Manone Medical Ltd

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Manone Medical Ltd. is operated by Ambulance Training and Staffing Solutions Ltd. The service provides emergency and urgent care as well as a patient transport service.

We inspected this service using our focussed responsive inspection methodology. We carried out the inspection on 19 February, 3 March and 9 March 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We did not rate the service as this was a focussed responsive inspection.

We found the following issues that the service provider needs to improve:

- The service had not documented the reasons why patients had lacked mental capacity when needed, in line with national guidance.
- The service had not always documented that vehicle defects had been rectified. This meant that there was an increased risk that ambulances had not been maintained in a way that would keep people safe.
- We had concerns that patients' pain had not always been managed appropriately.
- Leaders had not always operated effective governance processes and were not always clear about their responsibilities.
- Although evidence was provided following the inspection period which indicated that leaders had met to discuss the performance of the service, key information had not been discussed, there was limited evidence of discussions and there was no documented evidence of what actions had been identified to make improvements to the service when needed.
- Leaders had not always used systems to manage performance effectively.

However, we found the following areas of good practice:

Summary of findings

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service made sure that staff were competent for their roles.
- The service had a clear process to minimise risks to patients.
- The service had enough staff with the right qualifications and skills to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had operated an effective system to protect patients from potential abuse on most occasions.
- The service had a leadership team who were able to support staff both clinically and operationally.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected urgent and emergency care. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care		The main activity provided by the service was patient transport services. The service also provided urgent care services, mainly for a local NHS Ambulance Trust. We did not rate the service because this was a focussed responsive inspection.

Summary of findings

Contents

Summary of this inspection

Background to Manone Medical Ltd

Manone Medical Ltd. is operated by Ambulance Training and Staffing Solutions Ltd. The service opened in January 2015. It is an independent ambulance service in Ellesmere Port, Cheshire. The service primarily serves the communities of the North West of England.

The service has had a registered manager in post since January 2015.

A significant proportion of the business was patient transfers, for example, the discharge of elderly patients to their home or hospital transfers, as well as providing urgent care services, mainly for a local NHS Ambulance Trust.

The service also undertook the transfer of mental health patients from accident and emergency departments to wards on mental health units or transfers between wards. Most of such transfers were delivered via a contract with a local mental health foundation trust.

The service received bookings for private events and medical repatriations, however as these services were not required to be registered with CQC they were not looked at during the inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and an inspection manager. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

How we carried out this inspection

This inspection was carried out following CQC's focussed inspection methodology. The inspection was undertaken following concerns that CQC had received, indicating that staff who provided urgent and emergency care had not always completed the training that was needed to keep people safe from avoidable harm as well as ambulance vehicles not always being maintained in a safe way.

We spoke with four members of staff, including managers and support staff. We reviewed important information that was provided before, during and after our inspection, including 47 sets of patient records.

Information about Manone Medical Ltd

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.

During the inspection, we visited Manone Headquarters, which was based at Hooton, Ellesmere Port. The service provided urgent and emergency care from ambulance stations at both Wallasey, Liverpool as well as Altrincham, Manchester. We spoke with four members of staff, including managers and support staff. We reviewed important information that was provided before, during and after our inspection, including 47 sets of patient records.

Summary of this inspection

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in September 2018 (patient transport services). However, urgent and emergency care had never been inspected as this service was not provided at the time of the last inspection.

Activity (August 2019 to February 2020)

- In the reporting period August 2019 to February 2020 there were 2818 emergency and urgent care patient journeys undertaken.

Two registered paramedics, three ambulance technicians, and 70 ambulance care assistants worked at the service, both on a substantive and a temporary basis.

Track record on safety

- No never events
- No clinical or non-clinical incidents
- No serious injuries

Emergency and urgent care

Safe	
Well-led	

Information about the service

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in September 2018 and patient transport services were rated as 'good'. However, CQC have not undertaken any previous inspections of urgent and emergency care, as this was not provided at the time of the last inspection.

