Events Medical Services Limited

Events Medical Services Limited

Inspection report

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

Summary of findings

Overall summary

This service had not been rated before. We rated it as requires improvement because:

- The provider was unable to evidence that staff had appropriate training in key skills, recruitment was not in line with statutory requirements. Medicines were not always managed well.
- Managers did not monitor the effectiveness of the service or make sure staff were competent. The service did not provide information to demonstrate how it supported patients to make decisions about their care and or how they could access information.
- The service provided little evidence of its governance processes to enable its assessment and monitoring of quality. Policies and procedures were not always available to support staff. The service did not demonstrate it engaged well with patients to plan care and treatment and information could not easily be extracted or produced by the service.
- The service could not show how patients consented to treatment and care, including X-rays.

However:

- The service had enough staff to care for patients and keep them safe. The service assessed risks to patients and kept written records of care. The service could articulate how to manage safety incidents should they occur.
- Staff provided good care and treatment and gave patients pain relief when they needed it. Staff worked well together for the benefit of patients and advised them on how to lead healthier lives.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Requires Improvement 	The service had not been rated before. We rated it as requires improvement. See above summary for details.

Summary of findings

Contents

Summary of this inspection

Background to Events Medical Services Limited

Event Medical Service Limited is an independent ambulance provider which covers events of varying sizes. The Care Quality Commission (CQC) is the independent regulatory of health and social care services in England. Whilst the independent ambulance sector is regulated by the CQC, an exemption to this, determined by the Department of Health and Social Care are services provided solely within the confines of an event site. Whilst Event Medical Services Limited carries out event activity, it also conveys several patients from events to local NHS services. It also uses an X-ray machine at a large-scale event once a year. These activities are both regulated by the CQC.

The service had 6 operational vehicles and a portable X-ray machine which was set for 1 event annually in a field style hospital. In 2022, a total of 2,455 patients were treated, of these, 69 were conveyed to NHS trusts for further treatment, 2 were under the age of 18. Data was not provided on the number of X-rays undertaken by the service.

The service has been registered with the CQC since 2011 and has had a registered manager in place since that time. It was last inspected in 2014, at that time the commission did not provide ratings following an inspection; however, there was no enforcement action issued and no recommendations were made.

The service is registered to undertake the following regulated activities:

- Treatment of disease, disorder and injury
- Transport, triage and medical advice provided remotely
- Diagnostic and screening procedures

How we carried out this inspection

One inspector and 1 specialist advisor carried out the onsite inspection over the period of 1 day. This was supported by an off-site inspection manager. The inspection took place at the base of the service and due to the nature of the service no staff other than the registered manager were spoken with. Inspectors were told by the registered manager that patient contact information was not kept and so no patients or relatives could be contacted. Not all information could be captured during the visit, because it was not available, therefore not all domains could be effectively rated, and judgements made.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure it operates effective systems of governance which assesses and monitors the service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). Information must be accurate, up to date and properly analysed. Quality and safety of services provided must also be monitored. Regulation 17(1)(2)(a)
- The service must ensure it monitors compliance of safeguarding, mandatory training including mental capacity, and appraisals in line with statutory requirements. Regulation 17(2)(d)
- The service must ensure it has effective recruitment and selection procedures which comply with Schedule 3. They must ensure people employed have the competence, skills and experience required to undertake the role. Regulation 19(1)(a)(b)
- The service must ensure care and treatment of service users is only provided with the consent of the relevant person. Regulation 11(1)
- The service must improve its safety arrangements around the storage, recording and management of medicines including controlled drugs. Regulation12(20)(g)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires Improvement	Requires Improvement	Insufficient evidence to rate	Good	Inadequate	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Insufficient evidence to rate	Good	Inadequate	Requires Improvement

Requires Improvement

Emergency and urgent care

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Inadequate

Is the service safe?

Requires Improvement

The service had not been rated before. We rated it as requires improvement.

Mandatory training

The service did not demonstrate it provided mandatory training in key skills to all staff.

The registered manager told us mandatory training was undertaken by staff in the NHS trusts where they held substantive positions. Staff, we were told then uploaded their certificates to demonstrate they had completed the required modules. Mandatory training was monitored by a designated member of staff. However, the provider was not able to confirm the content of the mandatory training when requested. It was not clear how the provider assured itself training was appropriate for its own service.

