Alliance-Pioneer Group

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Alliance-Pioneer Group is operated by Mr Matthew Davey.

The main service provided by Alliance-Pioneer Group is events medical cover, which is outside the scope of regulation. However, they transport patients from event sites to local hospitals, which is in scope of our regulation.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 24 August 2017 along with an additional visit to the office on 1 September 2017.

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.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

During our inspection we identified a number of areas of serious concern. In particular there was lack of assurance the provider had or could evidence regarding the safe working practice and competency of their staff.

We found the following areas of concern:

- The governance arrangements did not assure Alliance-Pioneer Group it was providing a high quality and safe service. Performance was not monitored and there was limited internal or clinical audit. Therefore learning and improvements were not encouraged.
- Provider risks were not being identified and recorded. We were not confident Alliance-Pioneer Group were aware of the risks to enable them to manage and mitigate the risks effectively.
- The provider was unable to demonstrate they employed 'fit and proper' staff who were able to provide care and treatment appropriate to their role.
- Safe recruitment processes were not in place to ensure patients were safeguarded against unsuitable staff. Recruitment procedures were not robust to ensure required checks were completed.
- The provider was unable to evidence staff had the skills, knowledge and experience to deliver safe and effective care and treatment. There were no systems in place to demonstrate staff competence at recruitment and on an on-going basis. There was no formalised process for induction, regular appraisals or clinical supervision.
- Staff did not receive mandatory training in safe systems, processes and practices. For staff employed by other healthcare providers there was an assumption this had been completed, but no evidence of this was obtained.
- There was no evidence of the level of safeguarding training staff had received. Therefore the provider could not show us staff were kept up to date with how to recognise different types of abuse and ways they can report concerns.
- There was no evidence to confirm staff responsible for the administration of medicines were suitably trained and competent. The provider did not have in place patient group directions, a document permitting the supply and administration of prescription only medicines, and could not evidence staff training.
- The storage of medical gases was not safe and did not comply with the Department of Health HTM02 guidance or British Compressed Gas Association code of practice.
- The arrangements for storing and transporting morphine (a controlled drug) had not been risk assessed and the processes were not clearly documented within the provider's policy.
- There was a risk staff were not reporting incidents. The provider told us there had been no incidents in the last year. Policies did not include how staff should report incidents, or the type of incidents to report.

Summary of findings

- There was a lack of evidence of compliance with infection control standards. Although systems were in place, there was no audit of infection control practice and no evidence of training. We identified torn seat coverings, arm rests and mattresses in ambulances which posed an infection control risk.
- Vehicles were not cleaned immediately after use. During our announced inspection we observed three vehicles, which were all waiting to be cleaned. The crew for the vehicle following an event had not taken the responsibility to remove clinical waste and clean the interior to reduce the risk of the spread of infection.
- Policies, procedures and checklist documents were not available centrally to ensure all senior management team had access. This also meant some policies and procedures were not readily available to staff.
- There was limited engagement with the public and staff to formally seek feedback on the service to enable improvements to be made.

However, we also found the following areas of good practice:

- Patient observations were completed frequently and there was an awareness of sepsis tools. This ensured early identification of a deteriorating patient so they could be transferred to hospital quickly.
- Clinical records for patients who had been transported to hospital were well-completed. They were clear and concise.
- There was evidence of good event planning and risk assessing. Hospitals to which patients would be transferred to were identified and contact numbers made available. This reduced the chance of delays when transferring patients to the appropriate healthcare provider.
- Records of equipment maintenance and schedules were available, including vehicles and medical devices.
- Staff spoke of good relationships and co-ordination with other healthcare providers to enable the delivery of effective care and treatment.
- Staff understood the relevant consent and decision making requirements and this was evidenced in patient care records when patients had been transferred to hospital.
- During the inspection we were not able to observe any direct patient care but noted staff spoke in a thoughtful way about caring for patients. Staff provided accounts of events and situations which demonstrated either themselves or their colleagues “going the extra mile” to provide kind and compassionate care.
- A dedicated crew and ambulance were identified as the primary resource for transporting a patient off-site if needed. This ensured access to care and treatment was timely and delays were minimised.
- The Alliance-Pioneer Group were responsive to the needs of patients who were under the influence of drugs and were able to provide support through qualified counsellors to meet their needs.
- Managers were described as supportive and responsive to concerns. The feedback received from staff about working for the provider was consistently positive.
- The senior management team had a shared vision of future aspirations for the Alliance-Pioneer Group and were keen to make improvements. They spoke of their aim to evidence the quality and safety of the service.

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 six requirement notices that affected emergency and urgent care. Details are at the end of the report.

Amanda Stanford
Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services		Alliance-Pioneer Group provided medical events cover. This included a regulated activity when patients were transported from event sites to local hospitals for further care and treatment. We found the provider was not assured of the quality and safety of the service it was providing and the competence of the staff they were employing.

Summary of findings

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Background to Alliance-Pioneer Group

Alliance-Pioneer Group is operated by Mr Matthew Davey. The service started trading in 2002. It is an independent ambulance service providing events medical cover nationally, with the office based in Plymouth, Devon.

The service provides the following regulated activities:

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

We inspected the service on the 24 August 2017, which was announced two weeks prior to our visit. We further visited during the unannounced period on 1 September 2017.

Our inspection team

The team that inspected the service comprised of three CQC inspectors, one a registered paramedic. The inspection team was overseen by Daniel Thorogood, Inspection Manager and Mary Cridge, Head of Hospital Inspections.

Information about Alliance-Pioneer Group

Alliance-Pioneer Group is a Plymouth based company specialising in supplying safety services to the events, entertainment and sporting industries nationally. The company started trading in 2002 as a medical support provider. Over the years it has expanded operations to offer services outside of the events industry and now also includes other related safety services.

Alliance-Pioneer Group's main service provision is events medical cover. In emergencies, or as required, patients can be transferred off event sites.

The office base is at Safestore Building, Parkway Industrial Estate, Plymouth. Eight emergency ambulances and two four-by-four response vehicles are stored at this location. During the inspection there were two old patient transport service vehicles which were up for sale and were being used for equipment and staff transport.

During the inspection we visited the base. We spoke with the registered manager (group director), operations manager, HR co-ordinator, the lead nurse and practice development manager, the quality governance and safeguarding lead, and the clinical lead and effectiveness manager. Additionally, we spoke with five staff over the telephone: two paramedics, one GP, one ambulance technician and one emergency care assistant. We were not able to speak with any patients. During our inspection, we reviewed three sets of patient care records where patients had been transported to hospital. Additionally, we reviewed 70 patient care records for patients who had not been transported to hospital. This is a non-regulated activity, however there is potential that these patients could be transported if they deteriorate.

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 three times, and the most recent inspection took place in December 2013. This inspection found the service was meeting all standards of quality and safety it was inspected against.

The provider reported they employed 16 registered paramedics, three emergency nurses, 13 technicians and eight emergency care assistants to provide the regulated activities. The accountable officer for controlled drugs (CDs) was the registered manager.

Summary of this inspection

Activity (1 January 2017 to 23 August 2017):

- There were 311 clinical contacts. A total of 11 emergency and urgent care patient journeys (regulated activities) were undertaken, whereby patients were transferred from event sites on the highways to the local hospital or other healthcare provider.

Track record on safety:

- No reported never events.
- No reported clinical incidents.
- No reported serious injuries.
- There was one complaint.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate independent ambulance services.

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

- The provider was unable to deliver assurances they employed 'fit and proper' staff who were able to provide safe care and treatment appropriate to their role.
- Safe recruitment processes were not in place to ensure patients were safeguarded against unsuitable staff.
- Staff did not receive mandatory training in safe systems, processes and practices. For staff employed by other healthcare providers there was an assumption this had been completed but no evidence was obtained to show they had completed up to date training.
- There was no assurance of the level of safeguarding training staff had received. Therefore the provider could not show staff were kept up to date to recognise different types of abuse and ways they can report concerns.
- There was no evidence to confirm staff responsible for the administration of medicines were suitably trained and competent. The provider did not have in place patient group directions, to provide a legal framework to allow the supply and administration of certain medicines to patient groups. They could not evidence staff training.
- The storage of medical gases was not safe and did not comply with the Department of Health HTM02 guidance or British Compressed Gas Association code of practice.
- The arrangements for storing and transporting morphine (a controlled drug) had not been risk assessed and the processes were not clearly documented within the provider's policy.
- There was no clinical dashboard or equivalent system to monitor safety performance.
- There was a lack of assurance of compliance with infection control standards. Although systems were in place there was no audit of infection control practice and no evidence of training. We identified torn seat coverings, arm rests and mattresses in ambulances which posed an infection control risk.
- Vehicles were not cleaned immediately after use. During our announced inspection we observed three vehicles, which were

all waiting to be cleaned. The crew for the vehicle following an event had not taken the responsibility to remove clinical waste and clean the interior to reduce the risk of the spread of infection.
- There was a risk staff were not reporting incidents. The provider told us there had been no incidents in the last year. Policies did not include how staff should report incidents or the type of incidents to report.
- There were no policies or procedures in place to support a culture of openness and transparency.