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- No never events
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Summary of findings

We found the following issues that the service provider needs to improve:

- The service had not documented the reasons why patients had lacked mental capacity when needed, in line with national guidance.
- The service had not always documented that vehicle defects had been rectified. This meant that there was an increased risk that ambulances had not been maintained in a way that would keep people safe.
- We had concerns that patients' pain had not always been managed appropriately.
- Leaders had not always operated effective governance processes and were not always clear about their responsibilities.
- Although evidence was provided following the inspection period which indicated that leaders had met to discuss the performance of the service, key information had not been discussed, there was limited evidence of discussions and there was no documented evidence of what actions had been identified to make improvements to the service when needed.
- Leaders had not always used systems to manage performance effectively.

However, we found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service made sure that staff were competent for their roles.
- The service had a clear process to minimise risks to patients.
- The service had enough staff with the right qualifications and skills to keep people safe from avoidable harm and to provide the right care and treatment.

Emergency and urgent care

- The service had operated an effective system to protect patients from potential abuse on most occasions.
- The service had a leadership team who were able to support staff both clinically and operationally.

Are emergency and urgent care services safe?

We did not rate safe for the service as this was a focussed responsive inspection. However, we found the following;

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service made sure that staff were competent for their roles.

The service provided an induction programme for all staff. This was delivered as an internal training programme, including key topics such as infection prevention control, manual handling, basic life support as well as safeguarding for children and adults.

The service kept an oversight of who had completed training and were able to identify staff who were overdue training. Mandatory training records that were provided after the inspection indicated 100% compliance for all staff who were responsible for providing urgent care services.

We were informed by managers that once staff had completed their training to undertake patient transport services, they were able to progress and complete an internally delivered course which provided additional competencies, enabling staff to undertake urgent care work safely.

We noted that all training that was provided by the service internally had not been accredited by an external training organisation. Managers informed us that although they felt the training provided internally was comprehensive, they had planned to commission an accredited course for staff undertaking urgent care services. Managers had begun the process of securing this training and were hoping to implement this in the near future.

The current urgent care training that was delivered to staff covered several key topics such as demonstrating a range of airway management techniques, recognising and managing cardiac conditions, assessing and managing head injuries, managing diabetic emergencies as well as demonstrating the use of the national early

warning score (a system that is used to identify a patient whose condition is deteriorating, based on basic observations such as pulse rate, respiratory rate and blood pressure).

Urgent care training was provided to staff in a number of different ways, including face to face learning, practical scenarios as well as 'on the job' assessments. All competencies were recorded by managers electronically. Staff also completed paper based practice assessment documents, which staff completed themselves as evidence of their own continuing professional development.

During our inspection of 19 February 2020, we found that the most up to date training records were not available for review. This meant that we had concerns that not all staff had achieved the required competencies prior to undertaking urgent care work.

Following our inspection of 19 February 2020, we were informed by managers that the information provided on the 19 February had not been updated. Subsequently, we undertook further inspection visits on 3 and 9 March 2020, when the service was able to provide evidence that a total of 30 ambulance care assistants had completed training to undertake urgent care services.

Safeguarding

The service had operated an effective system to protect patients from potential abuse on most occasions. However, the service had not documented the reasons why patients had lacked mental capacity when needed, in line with national guidance.

The service had a safeguarding policy for adults and children which was in date, and available to all staff electronically. This provided key information and provided examples of safeguarding concerns, such as neglect, as well as emotional and financial abuse.

The safeguarding policy included guidance for staff on how to make referrals when needed, indicating that referrals should be made to the relevant local authority by staff who had identified the safeguarding concern. The service provided up to date contact details for several local authorities, which staff were able to access electronically.

However, we had concerns that the safeguarding policy did not reflect the actions that staff had taken when making safeguarding referrals. This was because the service made referrals to the clinical support hub of a local NHS ambulance trust as well as the local authority. This was not reflected at the time of the inspection.

