Mr. Matthew Davey

Alliance-Pioneer Group

Quality Report

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Alliance Pioneer Groupis 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. The provider was also providing patient transport services to transport patients between hospitals.

We carried out this focused follow-up inspection in response to a number of concerns which were identified at our previous comprehensive inspection in August 2017. We carried out our inspection on 6 and 8 February 2018.

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.

This inspection focused solely on the issues identified at our previous inspection where significant improvement was required.

The service had made some progress in addressing some of our concerns.

We found the following areas where the provider needed to make improvements:

- There was no evidence of robust incident investigation processes or any learning from incidents.
- Incidents, complaints and concerns were dealt with in the same policy and it was not clear if the service understood the difference between a concern and an incident.
- A training spread sheet had been introduced however some key evidence for safeguarding and resuscitation training was missing for some staff.
- Patient Group Directions (PGDs) and Medicines Administration Protocols (MAPs) needed further development, including appropriate authorisation before use.
- Two operational staff did not have evidence to show competence in emergency driving.
- Not all staff had provided evidence of DBS checks and one member of staff's file did not contain this information.
- There was no evidence of any action planning following the staff risk survey or evidence of any other staff engagement.
- There was no evidence of any audit or scrutiny of recent care records at the time of the inspection.
- There was an outline audit schedule for 2018 but there was limited evidence of current audit and no evidence of any actions taken a result.
- There was no formal induction process or standardised induction programme for new staff joining the service.
- Not all policies had been updated and the infection prevention control policy was not service-specific.
- There was no system in place for the spot-checking of vehicles.
- There was no formal assessment of staff competencies, although some training and assessments were being planned.
- Terms of reference had not been established for the newly formed governance group and it was unclear how frequently the team were intending to meet.

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

- There was a live spreadsheet for the recording and documenting of reported incidents.

Summary of findings

- The provider had a comprehensive medicines policy that provided governance and guidance for staff.
- A medicines management training and competence package had been developed.
- Medicines and medical gases were ordered, stored, recorded and disposed of safely.
- Staff completed an infection prevention and control competence-based training booklet in the absence of training from their primary employer.
- Vehicle cleaning checklists had been modified to allow staff to record their initials against checks, but this had not been assessed yet to see if it was working.
- Managers had created a shared platform for key documents, but this was not yet accessible to remote staff.
- All permanent and contracted staff were to be offered appraisals, although this had not yet been implemented.
- The service held valid Disclosure and Barring Service (DBS) checks for most eligible staff and where cautions or convictions had been identified comprehensive risk assessments had been carried out.
- Professional registrations had been checked for all paramedics employed; however, no risk assessment was present for one paramedic with conditions against their registration.
- There was a new comprehensive risk register which contained details of current risks, reviews and actions and was to be reviewed as part of the new clinical governance group.
- Two senior managers had undertaken additional complaints training.

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 five requirement notices that affected urgent and emergency services. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care 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. Since our last inspection where we found a number of concerns, we found the provider had made some improvements to the quality and safety of the service it was providing. The provider was better assured of the competence of the staff they were employing through improved recruitment and monitoring, however, there remained a lack of assurance that the provider held evidence to demonstrate all staff had undergone appropriate employment checks and mandatory training, relevant to their roles. The provider was yet to establish any induction programme for new starters, and we remained unassured incidents were effectively being captured and acted upon. We also saw very limited use of audits as a tool to drive improvements in the service, and audits and risk surveys which had been undertaken, did not demonstrate ay actions or changes as a result. Steps had been taken towards the safe management of medicines and medical gases, however Patient Group Directions had still not been properly authorised before use.

Alliance-Pioneer Group

Detailed findings

Services we looked at

Emergency and urgent care.

Detailed findings

Contents

Background to Alliance-Pioneer Group

Mr Matthew Davey, who was also the registered manager, operates Alliance-Pioneer Group. 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 previously inspected the service on the 24 August 2017, which was a comprehensive inspection and announced two weeks prior to our visit. We visited again during the unannounced period on 1 September 2017.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, one other CQC inspector and a medicines optimisation specialist inspector. The inspection team was overseen by Daniel Thorogood, Inspection Manager and Mary Cridge, Head of Hospital Inspections.

Facts and data 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 Safe Store Building, Parkway Industrial Estate, Plymouth.