We found the following areas of good practice:

- Patient observations were completed frequently and there was an awareness of sepsis tools. This ensured early identification of a deteriorating patient so they could be transferred to hospital quickly.
- Clinical records for patients who had been transferred to hospital were well-completed. They were clear and concise.
- Potential resource and capacity risks to the service were anticipated and planned in advance. Alliance-Pioneer Group were involved in major incident arrangements which were co-ordinated by the event provider.
- There was evidence of good event planning and risk assessing. Hospitals to which patients would be transferred to were identified and contact numbers made available.
- Staffing levels and skill mix were planned and reviewed. This ensured emergency transport vehicles were crewed to transfer patients from events sites to hospital if required.
- Records of equipment maintenance and schedules were in place including vehicles and medical devices.

Are services effective?

We do not currently have a legal duty to rate independent ambulance services.

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

- The provider was unable to evidence staff had the skills, knowledge and experience to deliver effective care and treatment.
- There were no systems in place to demonstrate staff competence at recruitment and on an on-going basis. There was no formalised process for induction, regular appraisals or clinical supervision.

Summary of this inspection

- Learning needs were not being identified for staff and therefore staff were not being encouraged and given opportunities to develop.
- Not all staff were able to access guidelines and protocols and there was a risk they were not aware of changes within these.
- Patients' care and treatment outcomes were not routinely collected and monitored.

We found the following areas of good practice:

- The provider had adapted a clinical response pathway for a collapsed athlete.
- Staff spoke of good relationships and co-ordination with other health care providers to enable the delivery of effective care and treatment.
- Patient care records were used to provide the detail when handing a patient over from the ambulance crew to hospital staff.
- Staff understood the relevant consent and decision making requirements and this was evidenced in patient care records when patients had been transferred to hospital.

Are services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- During the inspection we were not able to observe any direct patient care but noted staff spoke in a thoughtful way about caring for patients.
- Staff provided accounts of events and situations which demonstrated either themselves or their colleagues "going the extra mile" to provide kind and compassionate care.
- It was evident through conversations with staff that patient privacy and dignity was a high priority.
- We were told family and friends were involved when providing care to a patient and were provided with support and reassurance when required. They were encouraged to travel with the patient when transported to hospital.
- Patients were signposted to relevant support networks or onward care at discharge from Alliance-Pioneer Group to enable them to manage their own health.

Are services responsive?

We do not currently have a legal duty to rate independent ambulance services.

Summary of this inspection

We found the following areas of good practice:

- A dedicated crew and ambulance were identified as the primary resource for transporting a patient off-site if needed. This ensured access to care and treatment was timely and delays were minimised.
- Alliance-Pioneer Group were responsive to the needs of patients who were under the influence of drugs and were able to provide support through qualified counsellors to meet their needs.
- Services were planned to meet the commercial need. Information was captured about clinical activity at each event through the post event audit. This enabled trends and themes to be reviewed about the type of care and treatment provided at each event.
- Alliance-Pioneer Group were proud of the savings they were able to make to the NHS, reducing the pressure on the local healthcare providers through the provision of care and treatment on event sites and only transferring patients to hospital when required.

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

- The needs of different patients, including those in vulnerable circumstances, were not always taken into account to ensure care and treatment could be adapted to be accessible for all. For example, there were no communication aids to communicate with patients with communication difficulties. However, the provider was able to contact the local ambulance trust if they required support in meeting some people's needs, for example with bariatric patients.

Are services well-led?

We do not currently have a legal duty to rate independent ambulance services.

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

- The governance of Alliance-Pioneer Group did not provide assurance it was providing a high quality and safe service. Performance was not monitored and there was limited internal or clinical audit. Therefore, learning and improvements were not encouraged.
- Provider risks were not being identified and recorded. We were not assured the provider was aware of risks to enable them to manage and mitigate them effectively.

Summary of this inspection

- Recruitment procedures and on-going checks were not robust. This meant required checks were not always completed to ensure staff were eligible to work for the provider and competent to deliver care and treatment relevant to their role.
- Policies, procedures and checklist systems were not available centrally to ensure all senior management team had access. This also meant some policies and procedures were not readily available to staff.
- There was limited engagement with the public and staff to formally seek feedback on the service to enable improvements to be made.

We found the following areas of good practice:

- Managers were described as supportive and responsive to concerns. The feedback received from staff about working for the Alliance-Pioneer Group was consistently positive.
- The senior management team had a shared vision of future aspirations for the Alliance-Pioneer Group and were keen to make improvements. They spoke of their aim to evidence the quality and safety of the service.
- Alliance-Pioneer Group told us they were the only UK organisation represented at an international forum looking at the effects and appropriate emergency management of psycho-active substance misuse. Staff told us attendance at the conference was a big drive for improving their service.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are urgent and emergency services safe?

Incidents

- We were unable to ascertain the track record on safety and whether lessons were learned and improvements made when things went wrong. The provider told us there were no reported incidents within the last year. This meant there was a potential risk staff were not actively reporting incidents or being encouraged to report incidents.
- We were told staff would report incidents by completing a paper incident report form or via email to the registered manager or operations manager. There was no evidence of these being completed. Staff told us they had reported incidents prior to the last year on the paper form but there would not be a record of these as once actioned they were disposed of. Staff were confident the incidents they raised were managed in a timely manner and changes were made where relevant.
- There was no database or system to record incidents. Therefore, the provider could not demonstrate actions taken or learning that had taken place when things went wrong.
- The senior management team told us incidents were managed verbally. They would be reviewed by the registered manager and then passed to the relevant senior staff for further action if required.
- The incident management process document discussed in length the process for reporting and investigating serious incidents. However, this appeared to be relevant to NHS providers and not to Alliance-Pioneer Group. There was no reference in this document of the requirement to inform CQC of serious incidents. The policy did not include the process staff should follow to report an incident and the types of incidents they should be reporting.
- Staff spoken with understood the term duty of candour and how it would be applied in incidents. However, there was no mention of the duty of candour within the incident management process document. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.
- We were told safety alerts were cascaded to staff via emails or newsletter. However, there were no recent examples to evidence this. We were told policies and procedures would be updated to reflect any changes, however there was no process for ensuring and evidencing staff were aware of these changes.

Clinical Quality Dashboard or equivalent

- There was no clinical quality dashboard or equivalent system to monitor safety performance. There was a limited use of audit to monitor the quality and safety of the service being provided. This did not allow the provider to identify areas of strength or areas for improvement.

Cleanliness, infection control and hygiene

- There was a lack of assurance of compliance with infection prevention control standards. Staff had received no training in infection prevention and control and there were no audits undertaken in respect of standards, such as hand hygiene and vehicle cleanliness.
- There was an infection prevention and control policy (June 2017). This set out a commitment to provide staff induction training and regular refresher training in infection prevention and control (IPC). It also committed

to monitor compliance with safe systems set out in the IPC workbook through regular inspections of the workplace. We saw no evidence this commitment was met.