In addition, we had concerns that the service had not maintained oversight of safeguarding referrals on occasions that the registered manager had not been present. This was because during our inspection of 19 February 2020, the management team present were unable to provide us with assurances that safeguarding referrals had been made when needed as well as not being aware that they were responsible for monitoring this.

Records indicated that between 5 August 2019 and 5 February 2020, the service had identified a total of 79 safeguarding concerns; 60 for urgent care services and 19 for patient transport services.

During our inspection of 19 February 2020, we had concerns that safeguarding referrals had not been made to local authorities, in line with the service's safeguarding policy. On reviewing an overview sheet of all safeguarding incidents that had been recorded, there was limited evidence that this had been done, meaning that we had concerns that the service had not taken all appropriate actions to keep patients safe. Following our inspection of 19 February 2020, the service provided further evidence that all safeguarding referrals had been made to the local authority on all but one occasion.

Although the evidence provided indicated that safeguarding referrals to a local authority had been made, the service had not kept a record of who safeguarding referrals had been made to. On sampling patient records, we found that a safeguarding incident referral number had been recorded, but this was not present in any other cases. The management team recognised the need to make improvements regarding this, and we were informed during our inspection of 13 March 2020 that actions had been taken to make sure that this was documented in the future.

However, we found one occasion when patient neglect had been documented by a member of staff, but there was no documented evidence that a referral had been made to keep the patient safe.

Emergency and urgent care

The service had not made any statutory safeguarding notifications to the CQC between 5 August 2019 and 5 February 2020, which was not in line with Regulation 18 of the Health and Social Care Act 2009. This was important because it allows CQC assess whether providers have effective systems and processes to help keep children and adults safe from abuse and neglect.

On sampling patient records, we found that there had been three occasions when patients had been deemed to lack mental capacity, meaning that they had been unable to make a decision about their care and treatment. Although staff had ticked a box on each patient record form to indicate that patients lacked capacity, there was no documented evidence of how this decision had been made. In addition, the service's Mental Capacity Act policy did not outline the requirement for this. This was not in line with the requirements of the Mental Capacity Act 2005 and meant that there was an increased risk that patients would be deemed to not have the capacity to make a decision inappropriately.

The service completed enhanced disclosure and barring service checks for all staff. The service had previously operated a system whereby enhanced disclosure and barring service certificates were accepted from a staff member's previous employer. However, managers informed us that the service had completed new checks for all new starters since April 2019. This was important as it meant that the service had the most up to date information available about staff at the time that they had been recruited.

On sampling ten personnel files, we found evidence that enhanced disclosure and barring service checks had been completed for all staff, although two of these had been completed by previous employers. Managers informed us that these members of staff had started their employment before April 2019.

We saw evidence that the service had taken steps to risk assess any staff members who had committed offences, assessing their suitability to undertake their role.

Environment and equipment

The service had not always documented that vehicle defects had been rectified. This meant that there was an increased risk that ambulances had not been maintained in a way that would keep people safe.

During the inspection we sampled records for 10 ambulances, finding that MOTs and servicing had been completed appropriately on all occasions.

We were informed by managers that the service maintained oversight of when the next service and MOTs were due for all ambulances. However, on reviewing records that were provided during the inspection, we had concerns that the most up to date information was not always available.

For example, records indicated that MOTs were overdue for three ambulances. Records also indicated that servicing and MOTs had not been scheduled for two ambulances. This meant that there was an increased risk that vehicles would not always be serviced in a timely manner.

Records indicated that between November 2019 and February 2020, there had been 126 vehicle or equipment defects reported. The service had kept a log of all incidents reported which indicated that action had been taken to resolve defects that had been identified.

However, the service had not kept a clear audit trail of who had been responsible for fixing defects that had been reported. Managers informed us that they employed a member of staff who had mechanical qualifications and we were informed that they could undertake basic repairs such as changing light bulbs. However, due to the lack of documented evidence, it was unclear if they had undertaken any repairs outside of their competencies.