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the office base. We spoke with five staff including registered paramedics and management, as well as staff from the newly formed

clinical governance group. We did not speak with any patients or relatives. During our inspection, we reviewed 17 sets of staff records. We also inspected the main equipment store and resuscitation equipment.

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 four times. The most recent inspection took place in August 2017, which found the service was not meeting all standards of quality and safety it was inspected against.

The service employed 13 registered paramedics, nine paramedic technicians and 10 emergency or ambulance care assistants and also had a bank of temporary staff it could use. The accountable officer for controlled drugs was the registered manager.

Track record on safety since our last inspection:

- No reported never events
- One clinical incident graded no harm
- No serious injuries
- One complaint

Emergency and urgent care services

Safe	
Effective	
Well-led	
Overall	

Information about the service

The main service provided by this ambulance service was emergency and urgent care.

Summary of findings

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- There was no evidence of any action planning following the staff risk survey or evidence of any other staff engagement.
- There was no evidence of any audit or scrutiny of recent care records at the time of the inspection.
- There was an outline audit schedule for 2018 but there was limited evidence of current audit and no evidence of any actions taken a result.
- There was no formal induction process or standardised induction programme for new staff joining the service.
- Not all policies had been updated and the infection prevention control policy was not service-specific.
- There was no system in place for the spot-checking of vehicles.

Emergency and urgent care services

- There was no formal assessment of staff competencies, although some training and assessments were being planned.
- Terms of reference had not been established for the newly formed governance group and it was unclear how frequently the team were intending to meet.

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

- There was a live spreadsheet for the recording and documenting of reported incidents.
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- Managers had created a shared platform for key documents, but this was not yet accessible to remote staff.
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- Professional registrations had been checked for all paramedics employed; however, no risk assessment was present for one paramedic with conditions against their registration.
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- Two senior managers had undertaken additional complaints training.

Are emergency and urgent care services safe?

Incidents

- The safety performance over time remained difficult to determine, and since our last inspection there had been one incident which had been reported as part of a patient complaint against another company. We reviewed the incident investigation which consisted of a statement from one member of staff. We did not see any evidence of a formal investigation or any learning so we were not assured incidents were being captured and acted upon effectively.
- When things went wrong, thorough and robust investigations were not always carried out. We were told staff reported incidents by completing a paper incident report form in line with company policy. We reviewed one incident form and investigation, and found it to comprise of one staff statement, but it did not contain any evidence of any learning from the incident. At our last inspection, we found no record was being kept of any reported incidents, and paper forms had been destroyed after the incident had been dealt with. At this inspection, managers showed us a live spreadsheet that had been created to store details of incidents and any actions taken as a result of them, however there was nothing yet recorded as only one incident had been reported since out last inspection.
- Following our last inspection managers had carried out a staff risk survey which covered incident reporting, safeguarding, raising concerns and equipment and vehicles. The survey identified that 14.6% of staff had witnessed but not reported an incident which might have affected a patient. A further 62% of staff reported concerns over the mechanical worthiness of vehicles, 27% said they were unfamiliar with vehicle layouts and 19% of staff said they were unfamiliar with some equipment. We did not see any actions taken as a result of this survey.
- The senior management team told us incidents were managed verbally but actions were now recorded via the new incident records system. Incidents were still reviewed by the registered manager and then passed to

the relevant senior staff for further action. However, details of actions were to be fed back to the registered manager and recorded against the incident record on the spreadsheet.