- There was a vehicle cleaning policy (updated March 2013). The policy stated vehicles were to be deep cleaned on a weekly basis using steam cleaning equipment. However, staff told us this took place monthly or more frequently only if required. We saw records of completed monthly deep clean for vehicles.
- A make ready operative was employed to clean, replenish and maintain the vehicles. This role was not referred to in the vehicle cleaning policy. The IPC policy set out the responsibility to clean and equip vehicles and stated the group's performance against key performance indicators. There was no evidence of the group's performance against key performance indicators. We were told the make ready operative had not received any specific training in infection prevention and control. The make ready operative told us they had received IPC training when working for their previous employer.
- We were told vehicles were cleaned after each use, but this was not documented. However, a board was used to indicate when a vehicle had been cleaned and 'made ready'.
- The vehicle cleaning policy set out the responsibility of all staff to ensure their vehicle was "of the required standard" at the start and throughout their shift. Staff were referred to the infection prevention and control manual. Staff we spoke with confirmed it was their responsibility to sweep and mop the vehicle's interior and dispose of waste.
- We inspected three ambulances. The vehicles had not been cleaned or replenished since their last use, three days prior to our inspection. This was confirmed by the registered manager. This posed a cross infection risk within the vehicles because they had not been cleaned in a timely manner. We found:

- The inside of the vehicles were mostly tidy, however the cleanliness was variable. We found two vehicles were visibly clean but there was a disposable scalpel, medicine packaging and a broken pen on the floor of one vehicle and some grass on the floor of another. The third vehicle was visibly unclean.

- Vinyl seat coverings were torn in places on all vehicles. A torn arm rest had been temporarily repaired with gaffer tape, which was peeling away. The mattress covering on the trolley in one vehicle was torn. This made these surfaces difficult to keep clean and posed an infection control risk. The hook and loop fastening strap on one trolley was encrusted with debris.

- Hand cleansing gel was available on two of the three vehicles.

- Personal protective equipment was available; however, there were no aprons on one vehicle.

- Decontamination wipes were available on two of the three vehicles.

- There were clinical waste bags on two of the three vehicles.

- Bins used to dispose of sharps were not secured on two of the three vehicles and were not labelled.

- We found waste, which was possibly clinical waste, on one vehicle and this was not properly bagged or labelled.

- Re-usable equipment, for example splints and blood pressure cuffs, were visibly clean.

- Clean linen was available on all vehicles.

- On our second inspection visit we observed an ambulance which had been 'made ready', and therefore was ready to go to an event that day. This vehicle was visibly clean. We did observe a rip in the mattress on the stretcher, which was an infection control risk. The make ready operative told us they would swap this for a different mattress before the vehicle went to the event. On the whole, personal protective equipment was available on the vehicle; however, there was no alcohol hand gel.
- Linen and uniform was laundered via an external company. Should uniforms or linen be highly soiled they were disposed of and new items ordered. Clean linen was stored in sealed bags and labelled with 'I am clean' stickers.

Environment and equipment

- There was suitable secure storage for vehicles and equipment at the provider's base location. Premises were alarmed and there was CCTV in operation.
- Records of equipment maintenance and schedules were in place, including for vehicles and medical devices. The registered manager maintained records of vehicle

servicing, MOT and insurance and we saw records were complete and up-to-date. Equipment was serviced by an external contractor. A record was obtained of this and equipment was clearly labelled.

- We looked at three of the seven ambulances. On the whole these were well maintained and well equipped. We confirmed vehicle keys were held securely. We found:

- The outside of the vehicles appeared to be in good condition, with no visible damage. Doors functioned appropriately.

- There were seat belts and harnesses suitable for securing seated or lying patients during transport. However, on one ambulance a seat belt fastening was broken, meaning staff or patients would be unable to secure themselves in the back. There was no record of this being reported and when raised with the registered manager they had not been made aware. They said they would review this immediately. Equipment for safely securing children during transport was available in the store room, but was not readily available on the three ambulances we inspected.

- Ambulances were well equipped and equipment was safely stored. Sterile consumable items were stored appropriately, were in date and packaging was intact.

- Essential emergency and clinical equipment was available and there was evidence of regular servicing.

- Staff undertook vehicle equipment checks at the start of their shift and records were maintained.

- There were forms available for staff to report vehicle and equipment defects and we saw records which showed faults had been promptly rectified.

- Staff we spoke with told us they were happy with the condition of vehicles and equipment. They felt equipment was “on a par” with that used by NHS ambulance services. They also felt vehicles, although older, were considered to be safe and reliable. Staff said if equipment was faulty on site it would be taken off service and there was always spare equipment available to enable them to carry out their role.
- Consumables were stored in an orderly fashion within the secure storage. We did find some equipment which had expired, which we raised with the quality governance and safeguarding lead who removed it immediately. The resuscitation trolley, which we were told was checked before each event, also contained expired equipment. For example, a paediatric manual resuscitator expired in March 2015, over two years before our inspection. Two endotracheal tubes had expired in April and June 2017. The adult bag, valve and masks were not sealed and did not have an expiry date to show when they should be replaced. All out of date equipment was removed by the quality governance and safeguarding lead. There was no recorded signatory on the resuscitation trolley check or an indication of what equipment the trolley should contain.
- The storage of equipment posed a risk of injury to staff. We were shown the storage unit for the medical gases. Within this storage unit a large amount of equipment was stored. Equipment was stacked on high racking and included bulky equipment stored above head height. Some equipment would need to be moved to access other equipment. This posed a risk of injury through falling items and unnecessary lifting of bulky items.
- There was a contract to dispose of clinical waste. This contract involved a collection at least once every three months and could be requested more frequently as required. Staff would also deposit clinical waste bags at the receiving hospital to avoid the possibility of cross contamination through extended transportation of clinical waste. We were told sharps bins and clinical waste bags were not regularly labelled. Three out of four sharps bins we observed had not been labelled. The infection and prevention control policy states “all yellow bags should be sealed and labelled with the date and vehicle registration number where appropriate”. The policy does not clearly define this for sharps bins.

Medicines

- We were not assured of the proper and safe management of medicines. There was no evidence to confirm staff were suitably trained and competent, or had the relevant knowledge and skills, to undertake medicine related tasks required of them or to administer medicines.
- There were no patient group directions (PGDs) in place to provide a legal framework to allow the supply and administration of certain medicines to patient groups. A PGD is required for any prescription only medicine administered by paramedics or nurses that are not on the exemption list, for example salbutamol nebules and inhalers, glyceryl trinitrate and ipratropium. The provider’s ‘approved skill sets for staff grades –

medication use' identified paramedics and nurses were administering medicines without a PGD in place and technicians were being identified incorrectly as being able to administer medicines.

- Some medicines can be supplied and administered by all staff, for example oxygen, Entonox, glucose gel and paracetamol, but non-registered staff should have current training and a competency assessment. This training was not evidenced.
- Staff did not always record the administration of medicines on patient care records fully. We saw examples where only brief information about medicines was given, for example simply stating "neb" or "analgesia" with no times, medicine name or doses. This was not compliant with the provider's policy which states "recording accurately in the patient's clinical record the amount of drug administered, route and time of administration, relevant drug pack codes and details of any controlled drug wasted". There was also no information recorded that patients were given guidance on what they were given and why, or information about side effects.
- We were uncertain appropriate staff were administering codeine, a medicine used to treat mild to moderate degrees of pain. On review of patient care records we saw several where registered paramedics, nurses and non-registered technicians appeared to be administering codeine. They were completing and signing the patient care record and there was no evidence of the doctor's involvement or signature for these administrations. Codeine can be administered by a doctor, or by a registered paramedic or nurse with a PGD in place or a patient specific direction (PSD). The provider did not hold PGDs or PSDs and therefore only doctors could administer this medicine. The provider told us only doctors would administer this, however this was not evidenced within patient care records.
- Medicines were held securely within the storage unit. The senior team were able to access medicines by entering a code in to the keypad lock. The registered manager and operations manager were the only two staff who had access to the controlled drugs safe. A spare key was held by the registered manager.
- Processes were in place to replenish and rotate stock within the medicine bags. There were eight medicine bags which were stocked with medicines, each sealed with a tamper proof tag. We checked three random medicine bags and identified all medicines were in date and arranged orderly within the bag. We were told the bags were reviewed each month to remove expired stock.
- There was no documented system to sign in or out the medicine bags. The quality governance and safeguarding lead told us they were considering implementing a sign in and out process. The process at the time of inspection was the registered manager and other senior management staff would allocate the bags and know where each medicine bag was located and ensured they were collected at the end of each event shift.
- The registered manager was the accountable officer for controlled drugs. The provider had an appropriate controlled drug home office licence valid until 15 May 2018. This enabled the provider to possess and supply schedule two, three and four controlled drugs and supply schedule five controlled drugs. The licence identified the registered manager was an authorised witness to supervise the destruction of controlled drugs. The provider supplied us with a copy of their waste exemption certificate from the environment agency for the destruction of controlled drugs, however we noted this had expired on the 8 January 2017.
- The arrangements for storing and transporting morphine (a controlled drug) had not been risk assessed and the processes were not clearly documented within the policy and procedure for the use of medicines document. Morphine was stored securely at the base location. We confirmed the morphine stock balance and controlled drug register balance were consistent, and the controlled drug register was completed in line with best practice. When morphine was taken from base to event sites it was held in a locked safe by either the operations manager or the registered manager. This process had not been risk assessed. The controlled drug register remained with the travelling morphine and therefore there was no controlled drug register with the ampoules which remained at the base location. Morphine was signed out to paramedics and they were given a morphine pouch with five ampoules; however, the paramedics did not have a personal morphine book. When the paramedics administered morphine and disposed of any remaining this was recorded on a patient care record. Morphine pouches were signed back in at the end of a shift and any information from the patient care record was