The service had made sure that all equipment such as defibrillators, stretchers and wheelchairs had been serviced in line with manufacturers guidance. This meant that the risk of equipment becoming faulty during use had been reduced.

Assessing and responding to patient risk

The service had a clear process to minimise risks to patients. However, we had concerns that patients' pain had not always been managed appropriately.

Managers informed us that most of the urgent care work that had been undertaken was for an NHS ambulance Trust. We were also informed that the service had only received category three and four emergency calls (these are non-life-threatening emergency calls which are assessed by a member of the NHS Ambulance Trust by telephone before allocation).

Emergency and urgent care

Staff were required to complete a further patient assessment on arrival at a scene, which included basic observations such as blood pressure, pulse, oxygen saturations, respiratory rate as well as temperature. We reviewed a total of 19 patient records, finding that this had been completed on all occasions.

However, on sampling patient records, we found one occasion when a patient had a cardiac condition but there was no evidence that a further assessment had been made, meaning that there was an increased risk that the patient could have been transported unsafely. Staff did not have access to equipment to undertake an electrocardiogram and there was no evidence that the patient had been escalated so that this could be done. An electrocardiogram is a test that is undertaken to check the electrical activity of the heart.

In addition, the service used the national early warning score for adults (a system used to identify a deteriorating patient using observations such as blood pressure and pulse rate). We found that this had been completed on all occasions.

On occasions when a patient's national early warning score was four or above (meaning that a patient was at risk of deteriorating and potentially required further treatment), staff had been instructed to seek clinical advice from the clinical support hub of an NHS Ambulance Trust. We found that this had been completed on all occasions when needed.

The service had developed a number of 'red flag' indicators such as central chest pain or suspected stroke. On occasions when patients presented with a 'red flag' staff were required to contact a clinical support hub for further advice and the service had completed audits monitoring compliance with this.

Audits that had been undertaken between August and December 2019 indicated 89% compliance. This mean that on 11% of occasions, staff had not contacted a clinical support hub for advice when needed, meaning that there was an increased risk that patients had been transported unsafely.

The service had a policy which outlined what actions staff should take in the event of an emergency. This included dialling 999 if needed.

On occasions when patients did not need to or had refused to go to hospital, staff were required to contact a clinical support hub to determine how this could be done safely. We found evidence that this had been undertaken when needed and a record that patients had been given self-care advice or had been referred to another service, such as a GP.

In order to support staff with assessing patients, the service followed care pathways for specific conditions, such as if a patient had a minor injury or had fallen. Care pathways are important as it supports staff to assess patients and deliver care in a way that meets best practice guidance. However, we noted that not all parts of the care pathway had been reflected in the patient record. This meant that there was an increased risk that patients had not been fully assessed and may not have received the right care and treatment for their condition.

We had concerns that patients' pain had not always been managed appropriately. We sampled records between 14 December 2019 and 12 January 2020, finding evidence that patient's pain had not been managed appropriately on eight out of nine occasions when the administration of pain relief had been needed.

For example, although pain relief had been administered on three occasions, records indicated that this had been ineffective and there was no documented evidence that staff had taken any further action to reduce the patients' pain. On another occasion, there was no documented evidence that pain relief had been administered at all despite the patient's pain levels being high.

We had concerns that it was unclear what actions staff should take if patients' pain remained uncontrollable. This was because the service did not have any policies or procedures to support staff regarding managing patients' pain, meaning that there was an increased risk that patients' pain would not be managed appropriately in the future.

Staffing

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

The service did not have a clear policy or procedure which outlined the minimum number of staff needed or

the minimum skill mix that was required on all urgent care shifts. However, we found information about this within a contract that was held with a local NHS ambulance trust. In addition, we had concerns that the most up to date information had not always been available to staff who were responsible for co-ordinating staffing, meaning that there was an increased risk that urgent care shifts would not always be staffed safely.