- The incident management process document discussed in length the process for reporting and investigating serious incidents. At our previous inspection this had appeared to be relevant to NHS providers and not to Alliance-Pioneer Group. We had also found 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. A revised incident reporting policy had been written and was now specific to Alliance Pioneer Group. The policy contained details of the provider's responsibilities to notify certain incidents to CQC and other relevant external bodies where appropriate. Details of the incident reporting process for staff and the types of incidents staff should report was also contained within the policy. However, the policy also dealt with the complaints process, and it was not clear if the service understood the difference between a person reporting an incident and a person raising a complaint or concern.
- Staff did not understand their responsibilities to raise concerns, incidents, and near misses, and to report them. The staff risk survey demonstrated that some staff had witnessed near miss incidents but had not reported them to managers. The one incident which had been raised had come from an external source. This had not been reported by the staff member because no harm had come to the patient. Therefore, we were not assured staff or managers understood the benefit in recording incidents and near misses to improve the service.
- We reviewed one incident investigation that showed a patient had been contacted when something went wrong and offered an apology. The incident showed patient had been contacted verbally after a piece of equipment had moved during transport.
- The 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. Staff we spoke with were aware of their responsibilities regarding duty of candour. They were aware of the regulation and when to use it and understood the importance of being open and transparent with patients when things went wrong. At our previous inspection we had found no mention of duty of candour in any policies. This was not the case on this inspection, and we found the incident reporting policy made reference to duty of candour and clearly set out the responsibilities of permanent and contracted staff.
- Relevant safety alerts were cascaded to staff in emails and newsletters. At our previous inspection we saw no evidence to show this was happening, and there was no process to ensure staff were aware of updates and changes to policies. At this inspection, managers were able to show us posts from a secure social media page where managers posted links to updated practice, for example around the safe storage and use of pain-relieving medical gases.
- The provider reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Clinical Quality Dashboard or equivalent

- We had previously found there was no clinical quality dashboard or equivalent system to monitor safety performance. Since our last inspection, the governance team had established a governance dashboard. However, there was still a limited use of audit to monitor the quality and safety of the service being provided.

Mandatory training

- Staff received effective mandatory training through other employers and submitted evidence of this to the service. Where an employee did not have another employer to provide training, the service first pointed them in the direction of free training materials available online, for example Mental Capacity Act training. At our previous inspection we had found the service had not been monitoring training compliance, and had assumed training was undertaken by staff through their primary employers. Since then, the service had introduced a process to monitor staff compliance against seven key subjects, which was reflected in the service's recruitment and retention policy;

- Emergency driving
- Infection control
- Manual handling
- Medicines management
- Mental Capacity Act
- Safeguarding
- Resuscitation
- The provider assured itself that staff who were employed by both the NHS and the service were up to date with mandatory training. Managers held a spread sheet for all operational staff which showed copies of key training documents, such as medicines management, safeguarding and infection control, had been obtained. We looked at 17 staff files and saw copies of some documents had been taken. Managers told us training compliance was monitored on an annual basis, and staff were requested to submit evidence to show their training continued to be up to date.
- Compliance against mandatory training requirements had improved but we were still not assured it was being monitored or that the service was fully compliant. The service employed 13 paramedics and showed us evidence had been obtained for all mandatory training subjects for eight of these staff. For the remaining six paramedics, evidence had been requested, and managers told us this was chased on a monthly basis. However, resuscitation training was not included as a subject on the oversight spreadsheet. At our previous inspection, the service had been unable to demonstrate any oversight of mandatory training compliance for any operational staff employed.
- Managers showed us that since our last inspection, staff who had not provided all the required evidence of competencies had been restricted from working. At the time of our follow-up inspection, six paramedics, five technicians and two emergency and ambulance care assistants had been cleared to work. We reviewed these files and found two staff did not have evidence of formal emergency driving in their folders, although it had been requested from their primary employers. We also saw one paramedic who had not submitted a copy of their valid driving licence. We raised this with managers who contacted the paramedic to submit their licence before being allowed to undertake any further work.
- The service used the spread sheet as a training matrix however this did not show what level of training was expected for each role, so it was difficult to assess if the service held sufficient evidence for all operational staff employed.
- We reviewed seven paramedic files and found no evidence of any adult life support training in four of the files or paediatric life support training for five of the files. We escalated this and the lack of oversight of this training on the training spreadsheet, to the senior management team, who told us they would review all files to establish what life support training was missing and added an additional section to their spread sheet to monitor compliance with this training moving forward.
- The service also monitored training compliance for other operational staff, including technicians, and showed us evidence of compliance with all specified mandatory training subjects for all nine technicians employed. The service was able to demonstrate some compliance in mandatory training for emergency care assistants (ECA) and ambulance care assistants (ACA); however, all six ECAs were missing evidence of training in one or more subjects and four out of five ACAs were missing evidence of training in one or more subjects.
- The service did not ensure all drivers were appropriately trained to drive under blue lights. Evidence of training was only held for nine out of the 13 paramedics, although all other eligible staff, including technicians and ECAs, had provided evidence. For the four paramedics who had not yet provided evidence of training, three were awaiting evidence, and one had no evidence of training. Managers told us these paramedics were not permitted to work until they had submitted this evidence. However, we saw two staff who were currently working for the service whose files did not contain this evidence. Instead, both staff members had references written stating they were competent and had undergone training in the past. Since our inspection, both staff members have applied for copies of their driver training to show their competence.
- Managers acknowledged that certificates to demonstrate competencies were not a guaranteed assurance, and showed us emails from an external emergency driving assessor who they were arranging a training day with so current staff could have their driving skills formally assessed. This had not yet happened, but was due to take place in the next month.