recorded within the controlled drug register. The provider's policy states "there is an absolute requirement in law that each unit of morphine sulphate for injection purchased by Alliance-Pioneer Group must be accounted for from the point of ordering to the point of administration to a patient, or disposal either as unused or as out of date." There was a risk the current procedures in place did not enable compliance with this policy. The processes being carried out were not fully documented and there was no risk assessment to evidence the provider had considered safe security of the morphine.

- There were no assurance mechanisms of the systems and processes for managing medicines. The provider did not audit their medicines management. We were told random medicine checks and regular controlled drug checks were completed by the registered manager, however there was limited evidence of this.
- There was no record of expired or disposed of medicines. Out-of-date medicines were collected as part of the clinical waste contract. The lead nurse and practice development manager told us an audit trail for destruction was going to be implemented and the provider was waiting for the arrival of a book to record this information.
- Medicines, for example ibuprofen and paracetamol, were kept at base but not recorded within the medicines book. Receipts and withdrawals of these medicines from stock were not recorded. It is good practice for this to be recorded.
- The storage of medical gases was not safe. Storage did not comply with the; Department of Health HTM02 guidance on design and construction of a medical gas cylinder store or British Compressed Gas Association code of practice storage of gas cylinders . There was no risk assessment to ensure the chosen location for storage was safe. Staff told us the storage container was not well ventilated, which is not a suitable storage condition, the container was observed to not be well ventilated during the inspection. On inspection of the storage unit we also found there was no signage on the container to indicate medical gases were being held. Warning notices should prohibit smoking and naked lights within the vicinity of the storage. The storage unit was not on a level floor. Despite being propped up on bricks, there was a slight slope which meant there was a risk cylinders could fall over. The storage area was crowded and equipment was stacked high. Medical gases were stored with other equipment. A tyre was stacked just above the medical gases and had potential to drop on to them. There was also a fire risk with oxygen located next to combustible materials. Behind the medical gases was equipment which staff may need to access. The arrangements did not allow for staff to easily access medical gases and other equipment within the storage unit. There was no guidance for staff on the management of Entonox (a mixture of oxygen and nitrous oxide used for pain relief) and no reference to Entonox storage within the group's policy and procedure for the use of medicines. It is recommended that Entonox is stored at 10 degrees or higher for 24 hours prior to use, but where this isn't possible the cylinder can be inverted three times to ensure the gases are suitably mixed.

Records

- The provider maintained contemporaneous records in respect of each patient and these were stored securely. Patient care records (PCRs) were completed for all patients receiving care and treatment. For patients with a serious illness or injury requiring transfer to hospital, a carbonated record was completed and one copy was handed over to the receiving hospital. There was a PCR completion guide contained within the staff handbook to advise staff on how to record accurately and completely.
- Records were returned to the provider's base and filed securely. Records were kept for in excess of ten years. The registered manager told us they did not have a large amount of confidential records and therefore did not have a programme for destruction as storage was not an issue. However principle five of the data protection act says "personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or purposes". The provider told us they used an external contractor for destruction of confidential records.
- Each event supported by Alliance-Pioneer Group was audited and anonymised information was collected from patient care records and shared with event providers. This included, for example, patient numbers, presentations, treatments and numbers transported to hospital. The quality governance and safeguarding lead told us the audit required the scrutiny of patient records, although there was no internal reporting of the quality of record keeping.

- We looked at a sample of three patient records relating to patients who had been transferred to hospital. We found these were legible and provided a clear account of the patient's presenting condition. Records included baseline observations, which were repeated where necessary, and the care and treatment provided, including medicines given, consent to treatment and the reason for transferring to hospital.
- We reviewed a further 70 patient records where patients were not transported to hospital to review the quality of record keeping. Although this is not regulated activity there is potential that these patients could be transported to hospital if their health deteriorates and therefore these were reviewed as evidence of record keeping. We found these to be of variable quality. Four records were not signed and gave no information about who had provided the care, and five records gave no detail of the treatment given.

Safeguarding

- The provider was unable to evidence safeguarding training and compliance rates. The registered manager told us there was an assumption safeguarding training was completed as part of other NHS employment. We could not be assured staff had a suitable level of safeguarding adults and children training. This posed a risk staff were not up to date to enable them to recognise different types of abuse and the ways they could report concerns.
- A safeguarding vulnerable adults, children and young people policy was in place. This identified the responsibility of the safeguarding lead "to ensure the group is fully compliant with all safeguarding training requirements, and that all staff receive the appropriate level of training. That records are kept on the required training statistics." Therefore, the provider was not compliant with their own policy. The policy also stated "formal supervision sessions are held monthly for all staff in specialist roles to provide a forum for professional supervision of practice, support and continuing professional development". However, this was not being completed by the provider.
- Staff understood their responsibilities to safeguard patients and told us they were encouraged to be professionally curious. Staff spoken with were aware of the processes to follow to report a safeguarding incident and appeared confident in recognising and reporting safeguarding concerns. Ahead of an event the safeguarding contact details would be collated to ensure the provider had the appropriate telephone numbers to contact both in and out of hours. Staff were able to provide examples of when they had identified and reported a safeguarding concern and the exact processes they followed.

Mandatory training

- Staff did not receive mandatory training in safe systems, processes and practices. The provider was unable to evidence compliance with mandatory training. There was no training overview document to determine the modules, level and frequency of training required for each staff role. The majority of staff were employed in the NHS and the registered manager told us there was an assumption staff undertook relevant training with their main employer and therefore no internal training was provided. There were no systems in place to seek assurance or evidence from staff or their NHS employers that staff were up to date with their mandatory training. The seven staff files we reviewed contained little evidence of recent training. Furthermore, we identified 10 staff who held no current NHS or ambulance-related employment and there was no evidence they had undertaken recent training in safe systems, processes and practices.
- The provider told us as part of their provider information request submission "the provision of update/mandatory training is challenging for us as an organisation as our casual workforce are significantly committed to other employment duties." They also said "we don't currently have a mandatory training schedule that all staff need to complete to ensure they demonstrate competence in all the domains relevant to the Health and Social Care Act. Whilst we are fully aware that many of these staff receive mandatory training within their full time roles we still need to readily ensure that we are providing our own, organisationally relevant updates and training, particularly surrounding areas such as safeguarding and capacity to consent to care."
- The provider also told us about plans to provide a staff intranet to allow staff to access on line training "we are seeking to go live with a staff intranet site that will allow all staff to be able to access online e-learning around mandatory training needs, to include: safeguarding adults, young people and children, medicine management, capacity and consent, infection

prevention and control, BLS [basic life support] / ILS [immediate life support] / ACLS [advanced cardiovascular life support] and supported continuous professional development activities and support."
- There was no evidence to show staff were suitably trained, assessed and equipped to safely carry out manual handling activities. There was a reliance these skills were obtained through other healthcare employment.
- There were limited assurances of staff completing driving training, including being appropriately trained to drive under blue lights. Evidence was not obtained from the employee or their other employer to ensure this training was up to date.