Personnel files of 5 members of staff were reviewed, of these, 1 member of staff demonstrated a mandatory training compliance level of 96%. One member of staff was 60% compliant with mandatory training. Information provided for 1 member of staff was a certificate from the completion of a mandatory training workbook. This did not set out any further details, such as which modules or the level of compliance. Certificates for a further 2 members of staff in modules, such as fire safety, and health and safety were provided. The provider was unable to access electronic policies and procedures relating to mandatory training when asked during the onsite inspection when requested and did not provide them when submitting staff compliance data. After receiving the draft report, the provider sent a 1 page mandatory training document which which detailed that compliance would be gathered at the point of employment and on an annual basis. The service could not assure itself staff working for them had undertaken the correct training in line with statutory requirements.

Safeguarding

The service did not demonstrate that staff had training on how to recognise and report abuse and recruitment of staff was not in line with statutory requirements.

The registered manager told us staff received training specific for their role on how to recognise and report abuse in the NHS trusts where they were also employed. Staff then provided the service with copies of their certificates annually, to show they had completed the relevant training. The registered manager told us level 2 adult and child safeguarding training were undertaken by staff. We requested information to show what the compliance level of staff training was, but this was not provided.

The manager of the service was trained to level 4 adult and child safeguarding training. Staff could get help, support and guidance around safeguarding concerns if they needed it.

At the time of the inspection, a safeguarding referral process was available for staff to follow. We were told no referrals had needed to have been made. The referral process was in line with the safeguarding policy within the service. This referenced up to guidance including the Royal College of Paediatric and Child Health Intercollegiate guidance.

Recruitment procedures for the service were not in line with statutory guidance. Schedule 3 sets out 8 mandatory requirements for the recruitment of staff working with vulnerable people. This included an enhanced Disclosure, Barring Service (DBS) check, evidence of conduct and full employment history.

At the time of the inspection the registered manager for the service told inspectors the service recruited staff by word of mouth and did not carry out a formal interview. Instead, an informal discussion was undertaken. The personnel files of 5 members of staff were reviewed following the inspection, a DBS number was provided by the service for each of these staff members, indicating they had been checked. However, no further details, such as the date it was checked, by whom or whether the check was clear was provided. The service did not have a recruitment policy and could not demonstrate what standards were required for the selection of staff. We noted only 1 reference was sought for each member of staff instead of the required 2. The lack of due process could lead to unsuitable candidates being employed by the service.

The service was not meeting its statutory requirements and could not be assured the appropriate staff had undergone the correct recruitment checks and safeguarding training.

Cleanliness, infection control and hygiene

Equipment and control measures were available to protect patients, staff and others from infection. The service kept equipment and vehicles visibly clean.

All vehicles were visibly clean and had suitable furnishings, which were clean and well-maintained in line with the deep cleaning schedule for the service. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

Personal protective equipment was readily available including a filtering facepiece 3 respirator masks, aprons and gloves. A washing machine was on site within the service so staff could wash their uniforms before taking them home. The service did not audit infection prevention and control procedures and inspectors were told during the inspection that the registered manager could not access the policy on the cloud based system. An infection prevention and control policy was provided by the service following the inspection however, did not set out monitoring of infection prevention and control procedures. Therefore, it was not clear how the provider assured itself safe practices were followed by staff and if they understood their responsibilities.Hand washing facilities were available to the service base and hand sanitiser gel was available both on the vehicles and in the stores for personal issue to staff members. No incidents had been reported relating to hand hygiene.

Requires Improvement

Emergency and urgent care

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff managed clinical waste well.

The service had a maintenance schedule for the ambulance and rapid response vehicles it used, as well as 24 hour 7 days a week breakdown cover. At the time of the inspection, all vehicles had an in-date service and MOT test. Vehicles were stored in a private yard and secure garage which was rented by the service.

Equipment was in date, sealed and tested. This included electrical equipment, such as defibrillators; manual handling aids, such as stretchers; and consumable item equipment, such as dressings, fluids and oxygen masks.

Regular checks of specialist equipment including suction devices and defibrillators were undertaken by the staff at the beginning of their shift. Any defective equipment was identified and taken out of service prior to an event.

Oxygen cylinders were stored in line with guidance and radios used to communicate with each other were kept securely.

Clinical waste including sharps were disposed of by service level agreement with a national provider.

A quality assessment report of the X-ray tube and computed radiography digitiser in August 2022 stated the machine performed as expected and can continue to be used clinically. The radiographer undertaking the X-rays carried a dosimeter (an instrument used to measure radiation exposure) and wore a lead apron for protection. A service and repair agreement had been set up with the manufacturer to ensure any faults were detected and repaired as quickly as possible.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff used tools to identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool, the National Early Warning Score 2. This helped staff to recognise and respond to patients who deteriorated or became ill during their episode of care. An emergency bypass telephone number was used to contact the receiving NHS hospital so they would know to expect patients requiring urgent care and treatment.

Staff shared key information including the National Early Warning Score 2, which was documented on a written patient report form and shared with the local NHS trusts when handing over patients care to others to keep patients safe.

X-rays were initially interpreted by the requesting doctor working at the event. According to the clinical practice strategy for the service, fully registered doctors with licence to practice could provide clinical assessment within the remit of the strategy providing they were able to prove competence. This was in line with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017 Procedures for X-ray policy.

A senior doctor was assigned clinical lead at events and a medical director was available for clinical advice as needed. A dedicated radiographer carried out the X-ray. This was followed up by an offsite radiologist who reviewed the digital report remotely and electronically within 72 hours of the X-ray being taken to confirm diagnosis. Dosages of X-ray were recorded on the patient report form which was shared with NHS trust or local General Practitioner.

Local rules for the use of the X-ray equipment were set out in an annual report. This specified details, such as responsibilities, designated areas, monitoring, classified persons, and investigation levels, as well as what to do if an over exposure was suspected. This document was specific to 1 event only and was created in August 2022, with a review date of August 2024. A radiation protection advisor from a large NHS teaching trust worked with the service to ensure radiation protection for patients and staff.

An IRMER report set out scope of practice and recommendations for procedure content. This included justification, diagnostic reference levels and clinical evaluation. This report was due for renewal in August 2024.

Staffing

The service had enough staff with the right qualifications to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough staff to keep patients safe. Staff ranged from first aider to emergency medical consultant and were all employed on zero hours. At the time of the inspection, there were approximately 220 members of staff.

An annual statement of compliance was completed by staff and was a requirement of the service. This was a self-declaration that the appropriate mandatory training, driving license checks, appraisals and professional registration checks had been completed by the NHS employer and were appropriate, and the working time directive was followed. This included an annual General Medical Council review of competence progression for any doctors in training.

The manager of the service managed skill mix and numbers of staff and told us that if the required number of staff could not be sourced, then the service would not attend the event. A web portal accessible to all staff listed the available shifts needing cover. Staff files were stored electronically in a cloud-based system. The personnel files of 5 staff were reviewed. These included professional registration of those requiring registration, driver training and training certificates, such as resuscitation training.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were written, they were detailed, clear and easy to follow. All staff could access patient notes easily during an event. A copy of the patient record was transferred with patients if they were transferred to a local NHS trust.

Records were stored at the service securely in an area of the garage and kept for 10 years.

Medicines

The service did not always use systems and processes to prescribe, administer and store medicines. Daily checks of controlled drugs were not always completed kept up to date.

Staff followed systems and processes to prescribe and administer medicines safely which included schedule 19 paramedic exemptions.

Requires Improvement

Emergency and urgent care

A controlled medicines licence was provided to the service and a dedicated pharmacy supplier was used by the service. The registered manager for the service disposed of out-of-date controlled drugs in line with national guidance. Controlled drugs were stored in a locked cupboard when not in use however, daily checks were not always undertaken by the service. On site, controlled drugs were stored in a safe location on the vehicle. The registered manager for the service explained that the service did not have a daily service provision and therefore, a member of staff was not in attendance daily. There was no record clearly indicating when the service was operating or not and the management of controlled drugs policy did not set out a requirement for the frequency of controlled medicine checks.

Managers described how staff followed national practice to check patients had the correct medicines when they were given, or they moved between the event and NHS trust. No incidents relating to medicine management had been reported between April 2022 and April 2023.

Staff did not keep up to date with medicines records and checks, such as the secure anaesthetic fridge temperate checks which were not recorded. The provider had no system in place to ensure the fridge was taking accurate recordings of the temperature to ensure the safe storage of medicine. Information relating to mandatory training modules included medicine management was requested but not provided.

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated and when things went wrong,

Incident reports were paper based. The manager of the service kept an incident tracker which helped to monitor incident investigations, enabling themes and trends to be identified. Between April 2022 and April 2023, 7 incidents had been reported. Incidents included a sharps injury sustained during a cardiac arrest, shortage of intraosseous infusions (a needle used to deliver medicines and fluids into a bone), a medicine management incident and a misdiagnosed fractured shoulder. Each incident had been investigated, and feedback shared with the staff involved. Information sharing with the relevant NHS trust as well as reflections for future practice were undertaken where required.

The manager we spoke with during the inspection understood duty of candour and when to apply it although had not had to do so. A standard operating procedure set out duty of candour action so that staff knew when and how to carry it out.

Is the service effective?

Requires Improvement

The service had not been rated before. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Requires Improvement

Emergency and urgent care

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. This included specific guidelines for ambulance staff, as well as those set out by the National Institute for Health and Care Excellence, which could be accessed by all staff remotely on either smart phone or computer. The service was in the process of investing in point of care testing so blood gas monitoring could be checked whilst on site.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The manager for the service explained the pain tools used, which included one for children and people unable to verbalise their level of pain.

A range of different medicines were available for the management of pain. Administered pain relief was recorded on the written patient report form.

Patient outcomes

Staff monitored the effectiveness of patients undergoing X-ray tests at events.

The service did not undertake a schedule of audit of compliance with standards or otherwise. The monitoring of the outcome of patients who had undergone an X-ray was carried out. This was done within 72 hours to ensure the diagnosis was correct. Between April 2022 and 2023 no incorrect reports or missed diagnosis were found; however, there was an incident during this time relating to a shoulder fracture. Due to the nature of the service patient outcomes were not routinely monitored.

Competent staff

The service did not always make sure staff were competent for their roles. Managers had not appraised staff's work performance or held supervision meetings with them to provide support and development.

Managers did not provide information to demonstrate how they supported staff to develop through yearly appraisals. Performance reviews were not routinely carried out. At the time of the inspection, team meetings were not held between managers and staff. A private social media group was in use and messages could be shared via email when required.

Managers gave all new staff an induction tailored to their role before they started work. This included a venue and kit familiarisation. Evidence of any external training was reviewed on the first day. The induction varied depending on the skill set needed for the post. A scope of practice document set out clinical competency requirements for staff, as well as definitions of role and the aims of the document. The document had been reviewed in May 2023 and was due for renewal in 2026.

A consultant radiologist working with the service under service level agreement. They monitored the competency of the radiographer and undertook an annual appraisal and professional registration checks.

Requires Improvement

Emergency and urgent care

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked across health care disciplines and with other agencies when required to care for patients. This included sharing a copy of the patient report form with the general practitioner if the patient had required an X-ray meaning that any follow up actions could be carried out.

The service worked closely with multi agencies including the police, local authority, NHS ambulance trusts and security personnel at the event.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service provided sun cream to festival goers, leaflets on sexual health, as well as 'don't do drugs' literature.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

The service did not provide information about staff training of mental capacity and best interest decisions. Nor were any best interest decisions seen in documentation by inspectors.

A blank mental capacity assessment record was provided by the service following the inspection, this included a suicide and self harm risk assessment as well as best interest assessment section. No additional information to demonstrate monitoring and oversight of consent and capacity was provided.

Is the service caring?

Insufficient evidence to rate

The service had not been rated before. We did not have enough information to rate caring domain.

Is the service responsive?

Good

The service had not been rated before. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Requires Improvement

Emergency and urgent care

Managers planned and organised services, so they met the needs of the local population. This included a pre-event multiagency safety advisory group briefing, which set out the requirements. A multiagency debrief was used to inform the following years planning stage.

The service undertook 3 designated transfer journeys daily from the event for patients with non-time critical injuries and illness which required NHS attendance. To reduce the burden on local providers, the service referred patients back to their own NHS services, such as fracture clinics and dental services where possible.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

The service provided bottled water for patients and relatives using the service as often they were dehydrated and thirsty due to the nature of the event.