Following the inspection period, the provider submitted evidence that therewas a policy, outlining the minimum number of staff needed or the minimum skill mix that was required on all urgent care shifts.

During our inspection of 19 February 2020, managers who were responsible for the service were unable to provide evidence that all staff who had undertaken urgent care work had completed appropriate training. We were shown a training matrix by a member of staff who was responsible for making sure that all urgent care shifts had been appropriately staffed. The training matrix that was used as part of this process indicated that between 1 December 2019 and 11 January 2020, there had been 55 shifts undertaken without a member of staff having completed the required competencies to undertake this safely. We raised these concerns with the management team both during and after the inspection.

During our inspections of 3 and 9 March 2020, we were provided with further information which indicated that the service had made sure that all urgent care shifts had been covered appropriately. On reviewing rotas between 19 December 2019 and 28 January 2020, we found that all shifts had been covered by at least one member of staff who had fully completed urgent care training.

Records

The service had not always kept a contemporaneous record of care and treatment that had been provided to patients.

We found that the service had made appropriate arrangements for all patient records to be kept securely, reducing the risk of information being lost and patients' confidentiality being breached.

All patient records for urgent care services were paper based. Staff were required to complete a patient record for every patient that they had contact with, whether the patient had been transported to hospital or had remained at home.

We had concerns that staff had not always kept a full contemporaneous record of the care provided to all patients. We sampled a total of 47 patient record forms that had been completed the 14 December 2019 and 12 January 2020, finding that key information was missing from 19 records. This included whether a patient had capacity to decide about their care and treatment, a full record of whether safeguarding referrals had been made as well as important information such as a patient's medical history.

However, we did note areas of good practice, such as that patient's personal information had been documented fully on all occasions and that a clear record had been kept on occasions that advice had been sought from a clinical support hub which was run by a local NHS ambulance trust.

Incidents

Staff recognised incidents and near misses and reported them appropriately.

The service had an incident reporting policy which was available to all staff electronically. The policy included information for staff to follow, such as how to report an incident.

Managers informed us that they had maintained an overview of all incidents that had been reported, so that they could be investigated. Records indicated that between January and February 2020, a total of 22 incidents had been reported. None of these had related to the provision of urgent care.

Are emergency and urgent care services well-led?

We did not rate safe for the service as this was a focussed responsive inspection. However, we found the following;

Leadership

The service had a leadership team who were able to support staff both clinically and operationally.

The service was managed by a leadership team which consisted of a managing director and a clinical performance manager. Additionally, the service employed two paramedics who were responsible for providing clinical leadership to staff. At the time of the inspection, both paramedics were responsible for supervising staff who were based at Manchester and Liverpool.

Governance

Leaders had not always operated effective governance processes and managers were not always clear about their responsibilities. Although evidence was provided following the inspection period which indicated that leaders had met to discuss the performance of the service, key information had not been discussed, there was limited evidence of discussions and there was no documented evidence of what actions had been identified to make improvements to the service when needed.

At the time of the inspection, managers informed us that they had held monthly management meetings to discuss key topics. However, this was not provided following the inspection as requested.

Following the inspection period, CQC were provided with evidence of management meetings that had been held between September and December 2019. However, on reviewing the information provided, we had concerns that key information, such as audits, had not been included. In addition, there was limited evidence of what discussions had been had during the meetings and there was no documented evidence of what actions had been identified to make improvements to the service when needed.

We had concerns that the service had not operated an effective process to make sure that managers who had been responsible for the service were able to provide assurances about several key topics in the absence of the registered manager.

For example, during our inspection of 19 February, evidence was not available to provide assurance about that safeguarding referrals had been made when needed or if enough numbers of competent staff had always been available. This meant that there was an increased risk that oversight of services would not always be maintained.

The registered manager informed us that they had planned to take extended time away from the service in the near future but provided reassurance that contingency arrangements had been made to make sure that the service ran as normal and that safety was maintained.