Assessing and responding to patient risk

- The risks to patients were assessed and their safety monitored to identify the early risk of a deteriorating patient. We saw staff recorded patient baseline observations in order to identify or rule out serious or life threatening illness or injury.
- Staff told us patients were frequently monitored and rapidly assessed within event medical centres. This enabled decisions to be made with regards to whether patients needed to be transported to hospital for more specialist care. We were told patients with fractures were stabilised on the trolley, given appropriate pain relief and then immediately transported to hospital so not to delay their onward care.
- Staff told us they had access to medical advice on scene from an event-based doctor, or remotely through the local hospital emergency department. A recent example was provided of how the local hospital emergency department was contacted for advice.
- A pre-hospital sepsis screening tool, produced by The UK Sepsis Trust, was made available to staff to use for all adults over 16 years of age who were not pregnant. This flow chart prompted staff of the observations to complete and the indications for sepsis and immediate actions to take. The management team told us there was no sepsis training provided to staff and there was an expectation registered staff would receive this via their alternative employment.
- A transporting ambulance crew was always assigned to the medical centre to ensure there were no delays with patient transfers.
- A resuscitation team was allocated during events and would respond to resuscitation calls via the radio system.
- Staff told us they had no specific training to support violent patients but felt well supported at events, where they were likely to encounter people who were intoxicated with alcohol or other substances. They told us they were also deployed in pairs and were provided with radios so they could summon support from other staff, including security staff.

Staffing

- Staffing was planned and managed to ensure appropriate levels to meet patients' care and treatment needs. However, we were not confident of staff competency at recruitment and on an on-going basis to provide safe care and treatment.
- Staff were employed as casual workers on zero hours contracts. Staff supporting events included fist aiders, first responders, emergency care assistants, ambulance technicians, paramedics, registered nurses and doctors. Staff who worked under the regulated component of this service included the paramedics, ambulance technicians and emergency care assistants.
- Staffing levels and skill mix were planned and reviewed for each event. Rotas and shift patterns were arranged unique to each event. The provider used the Health and Safety Executive's medical risk assessment framework to assess the numbers of staff required for each role. Staffing would be based broadly on this framework and adapted as required. We were told contingency was built into the staffing. Staff told us staffing levels at events were appropriate and they felt well supported.
- Transporting crews were allocated on event sites; this was always two crew members including at least one paramedic. Crews would log via the radio system when they were off site and which hospital they were attending. This was updated on a map at control, which was colour coded to indicate if the crew were on a job, off site or available.
- Processes to ensure staff were suitably competent and skilled, on employment and on an ongoing basis, were not robust to assure the provider that staff could deliver safe care and treatment. The provider told us "we are not currently in a position to evidence each staff members competence assessed by our own standards".
- We were told by the registered manager most of the staff providing the regulated activity worked for the NHS

ambulance service or other NHS providers. However, on review of staff information we found 10 staff who did not undertake other NHS or ambulance-related employment. In the supporting information provided to us prior to the inspection, the provider acknowledged there was some assumption and reliance regarding employees' competence, based on their NHS employment. The provider recognised this was not supported by evidence of ongoing training and professional development. It was also recognised some staff did not have current alternative employment in clinical roles and therefore there was no assurance they remained suitably skilled and competent.

- Safe recruitment processes were not in place to ensure patients were safeguarded against unsuitable staff. Records for disclosure barring service (DBS) were incomplete and did not show when DBS checks were completed. The HR co-ordinator maintained a record of DBS checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. The registered manager acknowledged that records were incomplete and told us they were taking steps to rectify this. We asked how often DBS checks were required to be renewed. We were told that there was no policy to renew these checks. This meant the provider had not considered how on an ongoing basis staff remained suitable to work with vulnerable people. The provider did not tell us about the requirement for staff to inform them of any convictions.
- The HR co-ordinator checked staff's professional registration on employment and on an ongoing basis. A spreadsheet was maintained to show that all applicable staff were registered with the appropriate health professions regulatory body. This was complete and up to date.
- The HR co-ordinator maintained a record of staff's driving licences. This was incomplete and did not provide evidence of regular licence checks to verify that appropriate staff held current and valid licences.

Anticipated resource and capacity risks

- Anticipated resource and capacity risks were taken into account prior to attendance at an event. We saw examples of medical risk assessments and medical plans for three events. These documents provided an overview of the event, resources available and the command structure. Information and contact details were recorded for the local emergency departments and minor injury unit so staff were aware of the locations they could transport patients to. Event sites could be attended ahead of an event if the group were not familiar with the location.
- The anticipated risks were shared with staff. Safety briefings were completed at the start and end of each event. These incorporated the information within the medical risk assessments and medical plans. Printed copies of medical risk assessments and medical plans were made available to staff.
- Bigger events held safety advisory groups, co-ordinated by the event organiser. This enabled links to be made with the local ambulance trust to confirm the appropriate location to transfer patients with different clinical presentations. We were told local healthcare facilities were checked ahead of an event. For example, if the local minor injury unit had access to X-ray facilities patients could be transferred there to reduce pressures on the local emergency department.
- We were told contingency was built into the staffing to ensure there were enough staff should there be any impact on staff numbers.
- Alliance-Pioneer Group had a business continuity management plan (revised January 2017). This included the response to the loss of key personnel, loss of or inability to use company vehicles, loss of vehicle keys, and personnel not turning up for duty.

Response to major incidents

- We were told the response to major incidents was co-ordinated by the event provider, with Alliance-Pioneer Group co-operating as required. We saw an example of a medical standing order document on a vehicle, which was for a specific event and included the major incident arrangements.
- The registered manager was trained in major incident medical management and support (MIMMS). This teaches the nature and management of a major incident and how to deliver the medical support needed. We were told other members of the senior management team had attended or were in the process of attending the MIMMS course.
- All staff were equipped with haemorrhage kits within their responder packs. These were for the use in a major incident and ensured clinicians had quick access to kits if there were multiple traumas.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Evidence-based care and treatment

- Policies and procedures were based on the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. However, we were not provided with assurance staff who worked remotely had access to guidelines and protocols when they were changed or updated. The senior management team were also unable to locate some policies or procedures as they were not held centrally. The provider was developing a staff portal and hoped this would make policies and procedures accessible to all staff.
- Alliance-Pioneer Group was not using evidence-based guidance to measure themselves against clinical quality indicators and did not benchmark the service they were providing.
- The provider had adapted a collapsed athlete clinical response pathway, based on evidence-based care and treatment, which they used at marathon events. This pathway was designed to assist the rapid assessment and appropriate treatment of collapsed athletes, reducing morbidity and mortality. The senior team discussed how they would like to formulate more clinical decision pathways relevant to event medicine, for example the management of drug overdose. They commented how JRCALC was used for some of the clinical decisions; however, this was not targeted at events medicine.
- No other specific clinical guidelines or pathways were provided for staff. Not all clinical staff were registered clinicians, including those making decisions care and treatment. It was unclear how the group ensured all patients who needed transfer were transferred, or care given during transfer was in line with NICE and JRCALC guidance.

Assessment and planning of care

- Staff were able to access clinical advice from their peers, the on-site medical doctor or by contacting the local hospital.
- The transfer pathways for care were assessed prior to an event. This ensured patients were transferred to the most appropriate hospital. Senior staff told us patients were only transferred if they were not able to be managed effectively and stabilised at the event medical centre. Where possible, Alliance-Pioneer Group aimed to reduce the pressures on the local emergency department.
- Patients' pain was assessed and managed. Staff had access to appropriate pain medicine. We saw evidence in some patient care records of pain management, including the administration of pain relief. However, this was not always well documented.
- Clear protocols for patients who have a stroke or heart attack were not in place. Clinicians would follow standard NHS pathways, as used in their alternative employment or through their professional knowledge. Protocols weren't in place for different ages and patient groups.

Response times and patient outcomes

- Patients' care and treatment outcomes were not routinely collected and monitored. Therefore, there was no information for the provider to use to make improvements. We were told there was a 'hot debrief' with the clinical team following patient discharge to discuss what went well and how things could have been improved for effective delivery of care and treatment. This discussion was not documented and therefore learning was not shared with staff who were not present.
- The clinical lead and effectiveness manager, and the quality governance and safeguarding lead, told us about plans to look at the group's performance on clinical quality measures. There were no documented strategies or action plans to evidence this. They planned to set up pathways to follow which would enable auditable standards, however there was no planned timeframe for this.
- The quality governance and safeguarding lead told us they completed an audit against clinical presentations, for example asthma and diabetes. This was last completed for 2015/16. We requested a copy of the 2015/16 audit but this was not provided.
- The provider responded urgently to transport patients and would access the correct hospital facility as determined in the planning for the event. Transport crews were ring-fenced to ensure the timely transfer of patients to hospital.

- Following an event a clinical audit / activity summary was completed. This reviewed the clinical activity, clinical presentations and the interventions performed. However, it did not evidence the effectiveness of the care and treatment patients received.

Competent staff

- We were not assured staff were suitably competent, skilled, knowledgeable and experienced to enable them to meet the regulatory requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider recognised the gaps in their recruitment procedures and ongoing support for staff. Although they could tell us of the plans to address these gaps there was no formalised action plan and the identified risks had not been recorded.
- Staff received no formal induction on employment, although the HR co-ordinator told us new staff were allocated to work with experienced staff. Staff we spoke with felt comfortable they had been given time to familiarise themselves with vehicles, equipment and processes and were well supported by more experienced colleagues. One new staff member told us they had spent a day at the provider's base, familiarising themselves with the ambulances and equipment. Another new staff member told us they had gone through the staff handbook with managers and had been given the opportunity to 'shadow' a more experienced member of staff at an event.
- All new staff were issued with a staff handbook, which contained policies and procedures. They were required to sign a declaration to confirm they had read and understood these documents. We saw evidence of this on staff files.
- The HR and workforce manual stated new staff were subject to a probationary period of six months and would undergo a review meeting with their line manager after three months. We saw no evidence of this process taking place. The handbook stated an induction checklist should be completed during the probationary period to ensure all relevant information had been shared and understood. Again, we saw no evidence of this. The handbook was worded in such a way as to suggest it was not entirely applicable to Alliance-Pioneer Group and had been copied from another organisation.
- Staff training, learning and development needs were not being formally recognised. The provider was planning to put in place a training needs request so staff could ask for training for a specific training need. They were also planning annual updates and refreshers for core clinical skills and drop in learning sessions. There was no documented plan which included timeframes for implementation.
- Staff received no formal clinical supervision or performance appraisal and there was limited assurance all staff had access to opportunities for continuous professional development. There was an appraisal policy set out in the HR and workforce manual; however, the provider told us their ability to provide clinical supervision and appraisal was hampered by the nature of the service. The service was taking steps to address this gap. A practice development manager role had been introduced and a registered nurse appointed to this role. They were to obtain a formal qualification in clinical supervision, with a view to providing supervision, reflective practice and regular staff appraisal.
- The provider told us "assumptions around employees competence have often been made based on their previous or past NHS/clinical experience. We have, at time been guilty of this. These assumptions need to be avoided and we need to enhance the ways in which we continually assess and appraise the staff we regularly use to ensure they are practicing to the most appropriate and relevant clinical practice guidelines and that they feel safe, well and supported in the role they perform within the team. This is especially true of staff that have now left mainstream clinical practice, and as such are at significant risk of falling behind emerging evidence bases in relation to the safe and effective treatment of today's patients."
- There were no processes to support staff in their continued professional development (CPD). The provider recognised this gap and told us "we need to ensure, particularly in the private sector, that all health care professionals are regularly undertaking CPD to ensure their practice is current and up to date".
- Staff we spoke with told us there were opportunities during events for staff to share good practice, peer review and undertake reflective practice by means of peer support. This was not a formalised process and there was no documentation to evidence this took place.

- There were processes in place to check staff had maintained the appropriate and current registration with a professional body on an ongoing basis. We reviewed a spreadsheet confirming registration for staff.
- Staff in specific roles were not always experienced in these areas. For example, we spoke with the HR manager, who was also employed as an ambulance care assistant. They told us they had no qualifications in relation to human resources but they planned to do some relevant training in the future. We were later told by the provider how the role was a HR co-ordinator and this person was not at manager level. This was not consistent with the organisational structure shared with the inspection team.
- All staff received as a minimum 'first person on scene' training, which included basic life support and the safe administration of medicines.
- Staff were not provided with specific training to handle violence and disruptive behaviour from patients. The company stated they usually relied on event security when patients became violent.
- We were told poor practice was reported to the registered manager. The provider had a disciplinary policy within the staff handbook. This outlined the processes to follow to support staff if shortcomings or failures were identified. Staff worked on a casual contract and therefore there was no obligation to use these staff again if poor or variable performance was identified.

Coordination with other providers

- Staff described good relationships with local ambulance services and hospitals. Ahead of an event hospitals would be contacted, for example via an emergency department co-ordinator, to inform them Alliance-Pioneer Group were providing medical cover at an event and to explain their roles. Advice would also be sought from local ambulance services with regards to the most appropriate locations to transfer patients.
- If Alliance-Pioneer Group were unable to transport patients they would contact the local ambulance service, for example if an air ambulance would be the best form of transport.
- Patients were transported to the most appropriate service based on their needs. This included alternatives to an emergency department. One staff member told us how they transported a patient to a minor injury unit which had X-ray facilities as this met their clinical need.

Multi-disciplinary working

- Staff spoke of how the necessary registered clinical staff, including doctors, paramedics and nurses, were involved to assess, plan and deliver patients' care and treatment. Staff worked together to provide timely care and treatment.
- Staff told us when patients were discharged to hospital they held an informative handover to hospital staff. The patient care record was used to assist handovers and a carbon copy was provided to the hospital. A second copy was provided to the patient. Staff told us they were confident in this process as they had worked for NHS ambulance services and therefore applied the same principles. The registered manager told us "handovers have been receptive with local hospitals and we have good working relationships with trusts who we regularly visit."

Access to information

- The provider was reliant on the information provided from the patient to enable them to effectively assess and manage their care. Information was handed over verbally if patients moved between staff or if they were transported to hospital. This was supported by the patient care records.
- There was no central system for the senior management team to store documents, for example policies, procedures, recruitment checklists or audits. We found this information was not accessible when requested as they were saved on different staff computers. For example, the consent policy which should be readily available to all staff was only available on quality and safeguarding lead's computer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children

Acts 1989 and 2004. However, staff received no training in the Mental Capacity Act and there was no evidence in their staff files this had been completed through other employment.
- A 'staff guide to consent' was available within the staff handbook.
- Consent was well documented in the three patient care records where patients were transferred to hospital. In one case, where a patient was experiencing a psychotic episode and lacked capacity to provide consent, there was a clear explanation of the decision making process in respect of their immediate care and treatment. This was provided without consent in their best interests. The level of consent recording on other patient care records was variable.
- Staff could explain how patients were supported to make decisions. Staff spoke of managing the patient's care with their best interests in mind when patients lacked the mental capacity to make a decision.

Are urgent and emergency services caring?

Compassionate care

- In common with other ambulance services, Alliance-Pioneer Group had limited opportunities to capture patient feedback and we did not observe patient care during our inspection. Three staff, however, were able to describe events and situations which they thought provided examples of staff "going the extra mile" to provide kind, and compassionate care.
- One staff member told us about the care provided by colleagues to a patient who was taken seriously ill at a recent event. The patient received emergency treatment at the scene and throughout this time a first responder held the patient's hand and talked to them. Other staff, who were not directly involved in their care and treatment, took steps to prevent bystanders from watching the scene, to preserve the patient's dignity.
- Another staff member told us about a young person at an event who presented having a panic attack. The patient required no treatment but was given reassurance. The staff member spent a considerable amount of time with them and escorted them around the site to locate their parents.
- A third member of staff praised the genuine concern and care for the welfare of patients, often intoxicated and presenting with challenging or aggressive behaviour. They described how this concern extended to finding out how patients were getting home from the event.
- A doctor who worked with the provider told us "I wouldn't work for anyone else, it is reassuring to work for experienced staff. The personalities involved are appropriate. Care for patients is good and they look after the staff."
- The provider had a social media page where staff and patients could provide feedback. Recent patient comments included: "Couldn't ask for a better bunch of people to look after me...Thankyou you guys appreciate it" and "Big thank you …for looking after me after a fall and taking me to hospital. You were both very professional and reassuring."
- Female or male chaperones were available within the medical centre and when transporting a patient.

Understanding and involvement of patients and those close to them

- Staff told us how they always invited family and friends to come along when transporting patients. This was to enable support to be provided to the patient and to provide reassurance to the family member or friend. Staff explained how they tried to involve family and friends as much as possible.

Emotional support

- When speaking with staff they were able to tell us how they would provide emotional support to both the patient and their families or friends. One staff member told us about the importance of explaining to family and friends the response to drugs to indicate how their loved one was having a normal response. They explained how they would reassure them whilst also supporting the patient, as it could be traumatic to witness.