Telephone translation service could be accessed when required and communication booklets with pictures in them were available to help patients become partners in their care and treatment.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. The service had arrangements to investigate complaints seriously, investigate them and share lessons learned with staff if received.

The service had not received any complaints between April 2022 and April 2023. A complaints policy was available within the service and set out actions to be taken in the event of a complaint. This included liaising with the person raising the concern, investigating the complaint within a specified timescale, and providing feedback to both the person raising the complaint, as well as the staff involved.

At the time of the inspection, the service was developing a QR code, which would link directly to a concerns page for the service. Leaflets were available signposting people on how to raise a concern or complaint.

Is the service well-led?

Inadequate

The service had not been rated before. We rated it as inadequate.

Leadership

Leaders were visible within the service for patients and staff however there was a lack of governance procedures, staff development and oversight of key risks.

The registered manager was visible within the service. However, there was little oversight of these functions. Managers did not monitor the effectiveness of the service or make sure staff were competent.

Requires Improvement

Emergency and urgent care

Governance

There was no evidence that leaders used systems to operate effective governance processes, throughout the service and with partner organisations. There was no programme of audit or measures of the quality of service provided.

The service was relatively small, there was 1 registered manager and a silent director. The registered manager told us they took an informal approach to its governance. For example, 1 manager co-ordinated the service with the support of several members of staff who had responsibility in key areas. This included, stock and equipment, recruitment, and scheduling. However, there were no formal meetings or informal notes taken from any discussions. A lack of performance audits and measures of the quality of service meant the service was unable to demonstrate how it operated an effective governance process. This was further compounded by information, such as mandatory training; appraisal compliance and audit data not being held or available, indicating a lack of oversight and awareness of regulatory responsibilities.

Management of risk, issues and performance

The service had a system, an incident tracker to identify risks however, it could not be determined how this was used to manage performance and reduce impact and not all key risks had been identified. The service had plans to cope with unexpected events.

The service had a risk register. This set out several risks to the service, the control measures and a likelihood and consequence score. At the time of the inspection, 27 risks were registered, including, falls, working near to water, medical gases, sharps and ionizing radiation. The highest post control risk score was 10, which represented a minor risk. However, some risks were not identified. For example, recruitment was not in line with statutory requirements; and medicines were not always managed well. Risks associated with a lack of policies and procedures, lack of robust mandatory and staff training and no monitoring of patient outcomes including consent.

A business continuity policy was in use. This set out step by step actions to follow in the event of an unplanned incident, such as power loss.

Major incident planning formed part of the local authority safety advisory group (attended by multiple emergency services and other key stakeholders such as energy providers) meeting prior to the annual event. This set out key roles and responsibilities of services.

Information Management

Policies and procedures were not always available to support staff. Information systems were secure. Data or notifications were submitted to external organisations as required.

Patient report forms were written and stored appropriately. Policies and procedures were not always available to support staff. The service could not show how it monitored that patients consented to treatment and care, including X-rays.

The registered manager was aware of the need to submit statutory notifications for the service. Computer systems within the service were password protected and encrypted.

Requires Improvement

Emergency and urgent care

Public and staff engagement

Leaders and staff did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service did not provide any information relating to the engagement of its staff, the public or patient groups. It did engage with local authority and various stakeholders to plan the services it provided at the event.

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
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure it monitors compliance of safeguarding, mandatory training including mental capacity, and appraisals in line with statutory requirements. Regulation 17(2)(d)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 CQC (Registration) Regulations 2009 Fees • The service must ensure it has effective recruitment and selection procedures which comply with Schedule 3. They must ensure people employed have the competence, skills and experience required to undertake the role. Regulation 19(1)(a)(b)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The service must ensure care and treatment of service users is only provided with the consent of the relevant person. Regulation 11(1)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

The service must improve its safety arrangements around the storage, recording and management of medicines including controlled drugs. Regulation12(20)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure it operates effective systems of governance which assesses and monitors the service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). Information must be accurate, up to date and properly analysed. Quality and safety of services provided must also be monitored. Regulation 17(1)(2)(a)

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
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance A requirement notice was issued.

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Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance A requirement notice was issued.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed A requirement notice was issued.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 11 HSCA (RA) Regulations 2014 Need for consent A requirement notice was issued

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment A requirement notice was issued.