- Staff were suitably trained to safely carry out manual handling activities and had provided evidence of this to the senior management team, in line with the service's recruitment policy. There was, however, no formal assessment of competence by the service.

Safeguarding

- The systems, processes and practices that were essential to keep people safe were identified and communicated to staff. The service had a policy and reporting process for staff to raise safeguarding concerns via the incident reporting system.
- There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation, and staff understood their responsibilities to follow safeguarding policies and procedures. All staff were required to have a minimum of level two training for both adults and children. The safeguarding lead had completed level three training, and was currently undertaking level four training.
- Staff who were contracted to work at the service undertook safeguarding training as part of their mandatory training with their primary employers. Senior managers held a training spreadsheet to show they had taken copies of certificates for all contracted staff. However, we reviewed 17 staff files and found evidence of child safeguarding training was missing from 10 of the files. Since our inspection, evidence has been submitted to show adult and child safeguarding training had been completed by six of those 10 staff.
- Staff had awareness of, and could identify and deal with, concerning situations at the locations they attended. Staff could describe the different types of abuse and also considered patients' mental capacity around the self-neglect category. This was also outlined in the updated safeguarding policy, which had been lacking this information at our previous inspection.
- The staff risk survey undertaken after out last inspection had shown 21.9% of staff answered "no" or "do not know" when asked if they knew how to report a safeguarding concern. We did not see any evidence of any immediate actions taken as a result of the survey; however, evidence of safeguarding training competency was being gained as part of the service improvements after our last inspection.
- There was an effective system in place for front line staff to report safeguarding incidents to the duty manager via a text messaging system. Staff were aware of their responsibilities to report safeguarding concerns and were required to submit a form at the end of their shift. The text message alerted the manager to the form, which they then raised with the appropriate local authority.

Cleanliness, infection control and hygiene

- The implementation of safety systems, processes and practice were not always monitored and improved when required. At our previous inspection, we saw the service was not complaint with its own policy for infection prevention and control. Since that inspection the service had re-issued a number of polices, however the infection prevention and control policy had yet to be updated. Managers told us there was a timeframe for this and expected this and any other outstanding policies to be re-issued before the summer and the start of any planned regulated activities. However, since our last inspection the service had begun carrying out some remote triaging work for GP practices. We were therefore not assured there was an effective infection prevention and control policy in place for staff to refer to.
- We previously found 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. At this inspection we found staff had now submitted evidence of training from their primary employer or an external training source. We also saw a number of staff had completed a competence-based framework workbook to demonstrate their understanding of infection prevention and control techniques.
- The systems in place to ensure vehicles were cleaned appropriately and safely were not always effective. 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. This policy had not yet been updated and re-issued. We saw in meeting minutes there had been discussions about how to implement a spot-checking system, however at the time of our inspection this had not been implemented. Staff were, however, now required to complete initial vehicle cleaning logs to remind them they were accountable for the checks. We did not see any audits to show if this had been effective.
- We saw in governance meeting minutes the service discussed using the 'cleaning standards (ambulance

trusts: vehicles)' developed by the National Reporting and Learning Standards (NRLS) and the National Patient Safety Agency (NPSA). We saw no evidence to show this was being used in practice. However, managers could describe the standards in detail and could explain which of them they currently could not meet, such as the standard for vehicles to have wipe-clean kit bags. In this instance, managers described their alternative deep-cleaning arrangements for their fabric bags. We did not see this captured in any policy because the infection prevention and control policy had not been re-issued.

