their complaint and its investigation, or that any learning outcomes were shared with them.
- We found that a complaint response sent to a patient following a miscarriage was lacking in compassion and kindness.
- Minutes of a senior management team meeting on September 2017 stated that all complaints would be brought to the future senior management team meetings to discuss but further evidence of discussions was only seen once in January 2018 following this.
- There was no mechanism in place to share the reviews and learning from complaints with any other staff members.
- We found no information available with regard to how a patient could take action if they were not happy with the response to their complaint from the provider. A response to a complaint made in October 2017 had no details of the Health Service Ombudsman contact details in case they needed to take further action.

Are services well-led?

Inadequate

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

Our findings

We rated the practice as inadequate for being well-led.

The provider had significantly expanded services in recent months and had gained new contract obligations. This had taken place without the systems and processes being in place and embedded to manage services safely.

Vision and Strategy

The service had a five-year strategic vision and a set of aims and objectives. Not all staff spoken with during the inspection were aware of these or their responsibilities in relation to them.

Culture

- Staff feedback indicated some staff felt that they had little engagement with the senior management team. In addition some staff told us that they did not know who to approach in the senior management team if they had concerns or issues they wished to raise.
- Complaints were not dealt with properly and people not responded too in a timely way. In one complaint response letter we read that the provider had not been understanding or showed any compassion to the complainant.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour and this was demonstrated following a recent incident.
- There were delays in giving feedback to staff about incidents or concerns they had reported. There was little evidence of any learning being shared with staff
- There were limited arrangements in place to ensure the staff were kept informed and up-to-date with developments at the service. This included a lack of clinical and non-clinical meetings
- Not all staff had received inductions and not all staff had received a performance review.

Governance arrangements

The issues identified during the inspection did not provide assurance that there was an effective governance framework to support the delivery of the service. The governance framework in place had failed to identify risk and also failed to address known risk.

- There was a lack of clear responsibilities, roles and systems of accountability to support good governance and management.
- A significant event policy was in place. However, the four members of the clinical staff team we spoke to during the inspection had a poor understanding of what constituted a significant event. Significant events were not managed appropriately and there was limited evidence of analysis or learning being shared with staff.
- A significant incident in which a patient had died had not resulted in any revised guidance or specific training being given to staff. In addition this event had not triggered any review of clinical skills, competencies or judgements made by clinicians at the service.
- Inspectors saw evidence that lessons were not analysed or shared and action was not being taken to improve safety.
- During the inspection we were told of two other incidents that had occurred at the service that were also significant events but were not recorded.
- The provider had an understanding of their performance against National Quality Requirements. However, where performance required improvement there was no evidence that action had been taken to address this.

Managing risks, issues and performance

The governance systems and processes to identify and manage risks and issues were not always effective. The provider was not always operating and implementing effective systems or process to assess, monitor and improve the quality and safety of the services. There were not always effective systems for assessing, monitoring and mitigating risks relating to the health, safety and welfare of service users and others who may be at risk. We found that the delivery of high-quality care was not assured by the leadership, governance or culture in place. Significant issues that threatened the delivery of safe and effective care were not adequately managed.

For example:

- The clinical oversight was not effective. We found no evidence of appraisal or supervision of clinical staff. In addition the performance of employed clinical staff could not be demonstrated through sampling of their consultations, clinical judgements, prescribing and referral decisions.

Are services well-led?

Inadequate

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

- We found no evidence of audits and quality improvement activities to demonstrate monitoring and assessment of the service was being undertaken since the service first became registered in September 2017.
- There was no evidence that patient records had been reviewed following a serious incident to assess the clinical competence and skill of staff.
- The provider had not adequately ensured staff training was in place.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, we saw on the staff training matrix that was provided to us during the inspection that not all staff had completed information governance training.
- We saw no evidence of mechanisms for sharing NICE guidance. We saw evidence in patient records that did not demonstrate that up to date guidance and protocols were being used.

Engagement with patients, the public, staff and external partners

The service involved staff and patients in gathering views and feedback about the service

The provider had undertaken patient surveys to assess patients' views of the service. Patient surveys demonstrated that people were satisfied with the services they were receiving.

Services were developed as a result of consultations with the patient population. For example, the provider asked the public about opening times on a Sunday and following an overwhelming positive response the service now offered appointments on a Sunday to patients.

Continuous improvement and innovation

The service has been registered and operating since September 2017. The systems and processes in place to assess and monitor the quality and safety of the services provided were not embedded or operating effectively. The overarching governance and leadership of the service had weakness and required strengthening to ensure that the necessary improvements could be made and were sustainable.

This section is primarily information for the provider

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 Family planning services Maternity and midwifery services Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The provider has failed to ensure that there was an accessible system for identifying, handling, investigating and responding to complaints made about the service.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider has failed to ensure that persons employed in the provision of the regulated activity received the appropriate support, training and professional development necessary to enable them to carry out their duties.