Supporting people to manage their own health

- We were told how patients were signposted to relevant support networks or treatment options once they were discharged from Alliance-Pioneer Group's care. This aimed to help patients to manage their own health.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The service provision was led by commercial need and event work was booked as required. There was an awareness of the events being covered and the likely patient groups at those events. This enabled the provider to predict the type of care and treatment that would be required. Post event audits enabled this information to be captured, including clinical activity, the clinical and diagnostic interventions and clinical presentations. For regular events the team were able to look at the presentation of themes over each year the event was held.
- The provider told us their medical provision at events aimed to save the NHS money and reduce the pressures on the local healthcare services by only transferring patients when required. The provider did their own calculations predicting savings to the local healthcare after each event within the post event audit by reviewing the cost to dialling 999, walking through the doors of an emergency department and X-ray investigations.
- The registered manager told us they were always networking and looking at what other providers were doing. Clinically they were looking at ways to improve to meet the needs of the patient group.

Meeting people's individual needs

- The needs of different people were not always considered when delivering care and treatment. The provider had areas of strength, for example in supporting patients in vulnerable circumstances when they have taken recreational drugs, and an awareness of patient mental health illnesses. However, there were areas which had not been considered, for example the needs of people with learning disabilities, or those who were deaf or blind or had difficulties in communicating.
- All staff spoken with were aware of the patient groups they would encounter at different events. For example, at a large number of the events there was a prevalence of drug use which was a major cause for seeking medical attention. There were trained drug counsellors to offer non-judgemental harm reduction and education advice, and to provide further details of support networks and treatment options.
- Staff told us they were able to signpost patients to mental health services, or refer patients to counselling. We were told how the senior management team would follow up patients with a phone call if there were any concerns.
- The provider was able to access translation support to treat patients who could not speak English. A language line could be accessed via the police liaison or event co-ordinator.
- There were no aids used to assist with communication with patients who had communication difficulties, for example through the use of picture charts.
- There were no processes to care for patients living with dementia. However, we were told patients living with dementia were not a common patient group and if they attended events they were normally accompanied by family members.
- There was no equipment to deal with bariatric patients. In these instances the local ambulance service would be contacted.

Access and flow

- The provider ensured resources were where they were needed to be at the required time. When planning for events, staffing was arranged and two crew members were allocated to emergency transport vehicles. The number of emergency transport vehicles was dependent on the event size and nature. Crews placed the post code of the local hospital into satellite navigation systems at the start of their shift. This enabled the provider to respond immediately in the instance where a patient required transfer from the event site to hospital.

Learning from complaints and concerns

- We reviewed with the operations manager one recent complaint. The complaint raised concerns about how staff dealt with a situation. The operations manager had appropriately drafted a response to the complainant which addressed why staff made the decisions they did and apologised for the negative experience the complainant and family had received. The response also identified how this would be used as a training and supervision opportunity. This was evidence of good practice in responding to a complainant and learning being identified. However, there was not a clear

auditable trail of the staff member concerned being spoken with, there was no evidence of the training and supervision required and how this would be implemented.
- There was an Alliance-Pioneer complaints procedure document. Due to the low number of complaints Alliance-Pioneer Group received, we were unable to review compliance against the provider's procedure.

Are urgent and emergency services well-led?

Leadership / culture of service

- The registered manager was the owner of Alliance-Pioneer Group and had previously worked for the ambulance service and the police. Their role was operational working on the day-to-day management of the group.
- The management team named the 'clinical directorate' consisted of the registered manager, supported operationally by the operations manager and the human resources manager. We were later told the human resources manager was not a manager and was a HR co-ordinator. The service had recently put in place additional managerial roles, which had yet to be developed. These were: a medical director (a GP and British Association of Immediate Care Schemes doctor), a clinical lead and effectiveness manager (a registered paramedic and lecturer in paramedic practice), a lead nurse and practice development manager (a registered nurse), and a quality governance and safeguarding lead (an ambulance technician and substance misuse specialist).
- We spoke with the clinical lead and effectiveness manager, lead nurse and practice development manager, and the quality governance and safeguarding lead. All three members of the management team were passionate about their leadership roles and were keen to undertake additional courses and training to ensure they had the appropriate knowledge and expertise to be role models within the Alliance-Pioneer Group.
- We held a phone conversation with the named medical director. They were not aware of this title they had been given and told us they did not provide regular governance support to Alliance-Pioneer Group. However, they worked with the provider on event sites and were available for phone contact for advice on an ad-hoc basis.
- Managers were described by staff as supportive and responsive to any concerns or operational difficulties. Staff told us managers were "very hands on" and were visible and accessible to them. They said there was always a duty manager, who could be contacted for advice and support.
- One staff member described Alliance-Pioneer Group as "a professionally run, patient-centred service". Staff described the pride they felt for the service. The company was described as "a big happy family" where staff worked well as a team and supported one another.
- Comments from staff on social media included: "a great company to work for with an expectation of high standards of professionalism from their staff. I can't recommend them highly enough" and "great management team and always look after the staff working for them".
- Staff told us emotional support, de-briefing and counselling was available to them following a traumatic or distressing event. Two of the senior management team were qualified counsellors and we were told staff could be given their contact details to contact them 24 hours a day, seven days a week.
- Staff spoken with respected the registered manager as "a good leader and always looks ahead" and a "highly competent business man who is passionate". We were told the registered manager would respond to staff and performance concerns and act in the best interests of staff and the group.

Vision and strategy

- There was no formalised vision or strategy for the service provided by Alliance-Pioneer Group. This is a private company and therefore the registered manager identified the priorities and the direction, taking into account income. The registered manager said they would ask the senior team for advice in their specialist areas and the senior team would help to implement any changes.
- Alliance-Pioneer Group felt they were "one of the best companies in the area for events" and wanted to continue to build on this reputation and be a "model of the private event sector." We were told how the provider

was considering the introduction of X-ray facilities for some events, which would require the provider being registered for a third regulated activity, diagnostic and screening procedures.

- In discussion with Alliance-Pioneer Group's senior team, they seemed to have a shared vision of the future aspirations of the group. However, there was no documented action plan or set timescales for achieving these. The senior team were enthusiastic and had lots of ideas about things they wanted to implement to improve the quality and safety of the service being provided. They talked about focussing on the specialist nature of their work and the opportunity to create new guidance for scenarios not covered in National Institute for Health and Care Excellence and Joint Royal Colleges Ambulance Liaison Committee guidance, for example for marathons.

Governance, risk management and quality measurement

- There was not an effective governance framework to support the delivery of good quality care. Approximately three months prior to our inspection there was an identified need for a clinical directorate team. This had been formed with a plan to hold regular governance meetings to discuss quality and safety. These meetings had not been implemented at the time of our inspection. We were told "we have established a highly skilled cohesive clinical directorate team that will now meet quarterly to review and promote best clinical practice and emergency best practice relevant to the work we do." Staff were chosen for senior management roles based on their knowledge and areas of interest. Talking to these staff they were clear about their responsibilities. They were keen to make improvements to the service and were able to identify where there were gaps.
- There was not a holistic understanding of performance. Safety, quality and activity data was not regularly captured to enable the provider to understand their performance and make improvements when needed.
- The provider was open with their struggles to evidence compliance against policies and assurances of staff competency. The clinical directorate team planned to look at their systems, strategies, policies and procedures, in line with evidence based guidance, to improve and be assured of the quality and safety of the service. There was no documented plan for this or timeframes for implementation.
- Comprehensive assurance systems were not in place and the service's performance was not measured. There were no key performance indicators to enable the service to benchmark themselves and review their clinical practice. There was limited internal or clinical audit. Senior management staff told us there was a subjective check of care and treatment but not a formal or auditable system; this did not allow them to identify trends or themes. The management team told us there was an aim to build appropriate key performance indicators in line with NHS standards, however there was no documented plan or set timescale for this.
- Policies and procedures did not always reflect what the provider was telling us. It appeared some policies were uplifted from other healthcare providers and not changed to reflect the service being provided. For example, in the disciplinary policy and HR and workforce manual there was reference to a Chief Executive, a role which does not exist in the Alliance-Pioneer Group's governance framework. In the complaints procedure there was reference to the local NHS ambulance trust. The incident management process followed NHS processes and referenced the review by the commissioner's patient safety quality team. However, Alliance-Pioneer Group is a private provider and is not commissioned by the clinical commissioning group.
- There were no arrangements to identify, record or manage risks. The provider did not hold a risk register or system to manage risks. When asked about provider risks the registered manager was unable to tell us what risks there were to the service they were providing. In the information provided to us before the inspection the provider was able to identify areas facing significant challenge in ensuring the quality care and patient safety. This included not being able to evidence staff members' competence and no mandatory training schedule. We would identify these as risks to the service which required mitigation and formal recording.
- Robust recruitment procedures were not being operated. Applicants were required to provide evidence of qualifications, professional registration (where applicable) and evidence of a check by the disclosure and barring service (DBS). They were also required to

produce their driving licence, evidence of the right to work in the UK and provide the names of two referees, one of whom was their current or most recent employer. The HR and workforce manual stated offers of employment were made on condition of these checks being satisfactory. The HR co-ordinator had produced a checklist to verify all recruitment processes and checks had been completed and were satisfactory. We looked at seven staff files, selected randomly. Some files had a recruitment checklist; however, these were not always completed and, for staff who had worked for the company for some time, there were no checklists and no assurance checks had been completed. There was no documentary evidence within staff files to demonstrate good recruitment procedures. The HR and workforce manual did not set out a process for ensuring relevant checks were repeated at regular intervals during employment.

- The HR co-ordinator described the recruitment process to us. Applicants were required to complete an application form and attend for an interview with the HR co-ordinator or the operations manager. This was described as a "chat" and was not recorded so there was no evidence on staff files of this process. This was not in accordance with the provider's HR and workforce manual (2013) which stated an interview panel would comprise of a minimum of two, and ideally three, people.
- We could not be assured the recruitment processes, as set out in the HR and workforce manual, had been followed. We reviewed seven staff files and all were incomplete. We did not see any offer of employment letters or contracts of employment and it was not clear whether staff were employed before relevant checks had been completed. We found the following gaps:

- three staff had no references

- four staff had only one reference, one of which was not related to ambulance work and one was from a work colleague

- two staff had no evidence of DBS or driving licence checks.

- There was no process to ensure that clinical staff declared their working arrangements outside of the service, and to ensure these were monitored to make sure staff were not working excessive hours that may adversely impact on the care and treatment being provided.

Public and staff engagement

- Public engagement was challenging, given the nature of this service. There were patient feedback forms held on each ambulance, and we were told these were sometimes given out at events. Feedback forms were not given to patients who were transferred to hospital, since they were seriously ill or injured. We were told these feedback forms were only introduced a week before our inspection and therefore information had not yet been collated.
- There was no formal route for capturing staff feedback. Staff feedback was not actively sought and recorded, however the provider felt staff were confident to raise concerns or feedback what went well on a regular and informal basis. At the end of events staff were asked if there were any issues or improvements and these were discussed amongst the staff group.
- The service had a social media page which captured some feedback from staff and patients.
- The provider told us how they asked the event organisers to complete reviews on the service they provided, however they had not received any official documented feedback to help them to improve the service they were providing.

Innovation, improvement and sustainability

- At the time of our inspection the Alliance-Pioneer Group website was being developed. We were told this would include a staff portal to ensure staff have access to information, policies and procedures, and training. The provider was hoping this would overcome some of the challenges presented by employing casual staff, which meant there could be difficulties in getting staff groups together.
- The provider told us how they have been in collaboration with the University of British Columbia in submitting research data into the effects, and appropriate emergency management of psycho-active substance misuse. The team attended the Mass Gathering Medicine Summit conference at the start of 2017, which shared best practice and clinical developments across the evolving specialism of emergency care. Alliance-Pioneer Group were the only UK organisation represented at this forum. Senior management staff spoke about their attendance at this

conference and how this was a big drive for improving the service they were providing. We were told improvements were being reviewed at present with an aim to implement towards the end of 2017.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Implement an effective governance framework to support and monitor the delivery of good quality and safe care.
- Have in place robust arrangements for identifying, recording and managing risks, issues and mitigating actions.
- Ensure staff are competent and experienced to provide safe care and treatment relevant to their role, and be able to evidence this.
- Ensure recruitment procedures meet the requirements of the Health and Social Care Act 2008.
- Ensure staff have undertaken the appropriate level of safeguarding training, and be able to evidence this.
- Ensure the safe management of medicines, including medical gases.
- Ensure incident reporting is given sufficient priority and is supported with adequate policies and processes to ensure learning opportunities are not missed.

Action the provider SHOULD take to improve

- Review all policy and procedure documents to ensure they are accurate and reflective of the processes required.
- Put systems in place to monitor the hours which staff work, taking into consideration their alternative employment, to ensure they do not work excessive hours, which may impact on the their ability to provide safe and effective care and treatment.
- Put systems in place to monitor and provide assurance of compliance with standards in relation to infection prevention and control.
- Review and replace all damaged coverings, for example mattresses, seats and steering wheels, to ensure it does not pose an infection control risk.
- Review the storage of equipment within the storage container to ensure it is safe and easily accessible to reduce the risk of injury.
- Consider a process for reviewing equipment, particularly resuscitation emergency equipment, to confirm it has been checked, is in date and suitable for its use.
- Ensure all clinical waste is clearly labelled and the policy clearly reflects this for clinical waste bags and sharps boxes. Clinical waste should be disposed of from vehicles in a timely manner to prevent the possibility of cross contamination.
- Consider the retention period of personal data and timeframes for destruction.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **12(1) Care and treatment must be provided in a safe way for service users.** **12(2) without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –** **12(2)(g) the proper and safe management of medicines.** There was no evidence staff responsible for the administration of medicines were suitably trained and competent. There were no patient group directions (PGD) to provide a legal framework to allow the supply and administration of certain medicines to patient groups. The arrangements for morphine (a controlled drug) had not been risk assessed and were not fully documented within the medicine procedure document.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.** **13(2) Systems and processes must be established and operated effectively to prevent abuse of service users.**

This section is primarily information for the provider

Requirement notices

The provider could not evidence staff had received appropriate levels of safeguarding adults and children training. This did not provide assurance staff were kept up to date to recognise different types of abuse and ways they can report concerns.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **15(1) All premises and equipment used by the service provider must be –** **(c) suitable for the purpose for which they are being used.** The storage of medical gases at the base was unsafe. The current storage arrangements had not been risk assessed.

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 **17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements.** **17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to –** **17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)** There were limited systems in place to review and monitor the quality and safety of the service being provided. There was no system of audit or benchmarking of the service against key performance indicators.

This section is primarily information for the provider

Requirement notices

Incident reporting processes were not embedded and there was no formal incident reporting system to record and report on incidents. We were told by the registered manager no incidents had occurred in the last 12 months. Due to the lack of a recording and reporting system, incidents over 12 months old, which staff said they had reported, could not be evidenced. We were concerned staff were not necessarily aware of what constituted an incident, and that they weren't encouraged to report them. This meant opportunities to learn and improve were potentially being missed. The incident management process document did not provide guidance to staff on how to report an incident or types of incidents to be reported.

(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

There was no risk management process. The provider did not identify and manage risks. During a discussion with the registered manager they were unable to tell us the risks associated with their service.

Regulated activity

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

18(1) Sufficient numbers of suitably qualified, competent skilled and experienced persons must be deployed.

18(2) Persons employed by the service provider in the provision of a regulated activity must –

18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.

We were not assured staff were suitably competent and experienced to enable them to meet all the regulatory requirements. There were no support mechanisms in place for staff. There was no formal induction programme to prepare staff for their role. The provider

This section is primarily information for the provider

Requirement notices

did not provide training to staff and could not evidence staff completion of training from their other employment. Staff did not receive clinical supervision or other means of supervision to ensure competency in their role. There was no programme of annual appraisal to regularly review staff performance and ensure they are appropriately skilled and experienced.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **19(1) Persons employed for the purposes of carrying on a regulated activity must –** **19(1)(a) be of good character,** **19(1)(b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them** **19(2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in –** **19(2)(a) paragraph (1)** **19(3) The following information must be available in relation to each such person employed –** **19(3)(a) the information specified in Schedule 3.** Recruitment procedures did not provide assurance staff had suitable skills and experience for their role. There was an assumption staff were suitable if they were, or had been, employed by another healthcare provider. On review of staff files there was little evidence appropriate checks had been completed.