Environment and equipment

- The maintenance and use of resuscitation equipment had been changed so it kept people safe. At our previous inspection we found the service held no records to show resuscitation equipment had been checked, and we found out of date equipment on the trolley. Since our last inspection, the service had implemented a detailed checklist, which was completed each time the trolley was due to be sent out for use. Between uses, the trolley was wrapped in film so items could not be removed. Staff who checked the trolley before use were also responsible for replenishing any stock and reporting any out of date items. We checked the records and saw instructions for checking the trolley were clear and the records were complete and up to date.
- The maintenance, use and storage of equipment kept people safe. At our last inspection we found the storage of medical gases was not safe, had not been risk assessed and did not comply with guidance. At this inspection, we saw all medical gases were stored safely in the vehicles and this had been risk assessed. Procedures and cylinder tagging were in place to ensure additional steps were taken to maintain the effectiveness of the medical gases at low temperatures. The medicines policy had been updated to reflect this. Vehicles were clearly marked to show they contained medical gases.
- At our last inspection we saw the storage of equipment posed a risk of injury to staff. We were shown the storage unit for the medical gases where a large amount of equipment was stored. Equipment was stacked on high racking and posed a risk of injury through falling items and unnecessary lifting of bulky items. At this inspection the registered manager confirmed this storage unit was no longer in use and had therefore been cleared.

Medicines

- The arrangements for managing medicine and medical gases had improved since our last inspection. We had previously found in August 2017, concerns surrounding the proper and safe management of medicines and medical gases. At this inspection we found medicines processes and policies had improved, however further improvements were needed to ensure the safe use of medicines.
- At our last inspection the provider could not give us assurance staff were trained and competent to administer the medicines available to them. At this inspection, a detailed medicines policy had been developed to provide support for staff. The provider had arranged medicines management training for all staff. Non-registered staff (such as technicians and responders) completed a taught, assessed course that ensured they were competent. Responder medicines bags were only accessible to responders who had completed the course and assessed as competent. There were plans to deliver short training sessions before each event, for example accurate completion of medications recording in patient clinical records.
- During our last inspection we found staff administered and supplied medicines without the correct legal authorisation of a Patient Group Direction (PGD). Paramedics and nurses require a PGD to administer any prescription only medicine not on the exemption list. At this inspection, we saw improvements had been made and several PGDs had been drafted. However, these PGDs required review and appropriate authorisation before being suitable for use. The medicines policy identified two prescription only medicines that could be administered by paramedics or non-registered staff, however appropriate authorised documents were not available to support their use.
- The implementation of safety systems, processes and practices were now being monitored and improved when required. At our last inspection we found the arrangements and security of controlled drugs when removed from the base location had not been risk assessed and off-site records were not kept. At this inspection, we saw paramedics completed personal

controlled drug record books and carried over entries to controlled drug register at the base. Entries in the controlled drug register were accurate and the authorised individuals checked stock levels regularly. Controlled drugs were ordered, stored, recorded and disposed of correctly.

- A more robust process for codeine administration was being implemented to ensure only doctors administered and recorded codeine. At our previous inspection we found codeine administration was not well recorded, and codeine was being signed for on patient care records by technicians, paramedics or nurses without a PGD. We were told codeine would now only be provided directly to doctors and staff would ensure doctors were responsible for both administration and recording on the patient care record, in line with company policy. We were also told codeine based medications were now stored in a separate, secure lock box and would only be available to registered doctors during events. However, we were unable to test the new processes for codeine administration as codeine had not been administered since our last inspection.

Records

- People's individual care records were written and managed in a way that kept people safe. At our last inspection we found patient clinical records were of variable quality and staff did not always record the administration of medicines. Since that inspection, the provider had limited their activity and therefore patients requiring medicines administration had not been conveyed to hospital. We did, however, review six patient records for patient transport between hospital or where a paramedic attended a patient at home for observations on behalf of a GP. These records were clear and legible and recorded the patient's medicine history, including allergies.
- The implementation of safety systems, processes and practices necessary to monitor patient record quality were not always improved when required. At our last inspection managers told us each event supported by Alliance-Pioneer Group was audited and anonymised information was collected from patient care records and shared with event providers. 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 found this still to be the case, and the service had not completed any further audit or scrutiny of any of its care records. Managers told us there was very little going on, however they had recently begun supporting a GP surgery by providing remote triaging for some GP patients at home. There was no evidence the care records created by these visits had been audited or scrutinised at the time of our inspection and we did not see any plans for this to happen.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation identified were used to develop how services, care and treatment were delivered. 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. At our previous inspection we were not provided with assurance staff who worked remotely had access to guidelines and protocols when they were changed or updated. Also, the senior management team were unable to locate some policies or procedures as they were not held centrally. Since that inspection, the provider had started using a secure shared database where all managers could access key documents, meeting minutes and audits; however, this was not accessible to remote staff at the time of our inspection.
- Alliance-Pioneer Group had begun developing clinical quality indicators but was not benchmarking the service they were providing yet. We saw discussions about clinical key performance indicators contained within meeting minutes, with the intention to test them against some GP related work undertaken in January; however, at the time of our inspection this had not been yet happened.
- At our previous inspection we saw the provider had adapted a collapsed athlete clinical response pathway, based on evidence-based care and treatment, which they used at marathon events. The senior management team were still discussing ways in which to develop more pathways and hoped the new governance dashboard would show them the most commonly seen conditions during events to help them focus on relevant pathways for the events they covered.

Emergency and urgent care services

Response times and patient outcomes

- Information about the outcomes of people's care and treatment was not yet routinely collected and monitored. Senior managers told us progress had been made to establish a set of clinical measures for the group to work against. At our previous inspection we had seen no documented strategies or action plans to evidence this. We saw that since that inspection discussion had been held in clinical governance meetings and a dashboard had been created. However, the service had not undertaken enough regulated activity to generate any data.
- There was an outline planned audit schedule for 2018. However, the one audit of medications stock which had been carried out contained no evidence of any planned actions as a result of the audit. Managers told us they were working on a schedule; however, we did not see any evidence of any discussion around this in any meeting minutes and it was not clear if the outline audit plan had been discussed or agreed by the clinical governance group.
- Previously, senior managers had told us they planned to set up pathways for the most commonly seen conditions, which would enable auditable standards. We saw the new clinical dashboard contained a table for the top four patient contacts; however, the service had no data to record yet. Managers told us that because their work was seasonal, they would have more data by the end of the summer.

Competent staff

- Not all staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment. Staff files contained copies of qualifications, professional registrations and evidence of mandatory training updates, which was in line with the service's recruitment and retention policy. However, we did see some files were missing evidence of training for safeguarding and life support. At our previous inspection we found the service did not hold any evidence to assure itself staff had the appropriate skills and knowledge for the jobs they were employed to do.
- At our previous inspection 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 had gaps in their recruitment procedures and staff files contained no evidence of interview notes. Since then, the service had implemented a new interview form, which we saw in every staff folder we looked at. However, because of the issues identified on the previous inspection, all recruitment had been halted so we were unable to fully assess the effectiveness of the process.
- A staff risk survey carried out after our previous inspection asked staff if they had any staffing concerns. Of the staff who responded, 26.8% said they had felt some staff were not qualified for the role they undertook. The survey also found that 31.7% of staff answered "no" or "do not know" when asked if they knew how to raise a concern about unsafe clinical practice. We did not see any actions taken as a result of this survey.
- Staff did not have standardised induction training appropriate to meet their learning needs. At our previous inspection we found the service did not offer a formal or standardised induction programme for new staff. This was still the case. Staff still received no formal induction on employment, although the HR coordinator told us they continued to allocate new staff to work with experienced staff.
- Staff competence of delivering patient care was not formally assessed by managers or supervisors. However, managers told us of plans to incorporate practical resuscitation training into event day down time, to gain assurances of staff competencies. Managers also showed us emails planning a driver assessment day for staff that drove using blue lights, although this had not been finalised.
- All permanent employees of the service were required to have an annual appraisal. For staff who were contracted to work, the service offered the opportunity to receive an appraisal. However, the provider's recruitment and retention policy said contractors were not obliged to accept appraisal invitations. Offers of appraisals were to be recorded in staff files and were to include the contractor's response if they declined the offer. Managers intended the appraisals to be a forum to identify gaps in training or additional learning needs, and had identified several sources of free online training staff could access. In the run up to our inspection, managers showed us a number of staff had come into the office to undertake some refresher training to update their staff files.

- The service ensured staff had maintained their professional registrations and had checked all staff against the current professional register. The registration period for paramedics was every two years, and managers told us they would recheck all current employees on an annual basis, in line with company policy. As part of the recruitment process, managers also required registration numbers, which they held on file, and we saw this had been done for all 13 paramedics employed. One member of staff was subject to some interim conditions of practice and when we asked managers if they had risk assessed this. They were unable to provide evidence, although were aware of the conditions and had informally assessed the risk. At our previous inspection we found the service was not monitoring whether current employees had up to date professional registration.

Access to information

- Operational staff who worked remotely did not have access to all of the policies and procedures they needed to do their jobs. Since our last inspection, managers had developed a shared files platform which could be accessed via a tablet or smartphone and allowed permitted staff access to see all policies, procedures and audits. At the time of our inspection only the managers could access the files, but there were plans to allow staff to access policies remotely, or to download them from the platform.

Are emergency and urgent care services well-led?

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- At our previous inspection we found there had not been an effective governance framework to support the delivery of good quality care. The service had previously identified a need for a clinical directorate team, which had since been formed with a plan to hold regular governance meetings to discuss quality and safety. The team had met three times since our last inspection and planned to continue to meet on a quarterly basis to review and promote best clinical practice and emergency best practice. We reviewed minutes from the last three meetings and found they showed evidence of discussion around safeguarding, operational issues and concerns. It was clear the meetings were still being embedded and senior managers told us they hoped discussions would become more meaningful as the workload increased over the summer.
- The governance framework and management systems had been reviewed and improved, but remained untested at the time of our inspection. The service had recently introduced a new clinical governance group which had met three times since our last inspection. Meeting minutes were structured and contained details of all concerns raised in the last inspection, including planned actions, completed actions, dates and owners. A governance dashboard had also been developed which captured incidents, complaints, regulated and unregulated activities, and types of patient contact.
- The governance framework and management systems were newly implemented, however we asked the senior managers how regularly they would be reviewed and improved. The Managing Director told us the quarterly governance group would be the forum for this process, however at the time of our inspection the clinical directorate team had not yet established any terms of reference for the group. It was unclear what the exact remit of the group was, and key details such as the meeting's minimum attendees had yet to be determined.
- Comprehensive assurance systems were improved but still not fully embedded. Governance meeting minutes mentioned some key performance indicators which were being applied to the new GP triaging work, however we did not see any evidence of these or what they measured. There remained limited internal or clinical audit. Senior management staff showed us one medicines audit which had been completed since our last inspection, but it was unclear what had happened as a result of the audit's findings. There was an outline audit schedule for 2018, which included some timescales, however we did not see how this plan had been developed and clinical governance meeting minutes contained no reference to it.
- At our previous inspection we found policies and procedures did not always reflect what was going on in practice. It appeared some policies had been uplifted from other healthcare providers and not changed to reflect the service being provided. At this inspection we found the service had reissued some polices for recruitment and retention, information governance,

safeguarding, medicines management, and incidents and complaints, which were now specific to Alliance Pioneer Group. Managers were open about the fact some polices had not yet been updated, such as the infection prevention and control policy, but we saw there was a plan for this to be done before the start of the seasonal work. The infection control policy, business continuity plan and vehicle and transport policy all still required updating.

- There were improved arrangements for identifying, recording and managing risks, which captured the main issues and mitigating actions. At our previous inspection we found there were no arrangements to identify, record or manage risks. The provider did not hold a risk register or system to manage risks. However, at this inspection we found the service had implemented a comprehensive risk register which captured all relevant risks to the service and patients. The register contained details of the risk, action taken, risk score, owner and review date.
- Recruitment procedures had improved since our last inspection but still did not give assurances that staff currently working for the service had been subject to all necessary checks. 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. We looked at 17 staff files and saw the service was not always gaining these assurances. Managers held a spreadsheet for all operational staff which showed when copies of key documents had been obtained. Of the 17 files we looked at, 13 were for staff currently working for the service. We looked at the 13 files and saw copies of some documents had been taken. Of the six paramedics currently undertaking work, one was missing a national insurance number, one was missing a valid driving licence and three had no references on file. One ambulance care assistant was missing evidence of C1 category driving licence, national insurance number, passport, DBS check and had no references on file.
- The service did not ensure staff had the required, valid DBS checks. We saw most operational staff had supplied evidence of their enhanced DBS check, with three paramedics and three ambulance care assistants (ACA) outstanding. Managers told us if a staff member was unable to provide evidence of an up to date DBS check, they were removed from duty until the evidence was supplied. This had happened with one paramedic, however we saw that one ACA had not yet provided evidence of a DBS check but had been carrying out work for the service.

Leadership of service

- Leaders had the skills, knowledge and experience they needed. We saw two of the senior managers had undertaken additional online training to deal with complaints. At our previous inspection we found some staff held positions they did not have qualifications or experience for and a subsequent review of staff roles had taken place.
- The management team, named the 'clinical directorate', consisted of the registered manager, operations manager and the human resources coordinator. At our previous inspection we found the service had put in place additional managerial roles, including a medical director, a clinical lead and effectiveness manager, a lead nurse and practice development manager and a quality governance and safeguarding lead. At this recent inspection, we found all roles had been appointed and developed except the medical director.
- Leaders understood most of the challenges to good quality care. However, they were not always able to identify the actions needed address them. This was evident in the recent medicines audit, which had been carried out since our last inspection. The survey had identified a need to revise current stock monitoring processes, but contained no plan or timeframe for this to happen. However, managers told us they planned to repeat the audit at the end of February 2018.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Make sure all staff have undergone all necessary checks to ensure they are competent to carry out their role and show evidence of this at the point of recruitment and on an ongoing basis, including safeguarding training.
- Have a clear incident reporting policy and be able to demonstrate effective investigations and learning.
- Ensure all staff have undergone all appropriate training for their role and establish a matrix to demonstrate this.
- Ensure all new staff complete an induction process.
- Give staff access to formal clinical supervision relevant to their roles.
- Continue to implement key performance indicators to enable the service to benchmark its performance.
- Ensure Patient Group Directions (PGDs) and Medicines Administration Protocols (MAPs) are developed and include appropriate authorisation before use.

Action the hospital SHOULD take to improve

- Ensure the new governance group has clear terms of reference.
- Ensure audits and risk surveys which have been undertaken demonstrate actions or changes made as a result.
- Develop an audit schedule for the coming year and make sure audits undertaken contain evidence of actions as a result of findings.
- Ensure all polices are updated to reflect current practice within the service.
- Establish a system for the spot checking of vehicles.
- Establish a way to gain practical assurance of staff competencies.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

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 – (b) doing all that is reasonably practicable to mitigate any such risks (g) the proper and safe management of medicines Incident reporting processes were not yet embedded and there had been no incidents reported by staff since our last inspection. We were concerned staff were not necessarily aware of what constituted an incident, and that they weren't encouraged to report them which was demonstrated in the result so a staff risk survey. This meant opportunities to learn and improve were potentially being missed. There was no evidence staff responsible for the administration of medicines were suitably trained and competent. Patient group directions which provide a legal framework to allow the supply and administration of certain medicines to patient groups had not yet been authorised for use.

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Requirement notices

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. The provider could not evidence all staff had received appropriate levels of safeguarding adults and children training and evidence was missing from HR files. 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 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 – (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) (b) asses, 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 a regulated activity.

This section is primarily information for the provider

Requirement notices

There were limited systems in place to review and monitor the quality and safety of the service being provided. Although work had progressed on a system of audit and benchmarking of the service against key performance indicators, this was yet to be implemented at the time of our inspection.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	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 – (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. Whilst progress had been made to ensure persons employed were suitably competent and experienced to enable them to meet all the regulatory requirements, we were not assured the provider held sufficient evidence for all staff currently undertaking regulated activities. There was no formal induction programme to prepare staff for their role. The provider did not hold sufficient evidence to assure us that all staff had undergone the training mandatory for their roles. The provider did not hold evidence of adult or paediatric life support training for a number of paramedics and did not hold evidence of emergency driving training for two paramedics currently carrying our regulated activities for the provider. One care assistant was also working for the company without evidence of a disclosure and barring service (DBS) check. Staff did not receive clinical supervision or

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Requirement notices

other means of supervision to ensure competency in their role. Although this formed part of ongoing discussions between managers in the governance group, it had not been implemented at the time of our inspection.

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 – (a) be of good character, (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 – (a) paragraph (1) 19(3) The following information must be available in relation to each such person employed – (a) the information specified in Schedule 3. Recruitment procedures did not provide assurance all 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. Whilst progress had been made, on review of staff files there was still key evidence missing and we were not assured appropriate checks had been completed for all staff currently undertaking regulated activities.