All policies and procedures were available for staff to access electronically. During our inspection, we sampled 19 policies and procedures, including those covering topics such as safeguarding for adults and children, resuscitation, accident and incident reporting, risk assessments, the Mental Health Act as well as the Mental Capacity Act.

On reviewing the policies and procedures, we found that some of these did not fully reflect the service that had been delivered, and in some cases did not provide key information for staff to follow so that legislation and best practice guidance was met.

For example, the safeguarding policy did not outline all actions that staff should take on occasions that safeguarding referrals needed to be made. Additionally, the Mental Capacity Act policy did not outline the need for staff to document the rationale as to why a patient had not lacked capacity. This was not in line with best practice guidance and legislation.

We were informed by managers that policies and procedures were written and reviewed by an external organisation. All policies and procedures that we reviewed had review dates as well as references to relevant legislation and best practice guidance.

Management of risks, issues and performance

Leaders had not always used systems to manage performance effectively.

The service had undertaken audits of patient records to monitor compliance with the completion of these. This included an audit of general completion (whether all relevant sections had been completed) and separate

audits had been completed to make sure that appropriate action had taken if red flag indicators had been present, when pain relief had been given or when oxygen had been administered.

We had concerns that not all clinical audits had been fully completed, meaning that there was an increased risk that improvements would not always be made when needed.

For example, between August and December 2019, audits had been undertaken on 45 occasions when red flag indicators had been present. However, the records indicated that the audit had only been partially completed as only 34 out of 45 entries had been completed. In the 11 audits that had not been completed, important information, such as if staff had contacted a clinical support hub for advice had not been completed.

We also had similar concerns on reviewing the clinical audit for pain management (August to December 2019). This was because 16 out of 81 entries had not been completed, meaning that it was unclear on these occasions if patients' pain had been managed appropriately.

Records provided following the inspection also indicated that oxygen had been administered in line with best practice guidance and had been correctly recorded on 86% of occasions between August and December 2019.

It wasn't always clear what actions had been taken to make improvements to areas of poor compliance when needed. For example, on the occasions when the pain relief audit had been fully completed, records indicated 80% compliance between August and December 2019. On reviewing these audits, the sections which were used to outline actions were not completed.

During our inspection, we found that pain management had not been documented fully or patients' pain had not been managed appropriately on eight out of nine occasions between 14 December 2019 and 12 January 2020. This meant that the service had not made improvements to make sure that patients' needs had been met.

The service had a system for managing risk. We found that several risk assessments had been undertaken, covering important topics such as moving and handling as well as health and safety. All risk assessments were in date and had controls in place to reduce the level of risk as much as practicably possible.

On reviewing the risk register, we found that eight organisational risks had been identified. Seven out of eight of these had been reviewed regularly, all had been risk scored and had controls in place to reduce the level of risk, as well as having a person who was responsible for each risk.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that statutory safeguarding notifications are made to CQC when needed, in line with Regulation 18 (Registration Regulations), Health and Social Care Act, 2009. Regulation 18 (Registration Regulations).
- The service must ensure that an effective system is operated to make sure that managers are aware of their responsibilities and are able to provide evidence of safe care and treatment, particularly when the registered manager is unavailable. Regulation 17(2)(a)(b).
- The service must ensure that the service is monitored effectively and that improvements are made in a timely manner when needed. Regulation 17(2)(a).
- The service must ensure that a contemporaneous record is kept for all patients. Regulation 17(2)(c).
- The service must ensure that patients' pain is managed appropriately, and the management of patients' pain is documented fully when needed. Regulation 17(2)(c).
- The service must ensure that patients' mental capacity is fully documented on all occasions when needed, in line with best practice guidance. Regulation 17(2)(c).

Action the provider SHOULD take to improve

- The service should ensure a system is operated which evidences that safeguarding notifications have been made to a local authority in a timely manner when needed.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents